MCCMH MCO 2-015

Chapter: **CLINICAL PRACTICE**
Title: **PSYCHIATRIC EVALUATION**

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Chief Executive Officer Date

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I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, regarding the clinical indicators for a psychiatric evaluation to assess, diagnose, and recommend treatment services for appropriate MCCMH persons served.

II. APPLICATION

This policy shall apply to all directly-operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH that a psychiatric evaluation shall be provided to any person served who exhibits the clinical indicators established by MCCMH to identify and assess the person's psychiatric/medical needs.

IV. DEFINITIONS

Psychiatric Evaluation
A comprehensive evaluation, performed face-to-face by a psychiatric licensed prescriber that investigates an person's clinical status involving the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history, including substance use, abuse or dependence; personal strengths and assets; a comprehensive mental status examination; and concludes with a written summary of findings, a biopsychosocial formulation and diagnostic impression, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.

V. STANDARDS

A. A psychiatric evaluation shall be done as an integral part of the assessment process. It serves as the guide to the identification of medical and psychiatric treatment services, including but not limited to, the need for psychotropic medications, identifying treatment goals for the individual's person-centered plan, and physical medicine interventions.

B. A psychiatric evaluation performed within the last thirty (30) days by an MCCMH contracted network provider (e.g. conducted prior to discharge from a hospital stay) may suffice where the prescribing MCCMH psychiatrist reviews the psychiatric evaluation and agrees with the content and conclusions. The psychiatrist shall indicate his/her agreement with the psychiatric evaluation and shall note this action as a progress note in the person's medical record. The prescribing psychiatric licensed prescriber shall conduct a new psychiatric evaluation of the person when he/she disagrees with the content and conclusions of a psychiatric evaluation performed within the last thirty (30) days.

C. Subsequent psychiatric evaluations may be done according to the criteria listed in Standard D, utilizing E & M coding requirements

D. Clinical indicators for psychiatric evaluation are established by one or more of the following criteria. The person served is:

1. Currently taking psychotropic medication prescribed by a non-psychiatric physician and the person's symptoms are only partially remitted;

2. Experiencing an exacerbation or significant change in baseline of a psychiatric disorder that previously responded to medications;

3. Presenting with a psychiatric disorder for which there is evidence-based support that specific psychotropic medications are known to produce significant benefit for the rapid remission of symptoms which cannot be duplicated in a timely manner by non-medication therapies (e.g. Valproate and Lithium (mood stabilizers) for bipolar disorder).

4. Exhibiting symptomatology that may have a physiologic/organic basis (e.g. hyperthyroidism with anxiety symptoms), and/or substance use.

5. Presenting a complicated medical history with psychological factors interacting with physical conditions and the medical status of the person needs to be reviewed for appropriateness of care (e.g. depressed mood is interfering with compliance with insulin and the diabetes is worsening).

6. Presenting in crisis, at risk for hospitalization, at risk for injury to self or others, and/or with significant deterioration in functioning.

7. Continuing to exhibit symptoms after treatment interventions by the treating psychiatric licensed prescriber that have not produced amelioration of the symptoms

E. An updated psychiatric evaluation shall be done at the discretion of the licensed prescriber for individuals on psychotropic medication based on clinical indicators delineated in V.D.1-7.

F. It is the responsibility of non-psychiatric providers to refer an individual for a psychiatric evaluation when clinical indicators criteria have been met (V.D.1-7). The decision not to refer shall be documented in the clinical record.

G. Regularly scheduled medication reviews (at least quarterly) shall be conducted, which shall include, among other evaluations, a mental status evaluation.

H. Scheduled, regular reviews of psychiatric evaluations shall be conducted to determine compliance with this policy and to monitor for quality and appropriateness of diagnosis and treatment recommendations.

I. Results of quality assurance reviews and monitoring will be used when considering licensed prescriber renewal of privileges/contract.

VI. PROCEDURES

A. The referring provider will arrange an appointment for the person served with the psychiatric licensed prescriber as soon as possible, and in no cases longer than thirty (30) days for a routine situation.

B. The psychiatric licensed prescriber will complete, sign, and date the Psychiatric Evaluation using appropriate credentials, specifically MD or DO. The Psychiatric Evaluation shall be completed and typed promptly within two (2) business days. See Exhibit A for a sample Psychiatric Evaluation where the network provider does not have access to an electronic medical record (EMR) system. For network providers using an EMR system, the Psychiatric Evaluation shall be electronically signed and verified.

C. The Psychiatric Evaluation shall include the following:

1. Client Identification - Information such as name, age, gender, marital status, and other pertinent, specific, identifying data;

2. Source of Referral - Referring provider;

3. Chief Complaint/Presenting Problem (CC/PP) - A concise statement describing the symptoms, problems, conditions, clinical indicators, or other factors that are the reason for the evaluation, stated in the person's own words, when possible. If the information is provided by a third party, the name and relationship of the party shall be provided. In addition, the person's reaction to the hospitalization or treatment should be stated. The CC/PP explains why the person is seeking professional care at this time and may or may not be the same as the "Reason for Admission" to a hospital or clinic.

