Training Series

Medicaid Participation & Organizational Readiness for Behavioral Health Providers

Training 2 Handout

Clinical Documentation, Workflow & Sustainable Billing Practices

Supporting Your Medicaid Journey

This handout includes supplemental links to websites, resources, reference materials, and templates designed to reinforce the concepts presented in Training 2. Use it as a guide to strengthen clinical documentation, workflows, and operational practices to support successful Medicaid participation.

Links & Resources:

Colorado Behavioral Health Provider Solutions (CBHPS)

Behavioral Health Administration (BHA)
Health First Colorado (CO Medicaid Program)

Colorado Department of Healthcare Policy & Financing (HCPF)
HCPF Providers
HCPF Provider Trainings
HCPF Regional Provider Support

- Region 2 (Boulder, Broomfield, Clear Creek, Gilpin, **Larimer,** Morgan, & Weld)
    - **Gennesis Quinonez -** Region 2 HCPF Provider Support Field Representative

HCPF Provider Portal
HCPF Behavioral Health Policies, Standards & Billing References

- Service Documentation Standards
- Treatment Planning Standards
- Rendering Provider Oversight (RPO) Policy
    - Including updates on the NPI requirement for all pre-licensed clinicians and unlicensed professionals, starting January 1, 2027
    - RPO Policy Attestation Document

State Behavioral Health Services Billing Manuals (Capitated BH Benefit)
Behavioral Health Billing Services (Fee-for-Service)

Colorado HB26-1195 Psychotherapy AI Restrictions

Regional Organizations (RAE) Information
Additional RAE Information (from Rocky Mountain Health Plans)
Rocky Mountain Health Plans (RMHP)-Region 1

- RMHP BH Provider Contact Email: rmhpRAE_BH_PR@uhc.com

Northeast Health Partners (NHP)-Region 2

- NHP BH Provider Contact Email: nhpRAE_BH_PR@uhc.com
- **Larimer County is in RAE Region 2**

RAE 1 & 2 Provider Manual

Colorado Community Health Alliance (CCHA)-Region 3

- Provider Assistance Request Form

Colorado Access (CO Access)-Region 4

Additional Tools & Tips:

CMS Screening Tool for Social Determinants of Health

Tip: HCPF frequently references the 988 number, and many behavioral health providers have included this caveat on their website/email/intake paperwork. The 988 number is not only a valuable crisis resource for your clients, but it can also protect your practice from liabilities related to after-hours emergencies.

- 988 Colorado Mental Health Line
- Feel free to utilize as needed:

Call or text 988, or chat online at 988colorado.com, if you or someone you know is struggling with an emotional, mental health, or substance use concern. The 988 Colorado Mental Health Line is available for free, immediate, human support 24/7

Documentation Templates (see below):

- Medicaid Initial Assessment Template
- Medicaid Treatment Plan Template
- Progress Summary Template
- Supervision Contract Template

SILVER LININGS COUNSELING

Medicaid Mental Health Assessment

Silver Linings Counseling — Clinical Documentation

*** Member Name**

*** Date of Birth**

*** Medicaid Number**

*** Address**

*** City, State, Zip**

*** Parent/Guardian (If Applicable)**

*** Phone Number**

Legal Status

- ○ Voluntary
- ○ Court Ordered

Emergency Contact Info

Employer or School

*** Date of Service**

*** Time of Service**

*** Duration of Service**

Referral Source

*** Source of Information**

*** Presenting Concern/Chief Complaint (include symptoms, intensity and duration) (Add SDOH HERE):**

Why are you here today?
How long have your symptoms been going on?
What is your goal with therapy?
Client Statement "----"

Cultural Assessment/Strengths

What do people like/admire about you?
Leisure time activities?
Primary systems of Support?
Family systems of Support?
What's your biggest strength?
Who can you talk to about difficult/happy times in your life?

Psycho-social History

Early Childhood - Development - Prenatal Events

Where were you born and raised?
Did your mother have issues during her pregnancy?
Did you reach development milestones?
Do you have siblings?
Birth order?

Current Psycho-social Situation

Current Living Arrangements
Interpersonal Family Relationships
Educational History

Where do you currently live?
How are your relationships with those you are close too?
What level of education have you completed?

