YOLO COUNTY
Health & Human Services Agency

Avatar CalAIM Diagnosis Form/Problem List

Desk Reference

The purpose of this desk reference is to provide users information on accessing and entering Diagnosis and Problem List member data. Problem Lists are populated with information through the Diagnosis Form. Items that must be added to the Problem List will be entered using the Diagnosis Form.

- **Scope of Practice:** All direct service providers may update the Problem List according to their scope of practice. If you are unsure what Problem List elements are in your scope of practice to update, speak to your supervisor.

- **Uses:** To fulfill diagnosing and Problem List requirements. An appropriate diagnosis is required for Medi-Cal billing. Additionally, DHCS requires a Problem List, which is a complete list of applicable diagnoses, conditions, symptoms, and risk factors. The Diagnosis Form is used to capture required elements of the Problem List and assure accurate diagnostic information for billing.

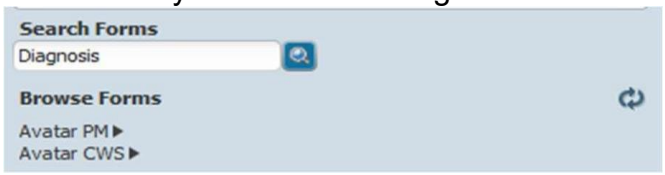
- **Details:** Prior to the completion of an assessment or the determination of a diagnosis, members are eligible to receive appropriate SMHS services and Yolo HHSA is able to claim for these services when the appropriate diagnosis codes are entered into the Diagnosis Form. ICD-10 codes are required to submit claims (DHCS BHIN 22-013); providers may use the following diagnosis options during the assessment phase of a members' treatment when a diagnosis has yet to be established:
  - ICD-10 codes Z55-Z65 – These codes are often referred to as Social Determinants of Health, meaning they are non-medical factors that influence health outcomes, such as the conditions a person grows up in, lives in, or works in. They include social and environmental factors as well as historical factors.
    - May be used by all providers as appropriate during the assessment period prior to diagnosis
    - May continued to be used throughout services to document members expressed areas of concern
  - ICD-10 code Z03.89 – "Encounter for observation for other suspected diseases and conditions ruled out".
    - May only be used by and LPHA or LMHP during the assessment phase of a member's treatment when a DSM diagnosis has yet to be established.
  - ICD-10 "Other specified" and "Unspecified" disorder codes" – In cases where services are provided due to a suspected disorder that has not yet been diagnosed, these options, as well as Z Codes, are available for an LPHA or LMPH. LPHAs and LMHPs may use any clinically appropriate ICD-10 code. These include codes "Factors influencing health status and contact with health services."

- **Accessing the Diagnosis Form** – the form may be accessed two ways, from within a

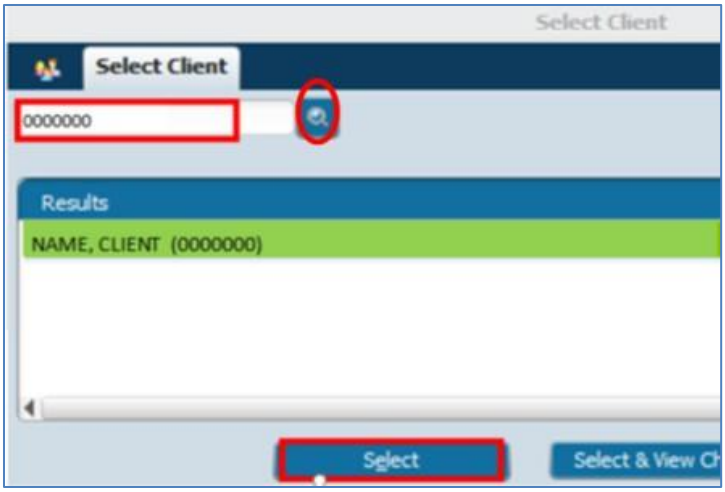
member's chart by clicking "Diagnosis" from the menu of forms on the left side of the screen or by following these steps.

- **Menu path**: Avatar PM >Client Management >Client Information (or you can enter "Diagnosis" under Search Forms)

- **Steps:**
  - From the Home view, click Avatar PM > Client Management > Client information or you can enter "Diagnosis" under Search Forms.

