

MENTAL HEALTH ASSESSMENT (pdf)

1. A Mental Status Exam (MSE) & Diagnosis are completed annually, but not at the same time as the rest of the MHA. For example, the psychiatrist would complete the MSE & Diagnosis on 07/01/10 & the clinician would complete the remaining sections by 09/01/10. The LPHA would review the MSE & the Diagnosis on 09/01/10 & attest that both are accurate & considered part of the 09/01/10 assessment. By 07/01/11 the psychiatrist would review/update the MSE & Diagnosis & by 09/01/11, the clinician would review/update the remaining sections. With the gap between when the MHA was completed & when our psychiatrists completed the MSE & Diagnosis, would we be in compliance if we added a statement above the LPHA signature on the disposition that said, "The most recent Mental Status Exam & Diagnosis were reviewed on the date of the LPHA signature below & were considered to be accurate & considered to be a part of this Mental Health Assessment? We are not asking for an extension to complete these sections, but for the completion of the various sections to occur at different times.

Answer: When an individual originally comes in for service, the MHA is completed by agency clinicians within 30 days and signed by the LPHA. The individual is then scheduled with a psychiatrist. As a routine, the psychiatrist does another mental status evaluation. On the schedule of psychiatric visits, the mental status evaluations get updated, but the schedule is different from the MHA updates, so when a MHA update is done, there's a mental status evaluation from a couple of months previous. This is acceptable, and the LPHA does not need to say anything special about it. However, since the mental status evaluation is a required part of the MHA update, the most recent mental status evaluation must be kept with all the MHA update documents and not filed elsewhere in the record.

2. We recently had a Medicaid audit and did pretty well, however we were cited on a few things like gap dates in ITP and MHA's. Gap dates in MHA and ITP occurred due to consumer being hospitalized, incarcerated or just refusing to work with staff due psychosis or delusions to complete these required documents/assessments. I inquired with the auditor on how we should proceed with covering gap dates when consumers are not available when the ITP needs to be consumer driven/consumer's language or the MHA needs a consumer present to complete the face to face mental status. The auditor recommended completing the MHA and ITP without consumer present just to cover gap dates until we can locate or connect with consumer to complete the MHA and ITP with consumers and we would not be billing for services but just to avoid citations. How should we proceed? Is the recommendation from the auditor valid?

Answer: The auditor's recommendation was valid. Another alternative is to place a note in the file that the client is not currently in service - dated and signed, and then when the client returns to service complete a new MHA and ITP.

3. We have been completing the MHA with MHP/interns consistent with the direction of the reimbursement guide by having direct supervision by a QMHP. We have been advised that we may reduce our QMHP involvement to just 15 minutes of a face to face contact and still meet the requirements of 132. Can 15 minutes really allow for a QMHP to claim he/she is responsible for the completed MHA report?

Answer: Rule 132 doesn't specify how long the required face-to-face meeting should take. However, you are correct that it needs to be sufficiently long to allow the Q to review the MHA with the client and assure that it is complete and correct. By signing the MHA, the QMHP is attesting to its completeness and accuracy and that it represents the needs and preferences of the specific client. I agree that 15 minutes to do that seems too little.

4. In order to bill for psychological evaluation, we know that it must be recommended in the MHA and included in the ITP. How should we proceed with consumers that we have been seeing for four months; the initial MHA did not recommend a psychological evaluation but the therapist (LPHA) or psychiatrist recommends a psychological evaluation to determine other diagnoses or as a rule out? Would a recommendation from a psychiatrist suffice as medical necessity or do we complete an MHA update/addendum adding psychological evaluation?

Answer: You would handle this as you would any other MHA and ITP modification for any other service.

5. Will a treatment plan review with a specific recommendation for Psychological Evaluation signed by the LPHA suffice as medically necessary? This also would be followed by a treatment plan modification adding the service. Could this be done instead of listing it as a recommended service on the MHA for existing (not new) consumers?

Answer: This will suffice as long as there is evidence in the record of the reason(s) for recommending the psychological evaluation.

6. The rule states that the mental health assessment must be completed in 30 days after the first face to face contact. There are times that we conduct more in depth assessments beyond the mental health assessment, such as sex offender specific assessments, which are quite lengthy. Can we submit bills for assessment beyond the mental health assessment as long as we have that assessment complete within the 30 days?

Answer: Mental health assessment is not a one-time thing. Whenever you're doing an assessment related to the consumer's mental illness and the services being or to be provided, you may bill MHA.

7. When a consumer's diagnosis changes during the course of treatment the ITP has to reflect the changed diagnosis. The goals, objectives, specific services and frequency of services may not need to change if so determined by the QMHP and LPHA. Would another mental health assessment be required, in addition to other clinical documentation explaining the diagnosis change?

Answer: An addendum to the MHA would be acceptable. The provider's clinical professionals should determine what portions of the assessment need to be updated, evaluate the consumer's changing needs and then reflect changes in the ITP.

8. We have a case that has been open for more than 3 months, as such a MHA and treatment plan have been completed, but upon further review the provider now believes a psychiatric evaluation would be beneficial, but this was not indicated in the recommendations in the MHA. If it is before the annual review of the MHA, can you prescribe a service that was not indicated on the MHA by simply completing a treatment plan review and adding a goal/objective that reflects this service in a new treatment plan? Or does a MHA addendum also need to be completed to reflect an additional treatment recommendation?

Answer: Psychiatric evaluation, if done as a physician service and billed directly to HFS, does not need to be on the MHA or ITP. If considered as part of the ongoing mental health assessment, it does not need to be on the ITP.

9. An auditor said that when a treatment plan is due the MHA is also due. The MHA is current for one year. If a treatment plan is due or expired and the MHA is still current, is there a need to do another MHA?

Answer: If a MHA is updated to reflect needs and preferences significantly different than the current ITP, the ITP must be amended. However, the two of them are not specifically tied together.

10. An MHP meets with a client to complete an assessment. The assessment takes two sessions. The MHP bills assessment for both sessions. However, the QMHP does not see the client until the end of the second session. Is it correct to bill assessment for both services? Can an MHP bill assessment for meeting a client the first time, gathering background info, and determining services needs? What if a Q does not see this client?

Answer: See 132.148a). A mental health assessment is seldom something that happens in one sitting. The Q must have at least one face-to-face with the client before signing off on the mental health assessment report.