Abuse History

Have you been sexually abused?
Emotional abuse?
Physical abuse?
DV relationship history?

Crime Victimization

Have you been a victim of crime:
Burglary?

Family History of Mental Illness/Drug Use

Tell me about your family drug use, mental health?

Current Occupational Assessment

Are you currently employed?
What do you do for a living?
Do you like what you do?

Military History: (n/a if client under 18)

Any involvement with Human Services

Have you as a child or as an adult have been involved with Social Services?
Do you have an ROI for SS?
Any out of home placement?
If yes, was it a foster home?

Custody Arrangements: (n/a if over 18)

Are there current court orders that I may need to know about?

Legal History

Have you ever been arrested, even if it was dismissed or plea deal was made?

Current Legal Status

Are you currently on Probation/Parole?
Do you have any "pending" legal issues? Civil, criminal?

Medical History: Current Issues, Allergies

Who is your Primary Care Doctor?
Do you have an ROI for this doctor?
What is your Pregnancy Status (if applicable)?
Have you been screened for Infectious Diseases (if applicable)?

Current Medications (type, frequency, dosage)

Mini Mental Status Exam

Presentation (include appearance, psycho-motor activity, manner/attitude)

Appearance
Age
Sex
Race
Body Build (Thin, obese, muscular)

Speech (include quality/quantity)

Rate? Slowed, long pauses, hesitant, rapid, pressured?
Rhythm?
Volume?
Articulation

Emotions (include mood, affect, impulse control)

Thought Process and Mental Status (include productivity, continuity, orientation, memory, attention/concentration, judgement, insight)

Associations
Coherence?
Logic
Blocking
Attention (concentration)

Thought Content (include preoccupations, perceptions, delusions)

Homicidal/Suicidal Ideation
Obsessions
Phobias
Ideas of Reference
Magical Ideation
Delusions
Other themes discussed by client

Somatic (include sleep, appetite, weight, energy)

Increase/Decrease

Previous Mental Health Diagnosis

Have you been previously diagnosed?
If so, what was that diagnosis?
By whom?

Previous Treatment Episodes and Responses

Have you had individual therapy/group/family?
How long was your treatment?
What was the outcome, positive, negative?
Did you meet your goals?
ROI

Family History of Mental Illness

Intellectual Functioning

Alcohol/Drug Assessment Current and Past

Tobacco Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, methods of use)

Alcohol Use (current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, method of use)

Other Drug Use (Current and historical to include amount and frequency, age first used, current frequency of use, frequency in past 6 months, methods of use)

Primary
Secondary
Tertiary

Previous/Current Abuse Treatments

Risk Assessment

History of violence toward self or others

History of Hospitalizations

Medical Concerns

Cause of Dangerousness

- ☐ Suicidal ideation
- ☐ Homicidal Ideation
- ☐ Grave Disability

If Suicidal Ideation

Suicidal Behavior

Ideation

- ○ Yes
- ○ No

Plan

- ○ Yes
- ○ No

Intent

- ○ Yes
- ○ No

Precipitants/stressors/interpersonal triggers

Change in current treatment

Access to weapons

Protective Factors

Internal (ability to cope, frustration, tolerance)

External (responsibility to children/pets, social supports)

If Homicidal Ideation

Identified Target

Notified/Duty to Warn?

Past assault history/legal history

Access to weapons/plant/intent

Psychotic disorder?

TBI

Cluster B traits/conduct

Substances

If Grave Disability

Medical concerns directly related to GD

Able to have this level at home through supports

Overall Risk Level

- ☐ High
- ☐ Medium
- ☐ Low

Crisis Plan (If Applicable)

*** Do you have an Advanced Directive (living will)? Indicate Y/N**

Yes No
Resources needed? Here's what to find the form online

*** Initial Diagnosis of Client (Completed under client profile, separately--> Required for billing) and can be changed at later date (For Diagnosis, Select New-->dropdown-->Diagnosis and Treatment Plan)**

Disposition Plan

Clinical Impressions

Referred to/ Recommendations

Signatures

Clinician Name and Credentials (printed)

