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1.0 THE PSYCHOLOGY CLINIC

The Psychology Clinic is located within the University of Florida's Health Sciences Center and is operated by the Faculty of the Department of Clinical and Health Psychology. The Department also operates several clinics in local rural communities, various physician clinics including Magnolia Park Women's Center. The purpose of our Clinic is to provide Clinical-training opportunities for post-doctoral fellows, departmental interns and doctoral students and for the delivery of high quality psychological assessment, consultation and treatment services. In order to maintain a steady stream of teaching cases as well as meet professional standards of care, continuous services must be available.

As a teaching clinic, it is our responsibility to inform all patients of that mission. Faculty members will introduce themselves to all patients. Either the faculty member or trainee will explain to the patient that the trainee is under the direct supervision of the attending faculty member who may observe assessment or psychotherapy sessions directly or via audio or videotape. Patients should be assured of their confidentiality and of the availability of the attending faculty member as needed.

A primary mission of the Psychology Clinic is the training of graduate students and interns in clinical and health psychology. Students and interns are, at all times, assigned to specific faculty mentors who are directly responsible for each case in the clinic.

For psychological and neuropsychological assessments and psychotherapy intake evaluations, faculty members will meet each patient, be on site during the intake, assessment and any formalized testing, and be part of the feedback to those patients when the assessment is completed. Faculty members will help prepare, review, approve, and sign all assessment reports done under their immediate supervision.

For ongoing psychotherapy treatment cases, faculty members will meet patients at the outset of treatment. Patients will be appropriately informed that the faculty supervisor is available throughout the course of treatment should the patient have concerns or questions about their care. At the outset of treatment, a therapy treatment plan and problem list is jointly prepared by the therapist and faculty supervisor and co-signed by the faculty supervisor who has responsibility for the ongoing treatment. Faculty members will be responsible for each therapy session and co-sign each psychotherapy session progress note. At the conclusion of treatment, a therapy summary is jointly completed by the therapist and faculty supervisor and co-signed by the faculty supervisor thus assuring proper termination of care and/or proper disposition of the case for further treatment if required.

Patients will be asked to sign consent for audio or video tape recordings that are an integral component for supervision. The Psychology Clinic, and the supervision of trainees, are in accordance with both the "Ethical Principles of the American Psychological Association" and the "General Guidelines for Providers of Psychological Services of the American Psychological Association."

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2.0 CLINIC PERSONNEL

The Clinic Director, Dr. Glenn Ashkanazi, is a Clinical Faculty member in the Dept of CHP. He is responsible for implementation of the Clinic’s mission and to assure efficient daily operations. He coordinates the activities of the Clinic with the rest of the faculty through the “Clinical Operations Group (COG)” monthly meeting of which he is the Chair. Dr. Ashkanazi coordinates Clinic budgetary issues with the Dept of CHP’s Business Manager, Mark Ivanowski.. Issues related to graduate student or intern training are coordinated with the Director of Graduate Student Training, Dr. James Johnson, and the Internship Director, Dr. Eileen Fennell.

Clinic personnel, involved in the day-to-day Clinic operations, include a Senior Clerk (Vera Hemphill), a Financial Assistance Counselor (Jeanne Beyer), and a receptionist (Khanya Bennett). Janice B. Ogwada, Front-end Office Manager, is responsible for the day-to-day operation of the Clinic "front office." Mr. Michael Sampson is the Back-end Billing Manager and oversees all clinic operations and focuses on billing and reimbursement issues. These individuals are central to the efficient operation of the Clinic as a service delivery system and perform a multitude of interrelated functions in helping faculty and trainees serve patients. These activities include serving as patient reception, taking referrals and scheduling appointments, sending packets of questionnaires for patients to complete prior to the time of their appointment, calling patients to remind them of appointments, paging providers when patients arrive, ordering medical records and psychological testing materials, ordering and managing clinic supplies, managing Clinic files including routing of information to designated recipients, copying and sending reports, interacting with patients regarding financial or scheduling issues, processing bills and monitoring the billing process, consulting with third parties regarding payment for Clinic services, and collecting and summarizing data necessary for the completion of reports regarding the functioning of the Clinic. Dr. Ashkanazi and Ms. Ogwada perform coordination and maintenance of the scheduling system. Clinic staff does not function as clerical support for trainees or faculty above and beyond the broad categories listed above.