11. If we discover that an MHA is not current but the treatment plan is current, can we still bill? We are thinking we cannot because the LPHA signature on the updated MHA determines medical necessity for the treatment plan. Can you clarify?

Answer: Services must be based on the consumer's assessed needs. If there is no current mental health assessment, the treatment plan is not reflective of those needs and services are not billable.

12. When comprehensive testing is done by a licensed clinical psychologist, some of the tests are done by the client who is alone with paper and pen. Is that reportable and billable time? (The psychologist would be in the building but not face to face with the client.) Is the review and write-up by the psychologist reportable and billable?

Answer: Only interventions provided directly by staff to a consumer are billable. When a staff person is not providing a direct intervention, that staff person may not bill. In this case, the psychologist may not bill for something the consumer is doing. Additionally, the completion of paperwork is not billable.

13. It is my understanding that Rule 132 requires a person to have a face to face contact with a QMHP prior to the billing for a completed Mental Health Assessment or Mental Health Assessment Update. Is my interpretation of the rule correct? If it is correct, would I be correct in assuming that in the process of completing and billing for the Mental Health Assessment Update by a case manager who is an MHP (with review and sign-off by an LPHA) that a recent (within the last couple of months) meeting with the agency psychiatrist (QMHP/LPHA) would be able to "count" as the face to face meeting with a QMHP prior to the completion of the Assessment Update?

Answer: Yes, if the psychiatrist functions as the QMHP, then the face-to-face by the psychiatrist is acceptable. Billing for mental health assessment is not required to wait until the face-to-face with the Q.

14. If a Mental Health Assessment/Treatment Plan is completed by a licensed clinician, can that clinician sign off as the LPHA or does the designated agency LPHA have to sign off on the documents?

Answer: An LPHA is required to review and approve the treatment plan so the signature of any LPHA meets the "letter of the law". However, it is better clinical practice to have the review and signature of the LPHA who is responsible for the implementation of the services. Not all licensed clinicians are LPHAs.

15. How do we bill application of quarterly OHIO Scales?

Answer: The OHIO Scales is a functional assessment instrument used in the web-based outcomes system for C&A, and should be billed as mental health assessment.

16. If a Mental Health Assessment is started and it is determined that mental health services are inappropriate for the client who is then referred out, does an LPHA still have to sign and does a Q still have to have a face-to-face?

Answer: If the only service is mental health assessment and the client is subsequently determined as inappropriate for mental health services, the assessment report does not need to be completed, i.e., LPHA signature or face to face with the QMHP. Document the client status/disposition in the record and you may bill for mental health assessment.

17. If the treatment plan expires and the client and I do the annual Mental Health Assessment in the appointment following the expiration of the plan, it would seem that would be okay because a treatment plan is not required prior to a mental health assessment. Right? Wrong?

Answer: Mental health assessment updates are not necessarily tied directly to ITP updates. However, it makes good clinical sense that when assessments are updated and new needs are identified, that the ITP gets updated as well. You are correct that there is no need to have an ITP to do a mental health assessment or update.

18. Is the requirement for an annual update of the Mental Health Assessment a rule violation or a payback issue?

Answer: Failure to meet the requirement for an annual update of the Mental Health Assessment is considered a Rule violation and a post-payment issue.

19. I wanted to run this by the Medicaid group to make sure that DMH/Medicaid Group is aware of and supports this way of handling the specific services. May we consider the attending psychiatrist's admitting orders and list of recommended services following seeing the client at the time of the intake, be considered as the MHA report?

Answer: No. At the conclusion of the mental health assessment there must be a summary analysis and conclusions report done (132.148a). This cannot be done prior to completion of all components of the mental health assessment.

20. I am a Clinical Director and would like some clarification regarding the following situation: A child transitioned from SASS to C/A MH services in early December. The MHA was completed at the beginning of SASS and indicated a need for intensive services. A new MHA was completed at the beginning of C/A MH services for new goals and less intensive services. The C/A counselor who had completed the C/A MHA left the agency in late December and a new C/A provider joined the agency in early January. Can the new C/A service provider simply review the existing MHA with the family and document that the symptoms, goals and information in the most recent MHA are still accurate and then develop a new ITP with the same goals but new objectives, or, is it necessary to do a completely new MHA and ITP? My basic question is: If there is a transfer of a client from one service provider to another and the MHA remains accurate except for who will provide services, can a note in the file, stating the MHA remains accurate with a new treatment plan, be sufficient?

Answer: SASS is only a funding stream, so if your agency has done an MHA and an ITP as the child/youth entered SASS, that MHA and ITP will remain effective as the child/youth moves into non-SASS funded services. If the responsible staff person changes during this switch, then an addendum to the ITP is necessary to note the change. Unless the services change, too, there is no change needed to the MHA.

21. Does a MHA update need to be done if there is only a change in intervention for a goal already established on the tx plan? When does the update need to be done? A new goal is established? A new service?

Answer: An addendum to the MHA must be done when assessed needs change. When a new goal/objective or approach to a goal/objective is needed the ITP must be amended.

22. In the Post-Payment Review Interpretive Guidelines document of the Collaborative the following statement appears: "Clinical assessment is ongoing...assessments can be documented in a number of ways depending on the agency's practice, such as, MHA addendums, as an assessment portion within a review of the treatment plan, or a clinical progress note..." It is our understanding that a progress note is a progress note, NOT an assessment document. Am I correct?

Answer: Assessment is not always a formal assessment document/instrument. It is sometimes information gathered as the result of interaction with a client. That interaction and the results can be documented in a progress note. However, this is not a required means of documentation if you use another.

23. Please clarify SASS intensive outpatient services. A SASS consumer is placed in a residential facility for two or more months after a psychiatric hospitalization or from home, and the only service provided by our agency is crisis intervention or follow-up case management by our SASS staff. We don't have a MHA or ITP completed because they are in the residential setting. Creating a MHA and ITP with that consumer would be duplicate billing - is this true? If so, what about continuity of care and stabilization? In the SASS handbook, CMH-202.4 states "For children in residential or group home placement, the SASS provider's involvement in the intensive

outpatient psychiatric component will be determined on a case-by-case basis and SASS activities must be coordinated with the residential/group home staff and/or the child's case manager." Can we provide other services such as individual therapy/coping skills or are we limited to crisis and a follow-up case management? What is the status of the MHA and ITP while a consumer resides in a residential facility?