Date

*** Clinician Signature**

Client/Minor Signature

Date

Guardian Signature

Date

*** Clin informed Cl that they can access their MCD information through the PEAK website at https://co.colorado.gov/colorado-peak or they can call the number on the back of their MCD card. Clients may also receive MCD documents via mail delivery.**

- [ ] Yes

*** Did therapist provide their contact info (direct email, direct phone number) to client?**

- ○ yes
- ○ no

Calendar reflects 90791

SILVER LININGS COUNSELING

Medicaid Outpatient Integrated Service/Treatment Plan

Silver Linings Counseling — Clinical Documentation

MCD Clients Seen Weekly

*** Is this Medicaid Client Seen Weekly?**

- ○ No
- ○ YES ----->Client MUST complete a PHQ-9 and a GAD-7 with every treatment plan

PHQ 9 Score:

GAD 7 Score:

Outpatient Integrated Service Plan

- ☐ Initial Service Plan
- ☐ Extension of Services
- ☐ Medication Only Status

Service Plan Start Date

Provider/Facility Information

Treatment plan must be completed within 14 days of intake. Please state reason if not present or complete.

Assessment review and tx plan update completed as needed, at least every 6 months for MHC and 12 months for independent providers, per Medicaid Requirements

Therapists Name

Phone

Email

Client Information

Client Name

Medicaid ID

Date of Birth

Diagnosis

Medications

Physician

Service Plan

Problem #1 (describe in functional/behavioral terms)

Current Problem Severity

- ☐ Very High
- ☐ High
- ☐ Medium
- ☐ Low
- ☐ Minimal

Consumer Strengths and Resources to address problem

Goal #1 (must be written in member's language)

Objective #1a (must be written with specific functional/behavioral and measurable terms)

Targeted Intervention #1a (include specific treatment modality and frequency measurable of service)

Target end date

Staff Responsible (with credentials)

Objective #1b (must be written with specific functional/behavioral and measurable terms)

Targeted intervention #1b (include specific treatment modality and frequency of service)

Target end date

Staff Responsible (with credentials)

Problem #2 (describe in functional/behavioral terms)

Current Problem Severity

- ☐ Very High
- ☐ High
- ☐ Medium
- ☐ Low
- ☐ Minimal

Consumer Strengths and Resources to address problem

Goal #2 (must be written in member's language)

Objective #2a (must be written with specific functional/behavioral and measurable terms)

Targeted intervention #2a (include specific treatment modality and frequency of service)

Target end date

Staff Responsible (with credentials)

Objective #2b (must be written with specific functional/behavioral and measurable terms)

Targeted Intervention #2b (include specific treatment modality and frequency of service)

Target end date

Staff Responsible (with credentials)

Case Management Plan (Purpose, Person, Agency, Goal)

Discharge criteria (specific functional/ behavioral criteria)

Member Comments

Signatures

Date

Clinician Printed Name

Date

Parent/Guardian Signature (required if member a minor)

If client is a minor, please describe how family/guardian will be involved to address child's issues or reason why their involvement is inappropriate

*** Calendar reflects H0032 + 90837 (Medicaid Treatment Planning)**

Clinician Signature

Client Signature-do this step after Clinician signs, select "SHARE" to have client sign

SILVER LININGS
COUNSELING

Progress Note

Silver Linings Counseling — Clinical Documentation

Medicaid Number (Only if Cl has Medicaid)

Location

- ☐ Teletherapy: phone (client at home)
- ☐ Teletherapy: video (client at home)
- ☐ Office
- ☐ Community
- ☐ Other (client not at home)

Encounter Type

- ☐ Teletherapy
- ☐ Couples/family Therapy
- ☐ Initial Intake/treatment plan
- ☐ Individual Face to Face
- ☐ EAP Session

Telehealth Protocol

- ☐ Verbal consent to telehealth
- ☐ Initial only: Nearest Hospital
- ☐ Initial only: Disconnect Plan Reviewed
- ☐ Initial only: Emergency contact reviewed/updated
- ☐ Verified Address
- ☐ Confidentially Breach keyword reviewed
- ☐ Other

