

List of SOQIC Forms

SOQIC Form Title	Form No.	AoD Forms
Demographic Information	SQ-04-010	Youth Admission Criteria
Health History Questionnaire	SQ-04-020	Recommendations for Treatment
Crisis Intervention Assessment and Plan	SQ-04-030	Youth Continued Stay/Transfer Criteria Youth Discharge/Transfer Criteria
Adult Diagnostic Assessment	SQ-04-040	Adult Admission Criteria
Adult Diagnostic Assessment Update	SQ-04-045	Recommendations for Treatment
Child/Adolescent Diagnostic Assessment	SQ-04-050	Adult Continued Stay/Transfer Criteria Adult Discharge/Transfer Criteria
Child/Adolescent Diagnostic Assessment Update	SQ-04-055	
Mental Status Exam (MSE)	SQ-04-060	
Lethality Assessment	SQ-04-070	
Initial Psychiatric Evaluation	SQ-04-080	
Individualized Service Plan	SQ-04-090	
Individualized Service Plan Revision/Review	SQ-04-095	
Psychiatric/Pharmacological Management Plan	SQ-04-100	
Medical Somatic/Psychiatric Progress Note	SQ-04-110	
Medical Somatic/Nursing Progress Note Long	SQ-04-120	
Medical Somatic/Nursing Progress Note Short	SQ-04-125	
Individual Progress Note	SQ-04-130	
Community Psychiatric Supportive Treatment Progress Note Long	SQ-04-140	
Community Psychiatric Supportive Treatment Progress Note Short	SQ-04-145	
Group Progress Note	SQ-04-150	
Partial Hospital Progress Note	SQ-04-160	
Transfer/Discharge Summary	SQ-04-170	

Section 4

Instructions for Using the SOQIC Forms

Introduction

We recognize the delivery of quality mental health services is dependent on good clinical practice, qualified and skilled clinicians and the relationship that is established between the client and clinician. This relationship emerges from face-to-face interaction, in a manner that is a good fit for the client/family and clinician.

The SOQIC forms toolset was designed to facilitate, not dominate, this interaction. Some portions of the forms can be completed prior to meeting with the client to help the Provider to prepare for the session. The forms prompt the Provider to document information that is required to appear in the client's record to support medical necessity, compliance with rules, regulations and clinical standards. The forms also help Providers demonstrate that services are being delivered within a framework of recovery and self-sufficiency with the goal of enabling a client/family to live a full life, while managing a chronic illness.

The SOQIC forms are intended to support and complement all aspects of Provider Agencies' good clinical practices and to:

- Simplify the record keeping
- Promote client-clinician interaction by reducing the amount of redundant information that is gathered
- Provide a good record over time for the Provider to assist a client/family in the recovery process

The purpose of this section of the training manual is to give Provider Agencies succinct and helpful information regarding the use and completion of the SOQIC forms.

Welcome to a new generation of easy-to-use clinical

documentation, that supports the delivery of quality, recovery-based, person-centered, mental health services that are compliant with payer and accreditor rules and regulations.

Form Titles

The intent of the SOQIC initiative was to make the forms usable by both mental health providers and alcohol and drug addiction providers. Therefore, the names of forms do not necessarily match the names of specific services as defined in the Ohio Administrative Code. For example, the Diagnostic Assessment Forms – Adult or Child - will accommodate both *Mental Health Assessment* and *Alcohol or Other Drug Service Assessment*; the Medical Somatic/Nursing Progress Note fulfills requirements for both mental health (*Pharmacological Management*) and AoD (*Medical-Somatic*) services. Additional cross-references appear in the *Service Standards and Forms Summary* following the *ODADAS Requirements* section below.

ODADAS Requirements

The SOQIC forms toolset was designed to be compliant with rules, regulations and accreditation standards for ODADAS as well as ODMH. (*See the Compliance Grids in the Appendix for specific information*).

ODADAS providers have some additional documentation requirements and will need to use additional ODADAS forms; samples of which are located at the end of the SOQIC forms section.