Answer:

1. SASS is a funding stream for 90 days following a psychiatric crisis.
2. SASS funding will pay for any 132 service.
3. In order to provide anything with SASS besides the crisis services, there must be a MHA and ITP.
4. Your development of an MHA and ITP for your agency is not duplicate billing, unless you're trying to claim for something another provider did and also claimed for.
24. I came across a situation where a clinician took more than 30 days to complete a MHA. In this particular case it took three months to complete it and the "L" signed it the day it was completed and that is not because they went into the hospital. In Rule 132 it states that we should have the MHA completed in 30 days. Would this be a valid MHA? How should we proceed with this and what happens to all services provided to the consumer up to this point?

Answer: The MHA would be valid. However, please note that the only services that may be provided prior to completion of the MHA are crisis services and case management services. And, you may only provide 30 days of case management prior to completion of the MHA, so if your agency had been providing case management for the full 3 months, two of those months of service could not be claimed.

25. If an MHP completes the MHA and a doctor signs as an LPHA and has seen the client prior to the completion of the original MHA or MHA update, does that suffice as a counter signature/face to face (vs. a QMHP signature and face to face)?

Answer: Rule 132.148a) states "A QMHP who has had, at a minimum, one face-to-face or video conference contact with the client shall be responsible for the completed mental health assessment report as documented by his/her dated signature on the mental health assessment. MHPs may participate in the mental health assessment." This means that the Q is responsible for the MHA report and must sign it. MHPs are not authorized to do the MHA or to be responsible for it. They may only participate. Additionally, 132.148a) states, "The mental health assessment report shall be reviewed and approved by the LPHA as documented by the LPHA's dated signature on the mental health assessment." This is a review of the assessments and recommendations made by the Q, not by an MHP. If the LPHA is acting as a QMHP, e.g., doing the annual MHA update, assuming responsibility for review of the ITP every 6 months and modifying the ITP in response to that review, then the L may sign as both the L and the Q. However, an MHP may not act as a Q. In summary, while a doctor would meet the qualifications for both the LPHA and the QMHP, the Rule requires that certain functions (besides signature) are required of each of those (the L and the Q.) If the doctor performs the FUNCTION of either the L or the Q, or of BOTH the L and the Q, then the doctor could sign the assessment for that function/both functions as appropriate.

26. If a patient is a doctor-only patient, and is not seeing a therapist, is there a requirement under Rule 132 that an MHA/ITP must be completed and kept updated? Doctor charges are billed directly to public aid and are not billed to MRO.

Answer: Physician services are not covered by Rule 132. When a physician claims for physician services directly to HFS, they are governed only by any regulations that HFS has for such claiming. If the client, at any time, needs Rule 132 services, all 132 requirements will apply.

27. An agency has multiple locations, and sometimes the LPHA who reviews and signs off on the MHA is not in the same office on all days. They can electronically review the MHA. The agency does not have electronic signature systems, and is not able to invest the money in one at this

time. Sometimes waiting until the LPHA is back in the office where the person is receiving the services, could delay getting a signature and therefore treatment. One possible solution would be that the LPHA could print out and sign the review, but then the LPHA signature and the Q signature would be on separate pages. Is there anything that says that the signatures all have to be on the same page? Is there a way for them to do this and have it meet all of our guidelines without getting into an electronic signature system?

Answer: There is nothing in Rule 132 that requires the L and Q signatures to be on the same page. However, it must be clear that both are signing the same document. Additionally, the MHA does not take effect until the date of the LPHA signature.

28. In most cases when we receive a referral for an ICG Client, the youth is either involved in SASS or with an Outpatient Therapist at a Medicaid Certified agency. An LPHA at the referring agency has already completed and signed an MHA and noted in the treatment plan that the client needs referral and linkage to Case Coordination services of an ICG Coordinator. Upon receiving the referral for Case Coordination, our LPHA requests the current MHA and ITP from the referring agency. At that point our ICG Coordinator meets with the family. The ICG Coordinator (MHP) and LPHA Supervisor review the MHA. The question is: Can our LPHA sign the MHA (below where the other agency's LPHA signed) and state that she concurs if there have been no changes?

Answer: It is important to note that each provider must have an MHA and ITP that is their own. The MHA must be developed to reflect the current status of the client as determined by a QMHP and LPHA. An MHP may assist with the MHA development, but the Q must review the MHA and have at least one face-to-face with the client (not just the family) before signing off on the MHA. Additionally, each provider must then develop their own ITP based on their MHA. It is acceptable to use the referring provider's information as a starting point, but all of it must be reviewed and changed as appropriate.

29. I could not find a standard in Rule 132.148 a) as it pertains to clients who are currently inactive, but not yet terminated. If their annual re-assessment is due/overdue, and possibly an ITP review, but the client has been inactive for better than a month or two, and we are preparing for termination due to non-compliance, non-attendance, etc. Should the re-assessment be done anyway - even without client input, since we are unable to engage them?

Answer: Each MHA must be updated annually. If the client is no longer active, but not yet closed, there will be little to update. However, if the update is not done and the record is part of a survey, there will be a citation.

30. According to the auditors an LPHA's signature must be on an MHA that is not completed because the client did not return. We do not find this in Rule 132. What the rule does state is that the QMHP is responsible for completing the assessment and the LPHA will review and sign the MHA. Is the LPHA signature required on an incomplete MHA? We have documentation that describes the circumstances that resulted in the MHA not being completed, is this sufficient to substantiate a billing?

Answer: If the only thing that was ever claimed was mental health assessment or crisis, then there is no need for an L signature if you were unable to complete the assessment.

31. Can multiple documents contain elements of the MHA? For example, can information in an intake/screening form and physical health questionnaire be accepted as part of the MHA? If yes, is it necessary that the documents be stapled together?

Answer: The required elements must be on the MHA report. The fact that you've done them and they're scattered throughout the record, does not meet the requirement of rule. All the information you mentioned is good, but it must be summarized in the MHA report.

32. On our MHA, we ask questions about the individual's communication concerns & needs. We do not ask "method of communication". Is determining the individual's communication concerns & needs evidence that we have sufficiently inquired about the person's communication?

Answer: No. The requirement is for a method of communication. An individual is not required to have communication concerns or needs in order to have a method of communication. Many communicate through spoken English, but others for example, communicate through American Sign Language or spoken Spanish.