4. Present Illness - A chronological description of the development of the person's current episode of dysfunction and/or suffering from the symptoms, problems, conditions, etc. It incorporates the chief complaint and explores details as to when the present failure in adaptation began, precipitating factors, circumstances surrounding the admission to service, and a summary of any interventions that have been utilized by a person served, family, or by other practitioners during this episode. It includes a description of the impact of the presenting problem on the behavioral and other functioning of the person.

5. History - A review of the person's relevant experience with serious and significant illnesses, including the psychiatric history, the non-psychiatric (i.e., General) medical history and treatment, the psychoactive medication history and personal and family histories:

    a. Psychiatric History - A brief summary of prior episodes of failure in adaptation such as that characterizing the present illness, other psychiatric illness, the extent of incapacity, treatment received, name of hospital (if utilized), length of stay, outcome and the impact of those experiences on the person's adaptation. The summary is to include information about use of psychotropic drugs, addressing such aspects as dosage, benefit, serious or intolerable side-effects, drug-drug interaction, and other reactions.

    b. Substance Use - A statement of substance use, including patterns of use, first use, frequency of use, patterns of abuse, and most recent use.

    c. Non-Psychiatric (i.e., General) Medical/Surgical History - Information about significant physical illnesses, operations, pregnancies and injuries, with specific inquiries about head trauma, unconsciousness, seizures, headaches, and other significant neurological conditions or symptoms.

    d. Personal History - An abbreviated exploration of aspects of the person's life pertinent to the major complaints, based on clues disclosed in relating the present illness. It also includes inquiry about education, employment, marital/sexual history, children, legal/religious beliefs/practices, etc. (i.e., social history), and identification of specific risk factors including those of dangerousness and HIV/AIDS.

    e. Family History - Any psychiatric illnesses, hospitalization, and treatment of parents, grandparents, siblings, and children.

6. Mental Status Examination - An appraisal of the "Here and Now" psychological functioning of the person served, based on interviewing methodologies which include observation, conversation, and structured exploration. It includes but is not limited to a description of appearance; attitude and behavior; affect; mood; stream of mental activity; mental content such as the presence or absence of delusions and hallucinations with descriptive examples if present; as well as estimates of intellectual functioning, memory functioning, and orientation which identify methodology used in reaching an interpretation. An assessment of judgment and insight, utilizing specific observations, is valuable.

7. Assessment of Risk Factors - An informed conclusion based on the person's history, signs and symptoms that indicate the present possibility of harm and/or risks to the person or others, such as suicide and/or homicide.

8. Summary of Findings/Biopsychosocial Formulation - A succinct summary of pertinent findings which:

    a. Takes into consideration a person's biological, psychological and social functioning;

    b. Where possible, incorporates information from assessments by other clinical professionals involved in the care of the person, review of old records, interviews of significant others and other reliable resources;

    c. Supports the examiner's conclusions about diagnosis/es and initial treatments planned, and

    d. Inventories the person's strengths/assets.

9. Prognosis - Evidence-based judgment as to how the person will respond to the management and treatment provided.

10. Diagnoses using current DSM criteria.

11. Recommendations for treatment planning - Identification of medical, psychiatric target symptoms and psychosocial risk factors and problem list with corresponding recommendations for their management. May include plans for further assessments to confirm diagnoses or to follow-up identified problem areas, length of stay estimate (possible length of time (days/weeks/months) the psychiatric licensed prescriber believes the person will continue to meet clinical indicators for this current level of care and discharge criteria (identification of level of functioning to be achieved to move person to next level of care) as applicable.

D. When a psychiatric evaluation or an update to the most recent psychiatric evaluation is conducted at the person's annual Treatment Plan update, the MCCMH licensed prescriber will request that the case holder complete coordination of care requesting the most recent annual physical. If available, this information should be reviewed and noted during the psychiatric evaluation under the biopsychosocial section of the evaluation.

E. Quality Assurance

1. Scheduled, regular reviews of psychiatric evaluation administration shall be conducted through the MCCMH's Chief Medical Office to determine compliance with this policy and to monitor for quality and appropriateness of diagnosis and treatment recommendations.

2. Results of quality assurance reviews and monitoring will be used when considering the renewal of privileges/contracts with licensed prescribers.

VII. REFERENCES / LEGAL AUTHORITY

A. Michigan Department of Mental Health Individual Plan of Service Volume III, Section 3, Subject 001, Chapter 6, 8/29/84, pgs. 1-21.

B. MDHHS Medicaid Provider Manual

C. 42 CFR 482.60

D. 42 CFR 482.61

E. 42 CFR 482.62

VIII. EXHIBITS

Psychiatric Evaluation Form (sample; may be used when the network provider does not have access to an EMR system