- To document Level of Care Criteria use these ODADAS forms:
 - Youth Protocol Level of Care
 - Admission Criteria
 - Continued Stay Criteria
 - Discharge / Transfer Criteria

- Adult Protocol Level of Care
 - Admission Criteria
 - Continued Stay Criteria
 - Discharge Criteria
- To document Intensive Outpatient Program (IOP) use the SOQIC Group Progress Note.

ODADAS certification standards define this service as a distinct service with specific documentation requirements, which are not covered in the SOQIC documents.

Additionally, ODADAS defines specific activities that do not require progress notes, but do require documentation verifying the client's attendance. These activities include: parenting skills training, alcoholism and drug addiction client education, nutrition education and urinalysis.

A sample form for documenting these specific activities is included with the ODADAS forms. (*Refer to OAC Rule 3793:2-1-06 (O) for documentation requirements.*)

SOQIC Forms and MH/AoD Service Standards Summary

SOQIC Form	Mental Health Service	AoD Service
Crisis Intervention Assessment and Plan	Crisis Intervention MH Service (5122-29-10)	Not Used
Diagnostic Assessment (Adult or Child) and Diagnostic Assessment Update (Adult or Child)	Mental Health Assessment (5122-29-04)	Alcohol and/or Other Drug Service Assessment (3793:2-1-08(K))
Initial Psychiatric Evaluation	Psychiatric Diagnostic Interview (5122-29-04)	Not Used
Individualized Service Plan (ISP) and Individualized Service Plan (ISP) Revision/Review	Individualized Service Plan (5122-29-05)	Individualized Treatment Plan (3793:2-1-06(K))
Psychiatric Pharmacological Management Plan	Pharmacological Management (5122-29-05)	Not Used
Medical Somatic Progress Note and Medical Somatic Nursing Progress Note	Pharmacological Management (5122-29-05)	Medical/Somatic (3793:2-1-08(S))
Individual Progress Note	BH Counseling and Therapy (5122-29-03)	Individual Counseling (3793:2-1-08(N)) Case Management (3793:2-1-08(M)) Crisis Intervention (3793:2-1-08(L)) Family Counseling (3793:2-1-08(P))
Community Psychiatric Supportive Treatment Progress Note	Community Psychiatric Supportive Treatment - Individual (5122-29-17) Community Psychiatric Supportive Treatment - Group (5122-29-17)	Not Used
Group Progress Note	Group Counseling BH Counseling and Therapy (5122-29-03)	Alcohol and/or Other Drug Service Group Counseling (3793:2-1-08(O)) Intensive Outpatient Program (3793:2-1-08(Q))
Partial Hospitalization Note	Partial Hospitalization (5122-29-06) only	Not Used
Transfer/Discharge Summary	Discharge Summary (5122-27-07)	Termination Summary (3793:2-1-06(P))

General Instructions for the SOQIC Forms

Completing Forms

It's important for every field (element/question) included on a form to have a notation in writing, to evidence the fact that the subject matter and its relevance to the client was considered by the Provider.

Most legal experts advise that it is best to avoid blanks on medical forms even when information requested is not relevant to the client/patient. To support this, most organizations have adopted documentation conventions for indicating that certain information being requested in a form does not apply to a client.

When developing the SOQIC forms some conventions were used to assist the Provider in easily and appropriately documenting certain information. These conventions are:

- Not Pertinent
- None Reported
- Not Clinically Applicable or Not Clinically Appropriate

Using *Not Pertinent*

In a clinical situation, *Not Pertinent* would indicate that the information being sought is not appropriate and is not important to the clinical picture of

the client being evaluated. Rather than explaining why, you would simply use the terms *Not Pertinent* as a form of shorthand for completing that element.

In many cases, using *Not Pertinent*, presumes that you already have some knowledge/information of the client, and that because of that information you can assess if the additional information being requested is pertinent. Examples are shown in the table at the bottom of this page.