33. Can we bill an assessment as MHA after the formal MHA has been signed by an LPHA? If an assessment service is performed & billed after completion of the MHA, it is necessary for the MHA to be updated & signed by an "L?" For example, a clinician completes a MHA and obtains an LPHA signature. Several weeks later, the clinician completes a Beck Depression Inventory & bills that service as MHA. Can this bill stand alone, or are additional signatures required by the "L?"

Answer: Mental health assessment is an on-going process. Each time an assessment service is provided, it may be billed as MHA. The MHA report does not have to be updated each time, however, if changes are made to the ITP as a result, the ITP update, changes, addendum, etc., must be signed by the Q, the L, the client and if applicable, the guardian.

34. Does a MHA update require a face-to-face contact with a QMHP?

Answer: Yes.

35. Would documentation of a new assessed need and an updated ITP, both signed by the L and Q, be sufficient documentation for the MHA?

Answer: Yes.

36. How do we bill an Admission Note - as an assessment or a treatment plan since it is a temporary version of both?

Answer: It is mental health assessment.

37. On our MHA we have vocational related questions. If we determine that a more in-depth vocational assessment be completed, based on the results of the MHA, can we complete the vocational assessment and bill as an MHA since it will be part of the MHA, i.e., physically attached. We would use this assessment to refer to DORS.

Answer: Billing Medicaid for vocational assessments is not allowed. It is not Medicaid reimbursable.

38. An agency's specialty assessment (among others) was covered for many years via a capacity grant issued by C&A to specific providers. It appears that the Multi-Disciplinary Grant will not survive the budget cuts. As a way to try to preserve these services, they are looking at alternate ways to fund the assessments. Referrals for them come to the C&A Network from other providers who are currently treating C&A who are in need of these assessments. Could you use that agency's treatment plan like TLA? Does this assessment qualify for Medicaid billing as a mental health assessment?

Answer: One of the problems with the idea is that the brochure sent says that the evaluation is free. No one may bill Medicaid for a service that is free to non-Medicaid recipients. Additionally, this appears to be primarily a psychological evaluation and not a mental health assessment.

39. I have had a staff ask if they can copy the dr notes for the annual assessment update and attach to the update instead of listing out the previous medications that have been prescribed. They would be listed on the dr notes.

Answer: We believe it would be best for this information to be photocopied to assure there are no changes made to what the physician has written. Then it is ok.

40. Regarding billing a mental health assessment that is required for Medicaid recipients seeking bariatric surgery. I understand that this is a Medicaid-billable service and I want to verify that it is billable under Rule 132.

Answer: Per rule 132, a mental health assessment is a formal process of gathering information regarding a client's mental and physical status and presenting problems...resulting in the

identification of the client's mental health service needs and recommendations for services delivery. A diagnosis of mental illness is not required prior to beginning a mental health assessment.

41. In billing for the MHA, we complete a MHA report that contains all of the required elements. In order to bill this, we have been writing "see mental health assessment in file" for the billing program. Is this acceptable, or does the note need to describe the intervention?

Answer: Notes must always contain a description of the intervention provided.

42. If we add a service to an ITP which is not identified on the MHA, do we need to do an MHA update with noted changes?

Answer: You would certainly need to be able to show documentation that the new service was needed. That doesn't necessarily need to be through an official MHA update, but could be an addendum to the MHA. When the MHA update is required, it could be incorporated. The service must be added to the ITP prior to being provided.

43. We did an audit and found some charts that had overdue MHA, but did have current Treatment Plans. We want to know if we have to unbill the services that were provided with the overdue MHA. I know we have to do that for overdue Treatment Plans, but wasn't sure if the MHA was a cause for unbilling.

Answer: Both the MHA and the ITP must be in effect at the time the services is provided. If the MHA has not been properly updated, then it is not in effect. The bills should be voided.

44. Can the QMHP meet with the client for their face-to-face contact if the MHA is not fully completed yet? For example, if the MHA is meeting with the client for the first time and has the QMHP meet with the client as well, but is not able to fully complete the MHA report on that day, so needs the client to return a second time to finish it, does the QMHP have to meet with the client again at or after the second meeting as it is at that time that the entire mental health assessment is completed or does the first face-to-face count?

Answer: Rule 132 does not specify when the face-to-face must happen.

45. In the past I have requested a response as to whether or not a crisis assessment, or more specifically, the "USARF" would suffice as an assessment for placement in our Crisis Stabilization Unit along with specific orders from the on-call psychiatrist authorizing specific Rule 132 services until we could complete the full bio-psychosocial assessment with all of the elements required for assessment under the Rule. The response was "no" unless all required assessment elements were collected and the assessment was signed off by the LPHA. Our on-call staff are not QMHPs (they are MHPs who consult with the on-call psychiatrist from whom the nurses on duty at the Crisis Unit obtain admission orders from). Would their crisis assessment be valid in this scenario, or must it be signed by an LPHA? For weekend admissions, when a comprehensive bio Psychosocial assessment is completed the next business day, would the Crisis Assessment suffice, even if the client is capable of assisting in completion of the assessment?

Answer: Only crisis & case management MH services may be provided prior to completion of a complete mental health assessment. Crisis services may be provided anytime. The completion date of a mental health assessment is determined by the dated signature of the LPHA. During the period of time between completion of the mental health assessment and completion of the treatment plan, other 132 services may be provided as long as they end up on the completed ITP within the required period of time.

46. Our clinic's psychiatric nurse sees clients for medical follow-up (weight mgt, blood pressure, etc.) before their appointment with the psychiatrist. Is this sufficient to cover the Rule 132 requirement of at least one face-to-face contact by a QMHP prior to the MHA annual review?

Answer: Only if s/he functions as the QMHP for the client and is the responsible QMHP for the delivery of services, i.e., signs the MHA report and ITP as the QMHP.

47. Once a full MHA has been completed, is a QMHP face-to-face required when billing MHA for supplemental assessments i.e. Ohio Scales, Multnomah etc., (assuming that they are completed with the client and meet all other billing requirements), or is the QMHP face-to-face required only when doing the initial and then annual MHA?

Answer: The face-to-face must be done at the initial and at each annual MHA update.

48. Must the QMHP who completes the face-to-face be the same one who signs off on the MHA?

Answer: Yes.

49. The 30-day time frame for completion of the MHA is difficult to meet with older consumers. It is hard to get them into the office, and they are often put on hold due to medical hospitalization. If the MHA or ITP come due while a client is on hold, and we have to be with the client to bill, how do we ensure compliance?