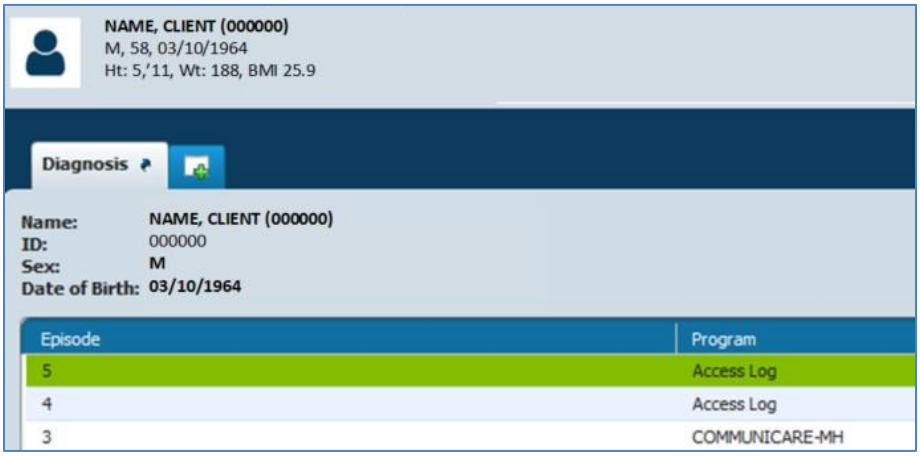


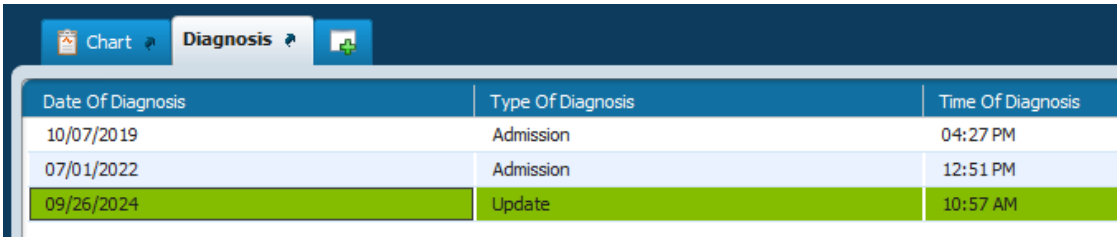
  - In the Select Client screen, enter the client ID, click the Search button, and select the corresponding entry:



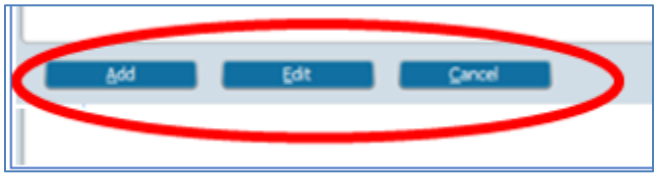
If the client has multiple episodes the episode pre-display shows. Select the correct episode, click OK.
Note: you may only enter diagnoses in open episodes with no "end date" in the "End" column.

- If the episode already has one or more completed diagnosis entries, they will display as a list from oldest to newest diagnosis





- At the bottom of the form with all previous diagnosis entries, the user will see options to ADD, EDIT, or CANCEL.



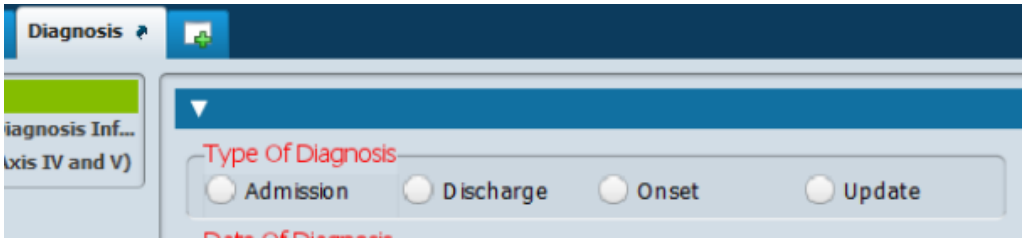
  - **ADD** allows the user to add a new diagnosis. By using Add, the user will enter a new type, date, time of diagnosis, diagnosing practitioner, etc. Use ADD to add a new diagnosis/problem.

  - **EDIT** allows the user to change only specific information for a previously entered diagnosis. For example, select EDIT to resolve or end a diagnosis/problem (see below for more information on resolving a diagnosis or problem).

  - **CANCEL** takes the user out of the Diagnosis Form without making any changes.