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3.0 CLINIC ORGANIZATION

The Clinic is organized into two major functions; (a) assessment/consultation and (b) ongoing treatment.

3.0.1 Trainee Supervision Policy

The changing and expanding roles of psychologists in health care require the rethinking and specification of supervisory relationships involving faculty and trainees. As little as five years ago, the vast majority of supervision in the department was directly offered by faculty for trainee-performed service delivery in the Psychology Clinic setting. Now, however, trainees are providing services in rural settings, in schools, in homes, and in other venues, and supervision is provided not only by faculty but also by postdoctoral associates. The Curriculum Committee has examined the issues brought up by such diverse supervisory relationships and offers the following guidelines and policies to govern each major type of relationship. The Curriculum Committee believes that these policies pertain to all supervised patient contacts occurring in research and practicum settings. A major distinction is made between “*direct supervision*” (supervision provided directly by a licensed faculty member) and “*indirect supervision*” (supervision provided by an unlicensed trainee [e.g., post-doctoral associate] or faculty member who is, in turn, under the supervision of a licensed faculty member). In “indirect” supervision, the student trainee typically does not meet weekly with the licensed faculty member, but receives most of the direct supervision from his/her unlicensed designee.

1) **Local Direct Supervision**. Local direct supervision is supervision offered directly by licensed faculty members for services delivered in the local health science center environment. Such supervision is expected to be face-to-face and is governed by the existing Psychology Clinic policy on Billing and Supervision. In cases where licensed faculty supervises ongoing psychotherapy cases, it is expected that the faculty will meet the patient directly during an initial therapy visit and that, during this meeting, the supervisory relationship between the faculty and trainee therapist will be discussed with the patient.

2) **Remote Direct Supervision**. Local direct supervision implies that the supervisor is physically available for supervisory consultation *at the time services are rendered*. In instances where the supervisor is not officially at work at the HSC or is out of town, the supervisor will find another faculty member willing to take on the supervisory responsibilities for the case until the original supervisor returns. In these instances, the faculty supervisor *de facto* transfers case responsibility to another physically present institutional representative (i.e., professional psychologist) for supervision of that service event.

Remote service delivery is defined as a service delivery event in which no institutional official is physically available to provide immediate supervision or intervention (e.g., in home or school visits). In these instances, documentation must exist prior to service delivery that a decision-making process has taken place that specifically includes an assessment of risk to the student. Three categories of risk are differentiated as follows: (1) no or low risk, (2) medium risk, (3) high risk. Definitions of risk will be considered on a case-by-case basis, and the specific conditions

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considered must be documented in the chart. For Category 1 cases, the student will be permitted to see the case alone. For Category 2 cases, students will be required to carry a cellular telephone that would permit immediate contact with the faculty supervisor. For Category 3 cases, students will be required to carry a cellular telephone and to be accompanied by an addition person who can perform the functions of oversight, witnessing, and/or physical intervention should such functions become necessary. After the service delivery event, the existing Psychology Clinic Policy on Billing and Supervision governs provision of direct supervision by the faculty supervisor.

3) Indirect Supervision. As indicated above, “*indirect supervision*” is defined as face-to-face supervision of student and intern service delivery by an unlicensed professional (postdoctoral associate, faculty) who is, in turn, supervised by a licensed faculty member. This is termed “indirect supervision” because the responsible professional (the licensed faculty member) normally provides oversight indirectly through the actions of an unlicensed psychologist.

(a) Supervision by Unlicensed Faculty. It is expected that unlicensed faculty members who provide supervision of graduate students and interns will follow all existing policies regarding billing and supervision. The licensed faculty member who is ultimately responsible for these cases should arrange to meet the patient during the assessment or during an early therapy session, at which point the supervisory relationships in place for that patient’s care are explained. Unlicensed faculty are expected to pursue and obtain licensure at the earliest possible time they are eligible for licensure.