Answer: There is no leeway in the 30 day requirement. The provider may, and is encouraged to, go to the consumer instead of requiring and/or waiting for the consumer to come into the office.

50. We have an initial MHA that includes all required information except the LPHA signature. If the consumer is later referred for MH services, can we do an MHA update including a face-to-face and QMHP/LPHA signatures instead of another full MHA, will this meet the requirements of Rule 132?

Answer: A Mental Health Assessment needs to have current information. If the original information remains current, then it can continue to be used for the MHA. The original is not considered an MHA because it was never signed, and therefore couldn't be updated.

51. The MHA needs to be completed within 30 days of initial contact. If a client comes in for counseling and meets with the therapist for one session, fails to show for the next two sessions and then comes back again, the MHA is due, but the therapist would not have had enough information or time with client to complete it. In the past, we were told that if we documented through case notes that a client does not attend a session, the 30 days was dependent on when the client came to session. Is this still true or does the MHA have to be completed within 30 days no matter what?

Answer: It is important to note that counseling may not be provided until the MHA report recommending it is completed. There has been no change in the requirement that the MHA report is to be completed within 30 days of the initial face-to-face contact.

52. Can we bill the time spent by the LPHA reviewing (and signing) assessments completed by staff who are not LPHAs as "assessment?" Since the assessment is not considered "complete" until it is reviewed and signed by the LPHA it would seem logical that this is part of the assessment process would also be billable as "assessment." Our LPHAs typically spend a minimum of 15 minutes reviewing the completed MHA before signing them as the liability implications of their signing off on these documents is significant and they take this responsibility seriously?

Answer: The rate methodology for mental health assessment, and all other Rule 132 services, includes a significant component for indirect costs. The LPHA review of the assessment and subsequent signature is part of that indirect cost of providing the service.

53. During a recent review we were cited for not having a 6-digit date as a response to the questions about last physical exam and last psychiatric exam on mental health assessments (MHA) and MHA updates. Until then we thought that a response of unknown or with month and year were acceptable responses. We understand this will also be a citation by the Collaborative during post payment reviews. Since a number of our MHA updates are not due again for a while, would you please suggest a way to correct this that would be acceptable?

Answer: There is no need for a month, date and year indication of the most recent exams. We certainly don't want anyone to make up a date when all that can be remembered was that it was June 2007. In fact, if the client can remember that it was summer 2007 that would also be

acceptable. While unknown is acceptable, it must be clear that it is the client that does not know and not the staff that do not know because they have not asked the client.

54. We understand that Rule 132 states that a treatment plan or review must be done every 6 months. However, there are times when the client is unavailable for any number of reasons (hospitalization, no shows, physical illness, etc) at that specific time. If we are not going to bill for services until the new plan is in place, could we write a review note stating that we know the review or new tx plan is due but the client is not available, state the reason why, and then document our plans to reengage the client and have their participation in the planning, or plans for closure if they don't engage. That note would have clinical relevance. Please consider this compromise and advise.

Answer: As long as the client is included as someone receiving services from your agency, the 6 month reviews must be done according to the 132 timelines.

55. Our staff complete the Mental Health Assessment and ITP. Psychiatric and medication services, however, are provided by either a Psychiatrist in the community or another Community Mental Health Agency. We usually send a copy of the MHA to the Psychiatrist and invite them to the ITP. Must the Psychiatrist sign the MHA and/or ITP?

Answer: The MHA and ITP must be signed by the QMHP, the LPHA and the client/guardian. All providers who bill for the provision of Rule 132 services must be certified providers, have a MHA and ITP and bill for the services they provide.

56. Can/should we use an Admission Note to authorize additional interventions needed for open/registered clients with a completed MHA who are admitted to our Crisis Stabilization Unit? The guidelines are clear if the admitted client is "new," without a completed assessment, but not when the client is already open and receiving services. If we can use the Admission Note for this purpose, would we then have to complete an assessment update as well?

Answer: If the client is known to you and is an open client, we do not recommend using an admission note. An admission note requires that you complete a mental health assessment and treatment plan within 30 days of the admission; it would be more paperwork than is necessary.

57. Are children placed in an out-of-state residential facility required to have a face-to-face interview for the mental health assessment? Can the residential facility and ICG/SASS provider share the mental health assessment and individualized treatment plan if they are jointly developed?

Answer: At least one face-to-face is required to be done by the provider's QMHP who works with the client. The residential facility and ICG/SASS provider may share the mental health assessment and individualized treatment plan if they are jointly developed and each maintains a copy in their records.

58. If an MHA is not updated within 12 months, but the client remains in services and is scheduled to return, should we complete a new MHA or an update?

Answer: An MHA update is acceptable if there is still an original MHA in the file that includes all Rule 132 required elements. However, if the MHA has expired, a new MHA must be done.

59. Please clarify, a client had an MHA in December 2006, an update in July 2007, and an MHA in February 2009. When does the need for an MHA start - from the date of the first MHA, or from the date of the most recent update?

Answer: Annual updates become due by the date of the most recent MHA or update. In the example you give, the next update would be required February 2010.

60. Can we use a rule-out diagnosis on a Mental Health Assessment or Physician/APN evaluation? Example: Axis 1, primary billable = 314.01; secondary (not billable) - rule out Oppositional Defiant Disorder.

Answer: The ITP shall include a definitive diagnosis that has been determined for all five axes in the DSM-IV or the ICD-9-CM. If the diagnosis cannot be determined by the time the MHA is

completed or a rule-out diagnosis is given, the client's clinical record must contain documentation as to what evaluations will occur in order to provide a definitive diagnosis in the ITP. A diagnosis shall be determined within 90 days and the ITP shall be modified to reflect the diagnosis, as necessary. Therefore, each axis must have a definitive diagnosis ultimately without a rule-out diagnosis. There is no statement in the rule about a secondary diagnosis on any axis. Of course, services provided must be to address the mental health needs of the client.

61. The MHA and the psychiatric assessment have large areas of overlap. Our psychiatrist is willing to do a document that would include all points in the MHA and the psychiatric assessment in one combined document. Is it acceptable to do so and title it "mental health and psychiatric assessment?"

Answer: There is nothing in Rule 132 that prohibits an expanded mental health assessment that includes more than the Rule 132 required elements, at least one face-to-face by the Q, and L and Q dated signatures. The title of the document could be mental health and psychiatric assessment.

62. Providers have 30 days to complete a mental health assessment. Does the 30 day clock start to tick with the face-to-face interview, the opening of the case?