Duration

Start Time

End Time

Major Presenting Symptoms

- ☐ Addiction
- ☐ Anger/Irritability
- ☐ Depression/Sadness
- ☐ Gender Dysphoria
- ☐ Guilt/Shame
- ☐ Hypersomnia
- ☐ Insomnia
- ☐ Isolation/Loneliness
- ☐ Lack of self-care
- ☐ OCD Sx/Bx
- ☐ Overwhelmed
- ☐ Physical Pain
- ☐ Poor impulse Control
- ☐ Restlessness
- ☐ Ruminations
- ☐ Other
- ☐ Anxiety/Worry
- ☐ Binging/Purging
- ☐ Fatigue/Lethargy
- ☐ Grief
- ☐ Hopelessness/Helplessness
- ☐ Hypervigilance
- ☐ Intrusive Thoughts
- ☐ Inability to make decisions
- ☐ Low self-esteem/Worthlessness
- ☐ OCSD
- ☐ Panic attacks
- ☐ Poor concentration or motivation
- ☐ Relational Problems
- ☐ Role Confusion
- ☐ Substance use
- ☐ Caregiver Stress

Major themes included

- ☐ Homework Assignment/Bibliotherapy
- ☐ Conflict in Relationship
- ☐ Stressors/Coping methods
- ☐ Traumatic Events
- ☐ Goals/Treatment Planning
- ☐ COVID-19 Restrictions
- ☐ Conflict with peer group
- ☐ Recovering from divorce/breakup
- ☐ Identity/Role Confusion
- ☐ Work/School Problems
- ☐ Childhood/Family of origin
- ☐ Substance Use
- ☐ Biopsychosocial Assessment
- ☐ Grief Processing
- ☐ Financial Worries
- ☐ Other Narrative

Treatments/Interventions/Techniques

- ☐ Anxiety Reduction
- ☐ Bibliotherapy
- ☐ Building Therapeutic Alliance
- ☐ CBT Thought Record
- ☐ Develop Safety Plan
- ☐ Developing Healthy coping skills
- ☐ Distinguishing What Happened and Narrative/Story
- ☐ Dreamwork/Analysis
- ☐ Encouraging Vulnerability to decrease Shame
- ☐ Five Senses Mediation
- ☐ Gestalt-based Technique
- ☐ Gratitude List
- ☐ Identification of Spiritual Resources
- ☐ Inner Critic Identification
- ☐ Linking to community resources
- ☐ Mindfulness
- ☐ Normalization/Validation
- ☐ Psychical exercise to improve mental health
- ☐ Psychoeducation
- ☐ Relationship Patterns Identification
- ☐ Solution-Focused/Strength-based problem solving
- ☐ Trigger Identification
- ☐ EMDR
- ☐ Assertive Communication Skills
- ☐ Biopsychosocial Assessment
- ☐ CBT Cognitive Distortions/Unhelpful Thinking Styles
- ☐ DBT Skills
- ☐ Develop Self-Care Plan
- ☐ Developing insight
- ☐ Drama Triangle
- ☐ Encouranging Engagement in Creative Endevours
- ☐ Establishing Boundaries
- ☐ GAD-7 Administration
- ☐ Goal-setting
- ☐ Grounding/Breathing
- ☐ Identify and Express Emotions
- ☐ Letter-Writing Exercise
- ☐ Making Meaning (Logotherapy)
- ☐ Motivational Interviewing (MI)
- ☐ PHQ-9 Administration
- ☐ Planning Day
- ☐ Reframing/Relabeling
- ☐ Role Play
- ☐ Tapping/Emotional Freedom Technique
- ☐ Values Identification
- ☐ Parts Work/Ego State/IFS

Assessment and Response

- ☐ Active and Engaged
- ☐ Mood: Euthymic
- ☐ Mood: Anxious
- ☐ Mood: Dysthymic
- ☐ Mood: Euphoric
- ☐ Dressed Appropriately
- ☐ Optimistic
- ☐ Psychomotor agitation
- ☐ Hostile
- ☐ Good eye contact/WNL
- ☐ Mood: Depressed
- ☐ Mood: Irritable
- ☐ Mood: Angry
- ☐ Mood: Happy
- ☐ Future-focused
- ☐ Tearful
- ☐ Resistant to Therapist feedback
- ☐ Assessment and Response Narrative