Using *Not Clinically Applicable* or *Not Clinically Appropriate*

In some cases the information being requested from the client is not applicable because of the particular clinical situation of the client and/or the level of care being considered. In these cases, *Not Clinically Applicable* is used. For example:

- In an emergency situation, it is *Not Clinically Applicable* to the care being given to know and understand the client's ability to function in social and recreational settings. At the community support level, however, this would be a *clinically applicable* and an appropriate area of concern.

In other cases, clinical applicability is not the issue, but appropriateness is. Certain levels of care are *Not*

Question / Element	Client Response / Provider Knowledge	Notation on Form
Marital Status	Client states that he is single and has never been married	Single
Describe Client's Relationship with Spouse	Provider knowledge based on previous response	<i>Not Pertinent</i>
Gender	Male	Male
Pregnancy History	Provider knowledge based on previous response	<i>Not Pertinent</i>
Toxicology Screen	Negative	Negative
Current Usage of Illegal Drugs	Provider knowledge based on previous response	<i>Not Pertinent</i>
Age	85 years	85
Future Employment Plans	Provider knowledge based on previous response	<i>Not Pertinent</i>

Clinically Appropriate. For example:

- In a floridly psychotic person, Outpatient Individual Therapy is *Not Clinically Appropriate*, but a partial hospital program might be. Completing an Outcomes Survey on a very paranoid individual is *Not Clinically Appropriate* in many cases, because it might exacerbate the individual's symptoms. If a clinician suspects that a client has been abused, but that the client's situation is too volatile to explore this, *Not Clinically Appropriate* might be documented in this section of the assessment with an explanation of why.

Using *None Reported*

In many clinical situations, the Provider:

- Must rely totally on the information reported by the client because there is no independent or objective means for determining whether or not the information is true or false
- May not have the relevant training or clinical skills to make an independent determination

In these cases, the term *None Reported* should be used instead of alternative documentation that suggests that the Provider has determined through their interview process that a situation, risk or historical fact does or does not exist.

Example One

Question: Does client have any suicidal ideation? *No*

In this example, the documentation suggests that the provider interviewed the client, evaluated the situation, and made a determination that suicide is not a risk for this client at this time.

Example Two

Question: Does client have any suicidal ideation? *None reported*

In this example, the provider is not making a determination of risk or of the existence of suicidality, but is instead reporting factually that the client states that he/she is not currently experiencing suicidal ideation.

Although *None Reported* is a term that can be used throughout the SOQIC documentation where the Provider believes it is appropriate, there are certain elements where *None Reported* is a checkbox option in the forms. These areas were carefully chosen. They appear in key areas where it is often difficult to make an independent or objective determination but where, for risk management purposes, it is important to document that the issue was considered and the client's response, be it negative or positive, was elicited. Some of the areas include suicidality, homicidality and abuse history.

Completing Client Name and Client Number on Multi-page Forms

It's also important for all multi-page forms to have client-identifying information on each page. The *Client Name and Client Number (No.)* fields appear on every page of multi-page forms.

The instructions for completing the *Client Name and Client Number (No.)* on all SOQIC forms appear below.

- Complete both Client Name and Client Number on the first page.
- Complete Client Name **and/or** Client Number on subsequent pages, in accordance with Agency Policy.

Instructions for Completing the Client Name and Client Number

Data Field	Identifying Information Instructions
Client Name (First, MI, Last)	Record the client's first name, last name and middle initial. Order of name is at agency discretion.
Client Number	Record your agency's unique identifier number for the client, or record the MACSIS UCI Number.

Completing Billing Strip Information

A *Billing Strip* appears on the bottom of the last page of each form for services that are subject to reimbursement. A sample *Billing Strip* and instructions

for completing the *Billing Strip* follow. These instructions do not appear in the individual form instructions in the Training Manual.

Standard Billing Strip Sample

Date of Service	Staff ID #	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code
Client Name (First, MI, Last)										Client No.	