Answer: The provider shall complete a mental health assessment report within 30 days after the first face-to-face contact.

63. If a clinician amends or adds an addendum to the MHA before the annual review date, is the signature of the Q/L required? The additional information may include recommendations for services to be added to the ITP.

Answer: According to the Rule, the ITP is based on the mental health assessment report and any additional evaluations. Given this, we do not believe they would need to get a Q/L signature on addendums, so long as the Q continued to do timely annual updates and incorporated the information from addendums into those updates. Certainly, revisions to the ITP should be acknowledged via signature of the Q/L, as well as the consumer.

64. In the past, we did linkages from the SOF and were allowed to use the hospital discharge as the assessment until the patient was released and a full assessment could be done.

Answer: The current rule requires that, in order to provide case management - transition linkage and aftercare, it must appear on a treatment plan. That treatment plan may be the treatment plan from the hospital.

65. Does the mental health assessment annual update have to be done based on an interview session where the client is present? If client has to be present while mental health assessment is conducted, does the same requirement for a QMHP contact apply? If it can be done based on review of the previous assessment and knowledge of the client (client not present) is this a billable service?

Answer: The same principles apply to the mental health assessment and the annual update. Some of the update is completed based on personal knowledge of and contacts with the client. Other pieces of the update can be done by reviewing the client's record, related documents or collateral contacts. The time spent completing the update can be billed; the client's presence is not required for billing. This is true for the initial mental health assessment as well. Just remember that time spent writing the report, without the client present, is not billable. Activities related to paperwork are part of the administrative component of the rate.

66. We have staff in the classroom completing a questionnaire while observing a student during class. It relates to the student being either on or off the presented task and is used to help determine a diagnosis of ADHD. They are not technically providing a face-to-face service - no interaction with the client occurs. What would be an acceptable DHS activity code for a service such as this when not in the assessment period, i.e., the assessment has already been completed, CS-Individual or CM-Mental Health? The service assists the client. If we use a non

face-to-face code, we have always indicated to staff that the location of the service is office; this observation is not in the office but the school.

Answer: Assessments may be ongoing, not just prior to completion of a mental health assessment. The activity that you describe seems to be mental health assessment.

67. I have two clients who need to see our PSR Coordinator for assessments (MHA & CASIG). She has never met one of these individuals and only had one meeting with the other, so is not familiar with either of them. One individual has a significant speech impediment. Some direct care staff have worked with him for a number of years and understand him quite well. The other individual is deaf, and though he reads lips well with people he knows, this is not the case with someone he has just met. He signs, but will not employ sign language. In addition, his conversations and responses are skewed by auditory and visual hallucinations. He sees auras, which speak, and to which he responds, therefore, you must separate responses to you from responses to the aura. That is a skill gained through experience with him. To ensure these appointments are effectual, I am having one of my MHPs sit in with these individuals to provide assistance with communication and help them answer questions, etc. Naturally, the PSR Coordinator will bill for the MHA and CASIG, but in such a situation, is it appropriate for both staff to bill different services for the same block of time or do you have an alternate suggestion?

Answer: Only one staff can bill for a direct intervention with a client at the same service event. The only exception is when the client is hearing impaired or English is not their primary language, and oral interpretation/sign language services are necessary for the provision of mental health services. The MHP's time with the deaf client may be covered if the MHP is versed in sign language or oral interpreter services, and the service meets the criteria for Oral Interpretation and Sign Language in the Service Definition and Reimbursement.

68. When a QMHP meets face to face with a client to gather info regarding application for service and to discuss their fee, is this considered part of the assessment?

Answer: This does not appear to relate to the mental health needs of the individual and as such would not be considered part of a mental health assessment.

69. What service do you bill for when completing the annual re-assessment of services?

Answer: Billing is always for the intervention provided. In this case, it seems most likely that it would be mental health assessment.

70. Does there need to be a note for the Q's face-to-face for the MHA and MHA Update or does their dated signature verify that they had a face-to-face with the client?

Answer: Often on MHA reports, there is a statement or box to be checked indicating that a face-to-face has been done. This, along with the Q's dated signature is sufficient evidence of the face-to-face. However, if the agency intends to bill for the time (at least 71/2 min) spent by the Q in the face-to-face, there must be a signed, dated note describing the intervention provided.

71. When doing an annual mental health assessment (MHA) update, does there have to be a face-to-face contact with the QMHP like an initial MHA? It doesn't really specify in the Rule in regards to annual updates.

Answer: Yes.

72. How often and in what programs is a provider of MH services required to administer the Multnomah?

Answer: None. The Multnomah is optional, not required.

73. What service is billed prior to a mental health assessment, following a SASS assessment? If Case Management is provided and no mental health assessment is completed due to the child leaving the area, are there billing consequences? We currently bill ongoing Social History.

Answer: You may provide case management prior to completion of the mental health assessment.

74. Can a psychological evaluation be provided and billed without completing the mental health assessment and ITP beforehand?

Answer: No. Psychological evaluation needs to be a recommended activity identified on the ITP.

75. May completion of the LOCUS be billed as part of the mental health assessment?

Answer: LOCUS is an event code billed as Case Management - LOCUS service.

76. Does a patient who will need ongoing, lifetime, medication management, seeing a doctor only, require a mental health assessment or is a Psychiatric Evaluation enough basis; what is the transition or end date?

Answer: All patients receiving on-going mental health services billed under Rule 132 must have a mental health assessment. The mental health assessment must be updated at least annually.

77. Can an updated mental health assessment be documented in chart (progress note) or will there be a need for an addendum to the mental health assessment yearly?

Answer: A progress note is not adequate. The mental health assessment is to be updated annually by a QMHP and needs to be approved by the LPHA as documented by the LPHA's signature on the assessment update.

78. For a C&A consumer, which contact starts the 30 day countdown for completion of the mental health assessment, the first contact with parent/guardian, who must consent for children under 12, or, the first face-to-face with the child/client? These may be two separate contacts, on different dates.

Answer: The first face-to-face with the identified client begins the 30 day countdown for completing the mental health assessment.

79. Please define "client preferences". Is it preference for MH Rx, mental health assessment, short-term or long-term Rx goals? A mission statement for MH Rx, assessment?

Answer: It could be all of the above, but in terms of Rule 132 it would primarily focus on short and long-term treatment goals.