Status

- ☐ No S/I Reported
- ☐ No H/I Reported
- ☐ Substance Use Reported
- ☐ Auditory Hallucinations
- ☐ Visual Hallucinations
- ☐ Oriented X3
- ☐ Medication Change Reported

Progress Towards Treatment Goal

- ○ Significant
- ○ Moderate
- ○ Minimal Progress

Risks and Barriers to Treatment

Strengths

- ☐ Assertiveness
- ☐ Open-mindedness (Judgement, critical thinking): Thinking things through and examining them from all sides; weighing all evidence fairly
- ☐ Honors own word
- ☐ Kindness
- ☐ Self-advocacy
- ☐ Humility
- ☐ Spirituality
- ☐ Humor
- ☐ Problem-solving
- ☐ Other
- ☐ Curious
- ☐ Generates self-insight
- ☐ Brave
- ☐ Persistent
- ☐ Vitality/enthusiasm
- ☐ Socially Intelligent
- ☐ Forgiveness
- ☐ Hope
- ☐ Self-regulations
- ☐ Express Gratitude
- ☐ Assembles own care advocates

Homework Given

- ○ Yes
- ○ No

Plan

- ☐ Resume therapy in 1 week
- ☐ Resume therapy in 2 weeks
- ☐ Client will schedule next appointment using online portal
- ☐ No further treatment is planned
- ☐ Resume therapy
- ☐ Future Issues/Interventions

Referrals

Estimated Discharge Timeline (Select Range)

- ☐ 1 Week - 1 Month
- ☐ 1 Month - 3 Months
- ☐ 3 Months - 6 Months
- ☐ 6 Months - 1 Year
- ☐ Unable to assess
- ☐ Change Frequency to
- ☐ Discharge Today

Session Notes (include Current Mental Status ie. speech, attitude, affect, cognition, judgment), and/or EMDR notes

* Medical Necessity Factors influencing length a/o frequency of sessions to avoid higher levels of care or longer / more frequent outpatient sessions

MEDICAL NECESSITY OF SERVICE: The service provided is necessary and appropriate for the treatment of the diagnosed condition, to achieve symptomatic relief, decrease functional impairment, reduce symptom interference with functioning, avoid hospitalization or other higher level of care and to promote improved emotional and behavioral functioning, meeting accepted standards of care.

- ☐ Rapport Building with New Client
- ☐ History of trauma
- ☐ Time necessary to address and contain intense emotional content
- ☐ Necessary for the therapeutic intervention utilized in session
- ☐ Limited healthy support network
- ☐ EMDR Protocol being utilized
- ☐ Monthly sessions to maintain acquired skills
- ☐ IFS Protocol being utilized
- ☐ Assessment and stabilization
- ☐ Address complicated issues related to diagnosis and clinical presentation
- ☐ Reviewed Homework
- ☐ Exposure therapy for posttraumatic stress disorder, panic disorder, obsessive compulsive disorder, or specific phobia
- ☐ BPD diagnosis requiring DBT sessions
- ☐ Other
- ☐ Client request for additional session time a/o increased frequency
- ☐ Client Crisis / Acute Issues
- ☐ Preventative measures to avoid higher level of care
- ☐ Addressing new or re-emerging symptoms
- ☐ Client is unable to share content with others in support system due to nature of topic
- ☐ Bi-weekly Sessions
- ☐ Symptoms are impacting multiple domains of life (relationships, work, school, community)
- ☐ Significant trauma history necessitates additional time for disclosure and containment
- ☐ Grounding needed for symptoms that emerged during session
- ☐ Prevent Escalation to intensive level of care
- ☐ Parental involvement for psychoeducation or parent skills / Unexpected complication resulting from pharmacotherapy
- ☐ Chronic Pain
- ☐ Functional Neurological Disorder (FND)

* Calendar appointment reflects 90791/90837/90832 to for correct coding

- ☐ Yes

SILVER LININGS COUNSELING

Supervision Contract for Pre-Licensed Clinicians

Silver Linings Counseling — Clinical Supervision

** indicates a required field*

Document Review Process: Supervisor will review all clinical documentation through the Electronic Health Record Database (EHR). Current EHR utilized by practice as of 9/2/24 is Simple Practice. Simple Practice utilizes a SUPERVISION folder that will hold all files needing to be reviewed. Both Supervisee and Supervisor will sign files on a weekly basis. Documentation is recorded in the EHR calendar as well as a separate supervision log.