- **Entering a Diagnosis**
  Unless otherwise indicated below, all fields on the Diagnosis Form are required regardless of whether they are indicated with red font in Avatar.

  - **Type of Diagnosis:** Make the appropriate selection in this field. Note: This selection cannot be changed when editing an existing diagnosis. Currently, only two “Types of Diagnoses” are utilized in Avatar: Admission and Update:



    - **Admission:** For new clients, select “Admission” to establish an appropriate diagnosis for the first dates of treatment (i.e., the assessment phase). This may include Diagnosis/Problem List items such as the Z-Codes that may be used during this period, as discussed on page 1 of this desk guide.

    - **Update:** Select “Update” when a change needs to be made for existing

diagnoses or Problem List items. The updated diagnoses are used for billing from the date of that updated diagnosis forward. Previous diagnostic information will be used for services prior to the date of the updated diagnosis.

- **"Discharge" or "Onset":** These options are not currently used by Yolo County Behavioral Health.

In the Date of Diagnosis field, enter the diagnosis date. When Admission is selected, the date populates to the date the episode was opened. Do not change the date of diagnosis for an admission diagnosis. In the Time of Diagnosis field, click Current.

- **There are additional optional fields for use if clinically relevant. They allow for "pulling forward" previously entered diagnostic information.**

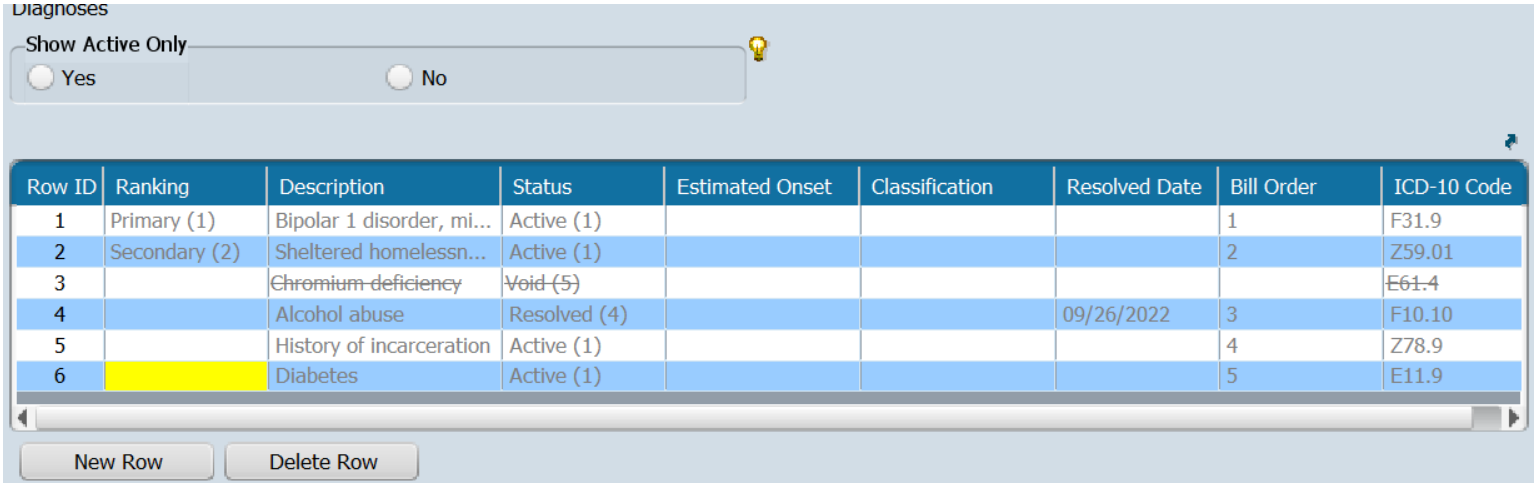
Note: Pulling prior diagnosis form information into the current diagnosis form will delete data the user has already entered. If you plan to pull other diagnosis information into the diagnosis form, do so **before** you begin to add any current diagnosis or Problem List items.

The additional fields are:

- **The "Select Episode to Default Diagnosis information From" field:** This allows the user to select diagnosis information from a previously completed diagnosis form from the same or a previous episode. This function allows the user to "pull forward" that diagnosis information which can then be modified (diagnoses added, removed, etc.).

- **The "Select Diagnosis Entry to Default Information From" field:** This allows the user to select diagnosis data from previously entered diagnosis forms within the episode selected in the field above, the "Select Episode to Default Diagnosis information From."