80. We conduct intake face-to-face for completion of mental health assessment, and bill under mental health assessment, but service/mental health assessment is not started until the client is assigned to a therapist. If there is a wait list, can we set the start of service/mental health assessment as first meeting with the therapist, rather than the intake date?

Answer: The Rule requires the mental health assessment report to be completed within 30 days from the first face-to-face contact. You need to identify the first face-to-face contact and follow-up accordingly.

81. Does DHS have a tool to document consumer preferences?

Answer: No.

82. Can the CASIG be utilized as a tool to assess consumer preferences?

Answer: It may be utilized, but it is not mandated.

83. If mental health assessment & CCP done by/with participation of MHP, do both the QMHP who had the face-to-face, the MHP & the supervising QMHP have to sign, or is the face-to-face Q signature sufficient to meet the requirement?

Answer: The QMHP who had the face-to-face with the consumer is the only signature required by Rule 132 along with the signatures of the LPHA and client.

84. For clients involved in a Crisis Assessment, do the 30 days begin at the time of Crisis or the first time they are involved in follow-up services to begin a comprehensive mental health assessment?

Answer: 30 days begins at the time of the first contact which can be defined by the agency.

85. How is the first face-to-face date of contact determined; may an agency "pick" any date they wish, or must all client contact be documented (who-what-when-where-why) in writing, so there is no doubt about the first face-to-face?

Answer: The second scenario.

86. What are the consequences of falsifying documentation in regard to first face-to-face, or other client contact?

Answer: The agency will have to pay back what they have been paid for the service; the staff person(s) and agency may face legal consequences for defrauding the state.

87. I see people for mental health assessment who don't understand how to take their medication, what it is, etc. Several people I have seen are also going to several different providers, and I may have been the first person to realize this. You can't always wait until the treatment plan is completed. In our area, it can take weeks to get an appointment with a doctor. Therefore, the mental health assessment needs to include medication monitoring & training - what do you think?

Answer: The mental health assessment can be amended or an addendum can be added when this need is identified. The targeted goal can then be incorporated into the treatment plan.

88. When an admission note is completed within 24 hrs, can services be billed in the two week period before the mental health assessment is completed? If so, what services are allowed, any that will be recommended on the treatment plan, or only those applicable to development of the mental health assessment?

Answer: The provider has 30 days to complete the mental health assessment and ITP, and can provide all services that were recommended on the Admission Note during those 30 days. If the mental health assessment is not completed within 30 days, then no services can be billed after the 30 day mark, until the mental health assessment and ITP are completed.

89. When a client is discharged from an inpatient psychiatric or other IMD setting, the mental health assessment & ITP of the inpatient setting may be used to authorize provision of CM-Transition Linkage & Aftercare. (per Service Definition & Reimbursement Guide) At this point, they are not likely to meet Rule requirements. What shall we do - is it okay to just keep the latest copy in the record, or must we immediately ensure that they are compliant with the Rule?

Answer: The inpatient ITP should be in the client record if it is used to provide transition linkage and aftercare services while you are developing an ITP and they do not have to specifically comply with Rule 132 requirements.

90. Once the mental health assessment face-to-face is determined, the majority of private insurance companies approve one, or, with an approved exception 2 sessions; how many sessions within the 30 days will the State approve for billing?

Answer: There is no maximum number of sessions for completing the mental health assessment at this time.

91. What happens if the agency provides Case Management prior to completion of the mental health assessment, the client fails to continue treatment, and a mental health assessment cannot be completed; must we reimburse the state?

Answer: Nothing happens, because Case management can be billed prior to the completion of the mental health assessment.

92. Will the LOCUS count as the annual mental health assessment update?

Answer: No. The LOCUS can be used to determine level of care changes for the consumer, but there are other elements of the assessment that still need to be reviewed annually.

93. When a client is placed into Crisis Respite as the result of a Crisis Assessment, the mental health assessment cannot always be completed immediately due to the client's mental status. As long

as the crisis assessment recommends CS-Residential, med adm & med monitoring, will that suffice for billing until the mental health assessment can be completed, usually within 72 hrs?

Answer: Only crisis services and case management can be billed prior to the completion of a Mental Health Assessment.

94. Iroquois county has one of the highest suicide rates in the state, and coupled with Kankakee and Ford counties, one of the highest rates nationwide. Procedures for face-to-face evaluation of prospective consumers are already established, with MH screening & assessment for suicidal &/or homicidal risk, including requirements that the person is seen within 24hrs after initial contact. Does the therapist have 30 days after the initial screening to complete a mental health assessment?

Answer: The mental health assessment must be completed after the first face-to-face contact with the client. The state is defining first face-to-face contact as the point in time that the client shows up ready to commit to participation in mental health services. Presentation at the time of a crisis may not be the first face-to-face contact if the client doesn't return for services when the crisis is over.

95. What has to be included in the annual mental health assessment update?

Answer: Rule 132 defines the necessary requirements in 132.148 a).

96. Can we bill for the first face-to-face contact prior to the mental health assessment completion?

Answer: Yes.

97. Is there a unique billing code for the annual mental health assessment update?

Answer: No.

98. How do we truly identify services consumer needs -v- fitting services to the consumer?

Answer: A comprehensive assessment should be the basis of developing an appropriate treatment plan for a consumer.

99. How should we bill for psychological evaluation provided by a Master's level professional who is not a licensed clinical psychologist? Would the Psychological evaluation then have to meet the mental health assessment Rule 132 criteria in order to bill?

Answer: A psychological evaluation must be conducted and signed by a licensed clinical psychologist. A master's level professional may administer standardized testing as part of the evaluation. If the master's level professional administers standardized testing, and the licensed professional does the review, analysis and signs, then the work of the master's level should be billed as psychological evaluation. If a licensed professional does not conduct and sign, then there is no psychological evaluation and the master's level person may not bill it as such. In such a case, if the Rule 132 requirements for mental health assessment are met, the master's level professional may then be considered to be doing part of the mental health assessment process, and may bill as such.

100. We are making an effort to reach out to primary care providers in the community to make mental health services more accessible to the community and more integrated with primary care. We want to initiate mental health assessments in the primary care setting. We hope that we can establish this kind of relationship with a number of medical providers in the community. Can we bill under 132 for these assessments as an off-site service?