(b) Supervision by Post-Doctoral Associates. Indirect supervision by post-doctoral associates is permissible provided that an explicit policy for supervision is in place. All supervision by post-doctoral associates is expected to conform to existing policies on billing and supervision. In all cases in which this arrangement is used, students and interns must be furnished with an explicit plan they should follow if they wish to contact the licensed faculty supervisor directly for consultation. It is expected that the post-doctoral associate who provides supervision to students and interns should have in place a regular supervisory meeting with the responsible licensed faculty member. It is also expected that the licensed faculty member meet with the patient during assessment or (for therapy cases) early in treatment so that the existing supervisory relationships that govern the patient’s care are discussed directly with the patient. It is advisable that periodic combined supervisory meetings involving the responsible faculty member, the post-doctoral associate, and the student/intern supervisees be arranged to allow for timely discussion of clinical and supervisory issues.

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3.0.2 Rules Regarding Initial Evaluations (For Both Inpatients and Outpatients):

Medicare rules for initial evaluations require that the billing provider personally provide the level of service necessary to support the billed code. Our current procedure, where our faculty establishes an initial plan of care for an initial patient and establishes a "problem" that is then evaluated by the trainee, with continuing involvement of the faculty, is appropriate.

Meeting this requirement necessitates that the provider either personally perform or provide supervision when non-licensed trainees are involved with new patients. In the case of supervision, you MAY be either:

In the room with the trainee when doing an intake on a new patient, OR;

You are observing in real-time (i.e. watching the intake on a video monitor), OR;

If not in the room, or watching real-time on video monitoring equipment, you are "immediately available" (defined as being within a 5 minute travel time to provide in-person supervision) which includes being within the Health Professions, Nursing and Pharmacy building. It IS permissible to monitor more than one intake simultaneously. OR;

It is permissible to personally perform a clinically pertinent interview of the patient after there has been an interview done by the trainee (basically a repeat interview). Your interview may be abbreviated (i.e. you first look over the data collected by the trainee and then confirm the clinically pertinent information with the patient to your satisfaction). What is required here is that you feel comfortable that you have personally gathered enough information to justify saying that you performed the intake by performing the key components. Medicare does not specify length of time that you spend with the patient. The American Medical Associations CPT Manual states that a Psychiatric Diagnostic Interview (90801) consists of a history, mental status and disposition examination.

Documentation Required:

Inpatient:

In the room (Inpatient on the unit): Trainee may sign and create a note and/or a diagnostic report. A separate note must be added that states that you were:

- 1) Directly observed and participated in the evaluation, and you agree with, and are responsible for, the observations, summaries, conclusions, diagnosis and plan of care. OR;
- 2) The trainee(s) listed above participated in this evaluation, but I conducted the interview and am responsible for the conclusions, recommendations, diagnoses and plan of care contained in this report.

Outpatient:

Outpatient in our/or other Clinic: Trainee may sign and create note and/or diagnostic report. A phrase needs to be added that states that you supervised the entire evaluation, were available to immediately intervene and you agree with the observations, summaries, conclusions, diagnosis and plan of care.

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Repeating Evaluation: If the trainee writes a note/report, you must also write a separate note/report documenting your separate assessment, performed by you and not by the trainee. These two notes/reports will undoubtedly be duplicative.

3.0.3 Rules Regarding Treatment (Different for Inpatients vs. Outpatients-See below)

Inpatient:

Same rules apply as for the initial assessments. See below:

These rules require that real-time supervision is necessary when non-licensed trainees are involved with return patients. That is:

“You, the licensed provider, must be present and carry out the entire treatment session, OR, Contemporaneously observe the treatment session the entire time through direct observation. “

If these conditions are not met, no bill may be submitted

Notes should contain the phrase; Patient is being seen in follow-up pursuant to plan of care from initial assessment, or Patient is being seen in follow-up pursuant to plan of care from initial assessment as revised by Dr. _____ on [DATE].