- **The Diagnosis grid** section of the form controls the diagnosis records for the member. Both mental health and substance use diagnoses and all Problem List items will be on the diagnosis grid.

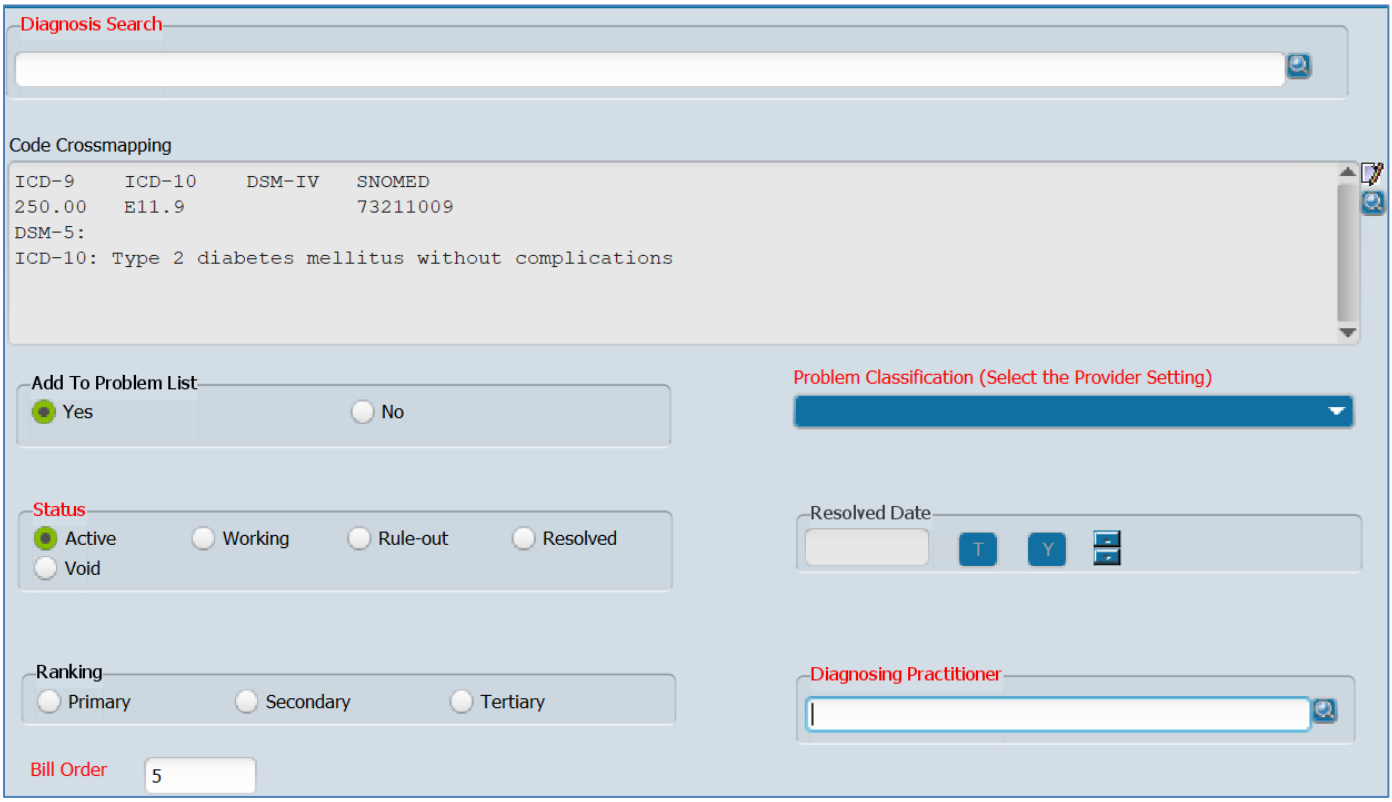


  - Voided diagnoses appear with a strikethrough, to see only Active diagnoses, select Yes under Show Active. Selecting No includes all entries in the grid. (Any rows that are missing a required field will not be removed, regardless of their status, and newly entered rows with any status remain on the grid until Yes is selected again.)

  - The “Light Bulb” icon displays help text if you select it. This explains the functionality of selecting “Yes” or “No” in this Show Active Only field.

  - Use the **New Row** and **Delete Row** buttons to add or remove records as appropriate.