Answer: First, we would stress that it's important to be doing assessments on consumers believed to have a MI diagnosis. Second, yes, MHA can be billed as a 132 service. Whether it's onsite or offsite depends on the circumstances. If the primary care provider provides office space for your staff to use to regularly do assessments, e.g. every Monday morning, then that site should become one of your certified sites and the service would be billed as onsite. If, however, you are called periodically to do an assessment that needs to be done at the primary care provider's location and your staff travel there, it would be offsite. If the primary care provider

refers the consumer to you for an assessment and the assessment can be scheduled and done in your office, then it would be billed as onsite. (2/22/11)

101. An agency does some of the initial mental health assessment when a family first calls. Some of the required information for a mh assessment is gathered and recorded. Can this time be billed as assessment time even though the family/child doesn't come in for maybe a week at which time the assessment is completed and other needed information to do the case opening is completed? So the agency does some of the mh assessment on one day, but doesn't do all the case opening things, as well as finishing the assessment until another date. Can the work on the first date be billed?

Answer: Yes. MHA is not a one-time event. It is the gathering of the Rule 132 required information and may take several encounters. The MHA report must be completed within 30 of the first face-to-face encounter with the client. (2/22/11)

102. Can staff bill for time spent reviewing the client's record and gathering information for the mental health assessment update, e.g., reviewing progress notes, psychiatric consults, hospitalization records, other assessment, etc., without the client present?

Answer: Time spent reviewing the client's record, related documents or discussion with collaterals for the purpose of completing a mental health assessment or mental health assessment update is billable. Time spent actually writing the results of those reviews is not billable. (9/1/11)

103. An LPHA reviews the MHA but isn't able to sign it that day because they are requesting some additions or changes to the assessment. Can they date it the day they reviewed it or do they have to date it the day the additions/changes occurred?

Answer: The LPHA must date the MHA the day it is sufficiently complete for a review and determination by the L that it is complete and ready to sign. The date must be the date of the signature. (12/1/11)

104. A licensed clinical psychologist meets with a family in order to explain the results of their psychological evaluation and recommendations for services/approaches for their child. How would this service be billed?

Answer: A psychological evaluation is done as a result of a recommendation in a mental health assessment report. In order for psychological evaluation to be billed it must also appear on the ITP. When completed, the psych eval report typically comes back to the Q or L who have signed off on the MHA and ITP for their review. If the eval results in a modification to the ITP, the Q must discuss with the client (and parents if a child) what modifications need to be made. The psychologist may be part of that process. As described, such a meeting would be for the purpose of ITP modification and would be billed as such. If a psychologist does the eval and then explains that eval to the client (parents), that is not a stand-alone billable service. (12/1/11)

105. Rule 132.148(a) states that the clock starts on the 30 days for the assessment to be completed at the first face-to-face meeting with the client. It is obviously clinically better for us to begin our initial assessment face-to-face to better determine the client's service needs but then we often place the client on our waiting list (unless we determine the needs are urgent) which can result in the assessment being completed late.

It seems to us that it is probably not the intention of the rule to encourage phone intakes over face-to-face initial assessments so we are wondering if we could be approved to continue with our current system and not be penalized for seeing the client face-to-face. The only way we can see to comply with the rule is to not see the client in person and do a phone contact instead which seems to be an unfortunate consequence of the rule.

Answer: The point of an assessment, as you know, is to determine the need for services. If in the initial assessment period, you determine that the person doesn't currently need services, then bill for mental health assessment and close the case. When the person again comes in for services, do another assessment. The delivery of services must be based on a current

assessment, so even if you don't close the case, when the person needs or is ready for services, you're going to need to redo the assessment to be able to appropriately address her/his needs in the ITP. (12/1/11)

106. We have a client who is a minor (16 yo). She has received psychiatric services in the past (within the last 12 - 18 months) and refuses to take medications due to the significant side effects. She is currently suffering with a severe episode of MDD with psychotic features. I would like to recommend further evaluation, specifically a psychiatric evaluation, but suspect that the youth will refuse the appointment and that her parents will not mandate the service. If this is to occur, what are the expectations from Rule 132 as it relates to the requirement in 132.148(a) that the mental health assessment shall include the LPHA's recommendations for further testing/evaluation within 90 days of the MHA (or update) in order to determine further treatment planning/services?

Answer: There are two separate requirements in Rule 132. 132.148(b) talks about the requirements when a psychological evaluation is recommended. This is where the 90 day requirement is found. In 132.148(a) there is a requirement for the LPHA to make a determination in writing about the need for additional evaluations. This only requires the LPHA to note in writing if additional evaluations are needed, OR if they are not needed. There is no requirement for follow-up on these recommendations or for the evaluations to be obtained. (3/1/12)

107. Can Medicaid (Rule 132) cover the administration of the Autism Diagnostic Observation Schedule, or ADOS (1999)? It can be used for children and adults, typically administered by a clinical psychologist.

Answer: The ADOS can be used in the course of diagnosing a mental illness if a psychologist uses it during a psychological evaluation ordered as a result of a mental health assessment to rule-out autism as the diagnosis. Autism is not a diagnosis for which 132 services can be prescribed. Additionally, if someone just wants an autism screen, it cannot be billed as a rule 132 service. (3/1/12)

108. The MHA page of the Service Definition and Reimbursement Guide lists under example activities administering CGAS/GAF or other acceptable instruments to the client to document substantial impairment in role functioning. Since one of the functions of the DLA-20 is to estimate GAF, can time spent in the administration of the DLA-20 be billed as mental health assessment?

Answer: Yes (6/1/12)

109. We have a staff member who is out on bedrest. While she is out, she will be working on completing some pieces of mental health assessments that she was not able to finish prior to leaving. She is able to access these documents from home but is not able to print and sign them. We do not yet have electronic signatures on our mental health assessment, but do have electronic signatures on progress notes. If we print the mental health assessment out at our office, can we attach an electronically signed progress note that is completed indicating that she completed the mental health assessment and would this be acceptable to authenticate her signature as the completer of the assessment?

Answer: This would be acceptable as long as it is clear that the signed note serves as signature on the MHA noting verification of review and approval of the MHA. It cannot just be a note that says reviewed MHA. The note must also be accessible as part of the MHA. (6/1/12)

110. How long after a MHA is completed does the L have to sign?

Answer: The MHA is not complete or effective until the L signs it. (6/1/12)

111. What qualifies as a face-to-face meeting by a Q? We have MHPs that go out in the community and complete MHAs. Can the MHP call the Q and them speak with the client over the telephone and that count as a face-to-face?

Answer: No, a telephone contact is not face-to-face. (6/1/12)