



DMH Billing and Documentation Training

Benefits of Training

- Paperwork is completed correctly the first time, allowing billing to be submitted on time.
- Less paperwork returned for corrections, enabling service providers to spend more time focusing on clients.
- Billing and documentation processes are consistent and alleviate stress for providers.

Purpose of Training

ATJ's Billing and Documentation Training gives providers the knowledge they need to complete paperwork on time and correctly the first time, and to manage the stress around deadlines, paperwork and changes in procedures.

The training is organized into modules. This enables us to serve particular audiences by targeting critical areas such as Mental Health, Multidisciplinary Assessment Teams and Wraparound programs. The training is experiential and includes group exercises that allow participants to practice their skills in a dynamic and interesting way. Participants receive detailed reference materials to use post-training.

Our trainings can be delivered onsite or at our offices. In addition to having ATJ's professionals lead the sessions, we also train our clients' staffs to conduct sessions and provide peer-to-peer cross-training.

Training Content

<p>Module 1 Mental Health Funding and Services Overview</p>	<ul style="list-style-type: none"> • Understanding why DMH is an important funding source and how timeliness, paperwork and productivity affects payment to the agency • Adjusting to DMH policies and billing codes that change regularly • Techniques to pass audits flawlessly • Ways to work with departments within your agency to provide high-quality client services
<p>Module 2 Assessment</p>	<ul style="list-style-type: none"> • Preparing error-free intake and assessment documentation • Conducting a thorough intake and assessment with a new client • Enhancing client engagement skills • Using attendance contracts and policies to improve therapy session attendance • Determining medical necessity in accordance with DMH standards • Writing successful goals for diagnoses related to anxiety, ADHD, depression, oppositional defiant disorder, trauma and adjustment disorder • Connecting diagnosis, symptom, behavior, goal, CCCP intervention, and progress note intervention throughout treatment and documentation • Using key information to complete important forms such as Open Outpatient Episode, Initial Assessment, and Client Care Coordination Plan (CCCP) • Which intervention verbs are acceptable and unacceptable in treatment documentation, and alternative words that can be substituted with commonly used behavior descriptors
<p>Module 3 Progress Notes</p>	<ul style="list-style-type: none"> • Understanding billing codes and accurately documenting activities in progress notes • Writing effective progress notes: <ul style="list-style-type: none"> • Avoiding common mistakes • Understanding which key elements are needed for specific procedure codes • Connecting progress notes to the overall treatment plan • Writing interventions that connect to diagnoses, symptoms, and goals • Key information to remember for all progress notes • Writing effective lead sentences, group goals, symptoms, medications, interventions, responses, and plans • Creating notes for evidence-based practices
<p>Module 4 Chart Updates and Collaboration</p>	<ul style="list-style-type: none"> • Completing documentation for single fixed point of responsibility (SFPR) • How to change a client's diagnosis • Identifying which forms need to be updated on an annual basis for case managers and therapists • Completing error-free Annual Assessment documentation
<p>Module 5 Closing a Chart</p>	<ul style="list-style-type: none"> • The process for closing a client's chart completely and accurately • How to complete necessary forms to close a client's chart • Writing progress notes that close a client's chart according to DMH standards