Instructions for Completing the Billing Strip

Data Field	Billing Strip Completion Instructions
Date of Service	Enter date of session/service provided.
Staff ID No.	Enter the staff identification number for the staff member delivering the service.
Location Code (Loc. Code)	Enter Location Code of the service. Refer to your agency's billing policies and procedures for determining which code to use.
Procedure Code (Prcdr. Code)	Enter the procedure code that identifies the service provided and documented. Refer to your agency's billing policies and procedures for determining which code to use.
Modifier 1, 2, 3 and 4 (Mod 1 thru 4)	Enter the appropriate modifier code to be used in the first position. Refer to your agency's billing policies and procedures for determining which codes to use for Modifiers 1 - 4.
Start Time	Indicate actual time the session started. Example: 3:00 p.m. <i>Note: For Partial Hospitalization, record start/stop times on each intervention, not on the Billing Strip.</i> <i>Note for Crisis Intervention Assessment/Plan: Record the start time of the initial billable intervention with the client. In most cases, this is the time of the first face-to-face contact with the client. Some payers may reimburse for initial phone calls and other interventions prior to any face-to-face contact.</i>
Stop Time	Indicate actual time the session stopped. Example: 3:34 p.m. <i>Note for Crisis Intervention Assessment/Plan only: Leave this field blank.</i>
Total Time	Indicate the total time of the session. Example: 34 minutes <i>Note for Crisis Intervention Assessment/Plan only: Record the total time of all interventions provided as part of this Crisis Intervention. This includes time spent completing the crisis assessment, the crisis treatment plan, and other billable interventions included in the overall crisis intervention.</i> <i>Note for Partial Hospitalization: Total the time of all interventions on this note.</i>
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Use either DSM-IV or ICD-9 (or successor) code as determined by your agency's billing policies and procedures.
Client Name/ Client Number	If needed for your agency's billing purposes, enter client name and or client number.

General Medicare “Incident to” Services Only Information

“Incident to” billing is a method of Medicare billing. It is a very useful tool for Providers to use to increase access for Medicare clients to community mental health services that are provided:

- As ordered in a treatment plan developed by a Physician, APRN, or Psychologist, who is the attending professional. The services ordered *must be within* the scope of their license to provide. For example, psychologists cannot order nursing or medical services.
- With the on-site supervision of a supervising professional, who can include Physicians, APRNs, or Psychologists. The supervising professional must:
 - Be licensed to provide the service they are supervising

- Follow strict rules regarding on-site availability
- Meet the regulatory requirements regarding their financial relationship with the Provider Agency.

The services provided must be an integral part of, but *incident to*, the services of Physicians, APRNs and Psychologists, as these professionals and services are defined in the regulations.

Services can also be provided by other professionals in accordance with regulatory requirements. Each Provider should consult with their Medicare Carrier’s Local Medical Review Policies for a complete set of the regulations.

Completing Medicare “Incident to” Services Only Information

The SOQIC forms allow for the easy identification of those services that are being provided “incident to.” A Medicare “Incident to” Services Only field appears on forms for services that may be billed using “incident to” service billing rules.

The standard instructions for completing Medicare “Incident to” Services Only fields follow. These instructions do not appear in individual form instructions in the Training Manual.

Standard Medicare “Incident to” Services Only box

<input type="checkbox"/> Medicare “Incident To” Services Only	Name and credentials of Medicare Provider on Site:
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Instructions for Completing the Medicare “Incident to” Services Only box

Data Field	Billing Strip Completion Instructions
Medicare “Incident To” Services Only	Check the box when service is to be billed using the “incident to” billing rules.
Name and credentials of Medicare Provider on Site:	Enter the name of the supervising professional who provided the on-site supervision of the “incident to” service. Note: The presence of an appropriate licensed supervising professional is one of the key requirements for an “incident to” service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional’s number should be used. Providers should consult with their Medicare Carrier’s Local Medical Review Policies.

General Instructions - Signatures and Credentials

Each Provider Agency must independently determine its own policy and procedures regarding signature requirements for each of the SOQIC forms. Most of the forms provide for multiple provider and/or supervisory signatures to accommodate Provider Agencies' internal policies/procedures. (*See SOQIC Signature Matrix at the end of this section*).