- **To Add a Diagnosis or Problem List item:** After clicking New Row, use the **Diagnosis Search** field; enter a term to describe the diagnosis, ICD-10 Code, or Problem list item,



i.e., “schizophrenia”, “F20.9”, or “homelessness”.

1. Select the Search Icon and make your selection by double clicking on it the option that populates in the list.
    - Some search terms or diagnosis types, such as diabetes or schizophrenia, will return a long list of possible diagnoses selections. It is important to carefully select the most appropriate code.

2. Once selected, the appropriate code information will appear in the “**Code Crossmapping**” field where other associated codes and the full title of the code will show.

3. The “**Add to Problem List**” will default to “Yes.” **Do not change this response.**

4. The “**Problem Classification**” filed is required. Use the drop down and select MH Provider Setting or SUD Provider Setting depending on whether the services are claimed through Mental Health or Substance Use Disorder treatment.

5. In the “**Status”** field, select if the diagnosis or Problem List item is active, working, a rule-out, resolved or void based on the definitions below. Keep in mind that to manage Problem List items that have already been created, the user needs to select “Edit” from the Add/Edit/Cancel button options reviewed on page 3.

    - **Active** - A diagnosis for which the client is currently being treated. The diagnosis will be included in claim information.

    - **Working** - A diagnosis for which the client is currently being treated in order to confirm whether the diagnosis is active or should be ruled out. The diagnosis will be included in claim information.

    - **Rule-out** - A diagnosis that was in a working state but has now been ruled out. The diagnosis will not be included in claim information.

    - **Resolved** - A diagnosis for which the client is no longer being treated. The diagnosis will not be included in claim information if the date of service is past the date entered in the Resolved Date field. The diagnosis 'Bill Order' cannot be edited for diagnoses with a status of Resolved and should not have a bill order value.

6. In the **Ranking** field, select the appropriate rank of the diagnosis being entered as applicable (primary, secondary, tertiary). When a client has a Co-Occurring Substance Use and Mental Health disorder (SUD, MH), either diagnosis can be entered as primary or secondary as long as

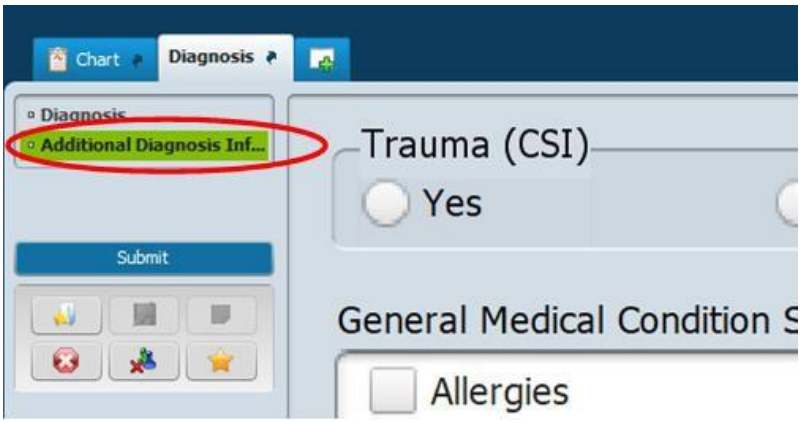
both diagnoses are present. If, through assessment, the client is determined to have a SUD diagnosis only, Specialty Mental Health Services (SMHS) prior to that determination are still billable, but the provider should work to coordinate care and transfer the client to SUD services once the "SUD diagnosis only" determination has been made.

7. **Diagnosing Practitioner**: Enter the provider responsible for the diagnoses or problems being added or changed. This value should default for each individual diagnosis entered. The diagnosing practitioner for different diagnoses and problem list items can be different as providers will add to and change the diagnosis form according to their scope of practice.