Interventions: Supervisee is required to present each client case file in both individual and group supervision. Supervisee is required to demonstrate evidence-based practices, ethical and legal issues in accordance with the policies and procedures manual.

Crisis Procedures: Supervisee will follow all crisis/emergency procedures outlined in the Policies and Procedures Manual.

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1. Purpose, Goals, and Objectives of Supervision

a. To fulfill requirements for Clinical Licensure.

b. To promote development of supervisee's professional identity and competence.

c. To ensure policies and procedures are followed accordingly.

d. To confirm proper documentation, treatment, and notes are completed in accordance with both practice and insurance policies.

2. Context and Content of Supervision

a. The content of supervision will focus on the acquisition of knowledge, conceptualization, and skills within the defined scope of practice.

b. The context will ensure understanding of ethics, codes, rules, regulations, standards, guidelines (including consent, confidentiality/privacy), and all relevant legislation.

3. Feedback

Feedback will be provided during each session. Notes will be signed by Supervisor during each session.

4. Rights and Responsibilities of Both Parties

Supervisor Rights:

a. To bring concerns/issues about Supervisee's work.

b. To question Supervisee about his/her work and workload.

c. To give Supervisee constructive feedback on his/her work performance.

d. To observe Supervisee's practice and to initiate supportive / corrective action as required.

Supervisor Responsibilities

1. To uphold ethical guidelines and professional standards.
2. To make sure supervision sessions happen as agreed and to keep a record of the meeting.
3. To create a supervision file containing supervision records and other documents relating to development and training.
4. To ensure that Supervisee is clear about his/her role and responsibilities.
5. To record the supervision session and to store their copy in the supervision file.
6. To monitor Supervisee's performance.

7. To set standards and assess the Supervisee against these.
8. To know what Supervisee is doing and how it is being done.
9. To deal with problems as they impact on the Supervisee's performance.
10. To support supervisee and the agreed personal development plan.
11. To complete all forms as mandated to DORA.
12. To have advanced training and experience in supervising unlicensed clinicians.

Supervisors must ensure that all client information be kept private and confidential except when disclosure is mandated by law. Supervisees should inform clients during the initial interview that their personal information is being shared in a supervisory relationship. Supervisors also have an obligation to protect and keep the supervisory process confidential and only release information as required by the regulatory board to obtain licensure or if necessary, for disciplinary purposes.

Supervisee Rights

1. To uninterrupted time in a private venue.
2. To Supervisor's attention, ideas and guidance.
3. To receive feedback.
4. To set part of the agenda.
5. To ask questions.
6. To expect Supervisor to carry out agreed action or provide an appropriate explanation, within an agreed time frame.
7. To have his/her development/training needs met in accordance with SLC guidelines.
8. To challenge ideas and guidance in a constructive way.

Supervisee Responsibilities

1. To uphold ethical guidelines and professional standards.
2. To be prepared to discuss client cases with the aid of written case notes and/or video/audio tapes.
3. To validate diagnoses, interventions, approaches and techniques used.
4. To be open to change and use alternate methods of practice if required.
5. To consult supervisor or designated contact person in cases of emergency.
6. Implement supervisor directives in subsequent sessions.
7. Maintain a commitment to on-going education and the counselling profession.
8. To maintain all required licensure/professional documentation in conjunction with DORA regulations.

Procedural Considerations

a. Supervisee's written case notes (plus diagnoses and treatment plans) and audio/video tapes may be reviewed in each session.
b. Issues relating to supervisee's professional development will be discussed.
c. Sessions will be used to discuss issues of conflict and failure of either party to abide by the guidelines outlined in this contract.
d. In the event of an emergency, supervisee is to contact supervisor. If not available, then an alternate practice supervisor will be appointed.

This contract is subject to revision at any time, upon the request of either the supervisee or the supervisor.

* I consent to the above supervision contract

Type your full name to sign