The development of each form was guided by state and federal regulations as well as the standards of the major accrediting bodies in allowing for provider, client, and supervisory signature lines.

Signature Instructions

Signature instructions for all forms **universally** require a **legible** signature. This is critically important. Federal and state auditors will throw out perfectly good claims on an audit if they cannot determine who provided the service. Additionally, day-to-day practice requires an understanding of who had an interaction with a client, and subsequently entered information into the medical record. JCAHO standards require that Provider Agencies develop a register of provider names and their signatures in order to be able to identify particularly obscure or sloppy signatures. (This is good practice regardless of your accrediting body.)

Additionally, signature instructions **universally require** that a provider's or supervisor's signature **be accompanied** by their **credentials**. This is both a payer/payment issue, as well as a risk management issue.

- Most states have laws regarding the licensure of professionals and the services or service array they are eligible to provide as a result of their licensure.
- Some states may issue certification requirements or licensing requirements for facilities that also are concerned with the credentials of providers and the services they are allowed to provide.
- Most payers have very specific standards for the

type of provider credentials they will allow to reimburse for specific services.

- In many cases, both the state and the payers have similar requirements. In some cases, payer standards are more stringent than state law or may cover providers who are not the subject of state laws, such as paraprofessionals. In those cases, payer rules must be followed in order to bill for a service. Provider Agencies may issue their own requirements that exceed and state and payer requirements, but **cannot** allow for lesser credentials.

Signature instructions also require that each provider date their signature. This may or may not be the date of service. Providers should not, under any circumstances, back-date their signature to match the date of service.

Credentials Instructions

In listing the credentials of the Provider, it is recommended that the following generally accepted conventions apply:

- If the Provider is licensed, he/she should list next to his/her name the highest level of licensure achieved that is related to the service being recording. For example; if an individual who is an RN, and is also an independently licensed social worker, is providing psychotherapy, then social work credentials would be recorded. If a medical-somatic service is being provided, the RN credentials would accompany the signature.
- If the Provider is not licensed and the service requires a certain educational degree, record the degree, e.g. B.A.S.W., B.S.R.N., B.S.
- If the provider is not licensed and the service requires specialized training and certification, record the certification, e.g. CADAC.
- If the Provider is not licensed and the service requires that the provider have a certain amount of

educational or specialized training or experience that is not easily recorded as credentials, then agency policy/procedure should be followed regarding the credentials that should accompany the signature. For example:

“The provider must have 2 years of experience in providing services to the seriously mentally ill population.”

In many cases, the provider should also list or abbreviate his/her job title; such as, CSW or Community Support Worker, CM or case manager, DSWI or DSWII or Direct Service Worker Level I or II.

Providers are encouraged to consult state laws, regulations and certification standards to define internal policy for signatures and credentials required to authorize services.

In **all** cases where licensure, training, education, and/or experience are required, the documentation that provides proof of this should be kept in the Provider Agency’s personnel files and available to auditors.

Using the SOQIC Signature Grid

The SOQIC forms contain multiple signature lines to accommodate multiple signature possibilities. The SOQIC Signature Grid is intended only to show the signatures that each form accommodates. The signatures required on the forms are determined by rule, licensure and scope of practice.

In general, the Provider authorizing and delivering a service is required to sign the clinical documentation for that service. Providers may “order” services only for those services for which they are licensed. Certain services, if provided by a “trained other” staff must be reviewed and signed for by the supervisor.

Client and/or family signatures are required by ODADAS and COA on treatment plans and are suggested as a good practice for all clients. Obtaining client signatures on Individual Progress Notes, Community Psychiatric Supportive Treatment Progress Notes and Group Progress Notes are suggested as a good practice.