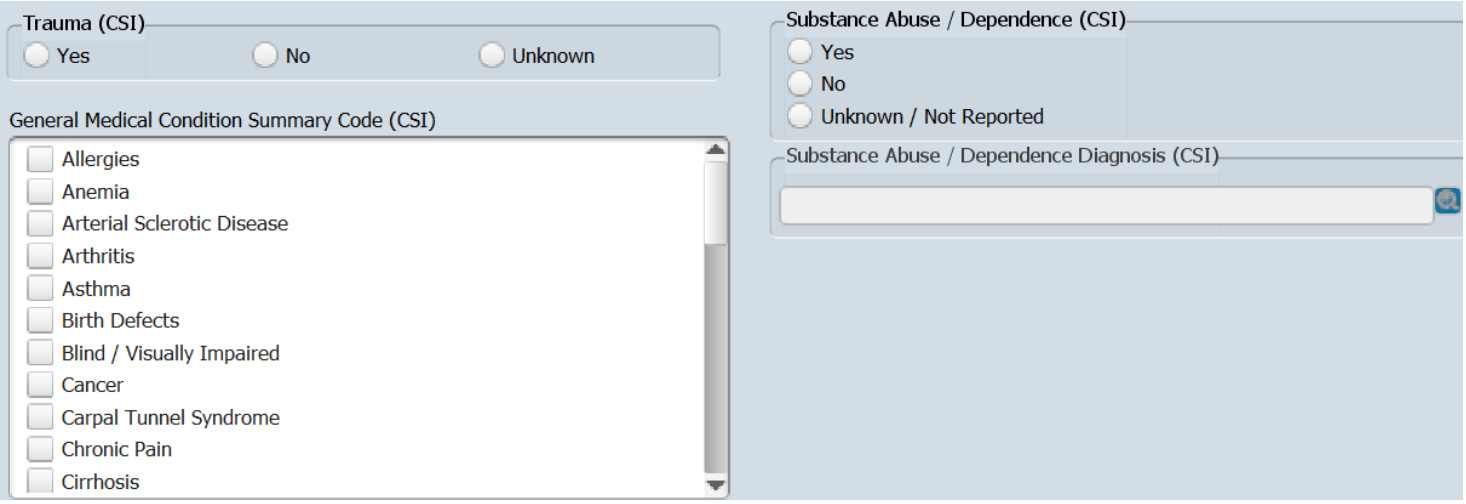
8. **Bill Order**: Enter the order in which the diagnoses will appear on a claim. The entry marked as "Primary" in the Ranking Field will default to a billing order of "1." The system calculates billing based on the diagnosis billing order.

9. **Remarks** (if applicable): an optional field which allows for entry of specific diagnosis remarks (for example, providing a brief description if a Z code had been entered or resolved, to provide a more clinically robust picture).

- **Additional Diagnosis Information** is the second page of the diagnosis form, the user will select it from the top left-hand corner of the window:



  - The fields on this tab collect important "Client and Service Information" (CSI), which is required data from DHCS for all counties to collect and report. These fields should be completed as follows:



- **Trauma**: select the appropriate response: Yes, No, Unknown
- **Substance Abuse/Dependence**: select the appropriate response: Yes, No, Unknown
  If "Yes" is selected, then the Substance Abuse/Dependence Diagnosis must entered (i.e., "alcohol") and the correct diagnosis from the list that will appear must be selected. An ICD-10 code may also be entered (i.e., F10.10 – Alcohol Abuse). **Note: if entering a SUD diagnosis here, it should exactly match any SUD diagnoses entered in the first "Diagnosis" tab. If "No orUnknown" is selected and there is a SUD diagnosis entered in the first "Diagnosis" tab, a CSI Error will be created.**
- **General Medical Condition Summary Code**: select any medical conditions the member has had and/or is currently experiencing.

- Once all data on this tab has been entered, select the "**Submit**" button towards the top left-hand corner of the screen:

Problem List Report

Once the Diagnosis Form has been completed per these instructions, you will be able to print a Problem List report for the member, support persons, and/or other providers. This report will include (but is not limited to) the following information:

- Diagnoses identified by providers acting within their scope of practice (i.e., DSM/ICD-10 Mental Health and/or SUD diagnoses)

- Problems identified by providers (within scope of practice, if applicable) with appropriate ICD-10 codes (i.e., “Homelessness”, “Problems related to primary support group”).
- Problems or illnesses identified by the client and/or significant support person (if any)
- Name and title of the provider that identified, added, or resolved a problem on the list with the date it was identified, added, or resolved.

- **Creating a Problem List Report**
  - **Menu path**:
    - For mental health programs - Avatar PM >Reports >MH Problem List by Client (or you can enter “Problem List” under Search Forms to begin the search)
    - For SUD programs - Avatar PM >Reports >SUD Problem List by Client (or you can enter “Problem List” under Search Forms to begin the search)

- Select member as described on page 2 of this desk guide.

- The Report Tab will launch. Select the “Process” button:

The Problem List report will launch. Select the print icon at the top left-hand side of the screen to print the report for distribution to the member, support persons, and/or other providers.