For further clarification on signature requirements refer to:

- The Compliance Grids (see Appendix)
- The appropriate ODMH or ODADAS rules
- Your agency’s policies on signatures

SOQIC Signature Grid	Client	Family/Guardian	Provider	Co-Provider	Provider Rendering Diagnosis	Supervisor	Nurse	Physician/APRN	Medicare Incident to
Demographic Information (Sample)									
Crisis Intervention Assessment and Plan	X^O	X^O	X			X		X	
Adult Diagnostic Assessment			X		X	X		X	
Adult Diagnostic Assessment Update			X		X	X		X	
Child/Adolescent Diagnostic Assessment			X		X	X		X	
Child/Adolescent Diagnostic Assessment Update			X		X	X		X	
Individualized Service Plan	X^R	X^R	X			X		X	
Individualized Service Plan Revision/Review	X^R	X^R	X			X		X	
Psychiatric/Pharmacological Management Plan	X^R	X^R					X	X	X
Health History Questionnaire (Sample)	X^N	X^N	Non-Medical Reviewer				Medical Reviewer	Medical Reviewer	
Initial Psychiatric Evaluation								X	
Medical Somatic/Psychiatric Progress Note								X	
Medical Somatic/Nursing Progress Note (Short Version)							X		X
Medical Somatic/Nursing Progress Note (Long Version)							X		X
Individual Progress Note	X^O		X			X			X
Community Psychiatric Supportive Treatment (Short Version)	X^O		X			X			
Community Psychiatric Supportive Treatment (Long Version)	X^O		X			X			
Group Progress Note	X^O		X	X		X			X
Partial Hospitalization Progress Note			X	X		X		X	X
Transfer/Discharge Summary			X			X			

The X's indicate signature lines that appear on each form. Required provider signatures are determined by rule, license and scope of practice. See the Compliance Grids for further clarification.

N Obtain signature of person completing the Health History form. May be client or family member or other.

O Client signature optional, but suggested.

R Client signature (or Family/Guardian signature, as appropriate) required by ODADAS and COA.

SOQIC and AoD Forms

Introduction

Forms for printing and use are available on the SOQIC website and on CD-ROM by request from the Ohio Department of Mental Health.

The SOQIC form name is located at the lower right of each page and the form number, SQ-04-xxx, is at the lower left of each form. The “04” indicates the year (2004) and the last three digits (xxx) are the specific number for each form. In the future when forms are revised, the date will change so that you

will always know you are using the most recent version of the form. The AoD forms do not have numbers or dates.

Also included in this section is the SOQIC Forms Matrix. This is an overview of the purpose of each form and is designed to help in decision-making about which form to use. A simple electronic form set will be available by January 2005.

List of SOQIC and AoD Forms

Form Title	Form No.		
Demographic Information	SQ-04-010	Medical Somatic/Nursing Progress Note Short	SQ-04-125
Health History Questionnaire	SQ-04-020	Individual Progress Note	SQ-04-130
Crisis Intervention Assessment and Plan	SQ-04-030	Community Psychiatric Supportive Treatment Progress Note Long	SQ-04-140
Adult Diagnostic Assessment	SQ-04-040	Community Psychiatric Supportive Treatment Progress Note Short	SQ-04-145
Adult Diagnostic Assessment Update	SQ-04-045	Group Progress Note	SQ-04-150
Child/Adolescent Diagnostic Assessment	SQ-04-050	Partial Hospital Progress Note	SQ-04-160
Child/Adolescent Diagnostic Assessment Update	SQ-04-055	Transfer/Discharge Summary	SQ-04-170
Mental Status Exam (MSE)	SQ-04-060		
Lethality Assessment	SQ-04-070		
Initial Psychiatric Evaluation	SQ-04-080	AoD Forms	
Individualized Service Plan	SQ-04-090	Youth Admission Criteria	
Individualized Service Plan Revision/Review	SQ-04-095	Recommendations for Treatment	
Psychiatric/Pharmacological Management Plan	SQ-04-100	Youth Continued Stay/Transfer Criteria	
Medical Somatic/Psychiatric Progress Note	SQ-04-110	Youth Discharge/Transfer Criteria	
Medical Somatic/Nursing Progress Note Long	SQ-04-120	Adult Admission Criteria	
		Recommendations for Treatment	
		Adult Continued Stay/Transfer Criteria	
		Adult Discharge/Transfer Criteria	