Outpatient:

Our current procedures, where our faculty provides a plan of care for an established patient with an established problem that is then followed by the trainee, with continuing involvement of the faculty, are appropriate.

It does not require real-time observation. Taped supervision (time-delay) is acceptable.

Notes should contain the phrase; Patient is being seen in follow-up pursuant to plan of care from initial assessment, or Patient is being seen in follow-up pursuant to plan of care from initial assessment as revised by Dr. ____ on [DATE].

Billing (Inpatients and Outpatients)

Faculty will be required to indicate on the actual bill those portions that fall under these rules and are therefore appropriate to bill Medicare. They will further indicate (for tracking purposes) those services performed by a trainee (but which do not comply with said rules) and are therefore not billable to Medicare (i.e. Medicare does not say that you cannot use non-licensed trainees in the care of Medicare beneficiaries, however, they will not reimburse for those services). The actual edits to our current bill will be distributed at a later date.

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Faculty are expected to track those CPT codes, and time spent in the care/assessment of Medicare beneficiaries, for both themselves as the licensed provider and for non-licensed trainees. Notes can be written directly on our current bill sheet that reflects this information.

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3.1 Assessment and Consultation Services

Major assessment and consultation functions (including the provision of short term interventions for hospitalized medical patients) are provided by "teams" of trainees working with faculty members representing the core training areas of the Clinic (i.e. Neuropsychology, Child Psychology, Health Psychology).

Many of the faculty in the department are affiliated with the Psychology Clinic. The Neuropsychology and Child Psychology “teams” provide Clinic coverage one day per week (Monday through Friday). Health Psychology “teams” provide Clinic coverage across days.

In conjunction with their respective training directors, Neuropsychology and Child Psychology trainees (practicum students and interns) are scheduled for specific days in the Clinic and supervised by faculty members who are members of the Clinic team responsible for coverage on that day. Health Psychology trainees are scheduled across days but only in conjunction with their respective training directors and faculty supervisors.

Outpatient evaluations are scheduled Monday through Friday on a first come, first serve basis (with the exception of emergencies). Evaluations are typically scheduled for specific faculty members and are scheduled for a team based upon available trainee and faculty time and specialty.

The team “on Clinic” for a given day meets at the beginning of that day to discuss cases scheduled for that day and the nature of those resources necessary to meet Clinical demands (e.g., rooms, tests).

3.1.1 Outpatient Assessments:

Outpatients who are scheduled to be seen on a given day (and inpatients that are scheduled in advance) should be seen promptly at the time they are scheduled.

3.1.1.1 Billing and Supervision

All trainee conducted Clinic assessments should receive face-to-face supervision within 24 hours of service delivery. Reports for all assessment services should be completed within 48 hours of the service date. The assessment supervisor will sign the final report. It is ultimately the faculty’s responsibility to see to it that the bill is properly submitted to the Clinic for processing. There is no need to wait for a final report to be completed for a bill to be submitted. The trainee and faculty bear equal responsibility for performing this task in a timely fashion.

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3.1.2 Consult and Liaison Service Assessments:

Inpatient referrals are to be responded to the same day the request is received in the Clinic. However (except in the case of emergencies), if the consult is received after 4:00 p.m. the evaluation can be considered a consult for the following day. In such instances, however, it is necessary to make contact with the referral source, obtain sufficient information to determine that the consult does not constitute an emergency and arrange for the case to be seen the following day. **A note to that effect should be included with the referral information** that is passed on to the next team responsible for the consultation.

3.1.2.1 Inpatient consults for Neuropsychological Assessment

All inpatient consults for Neuropsychological Assessment received by clinic staff will be reviewed by the Neuropsychology Faculty member on Clinic that day. The faculty member will contact the referring physician to determine the consult question. The faculty member will then decide if the patient can be seen the same day or moved to the next available day. Before deciding to move the patient to another day, the Neuropsychology faculty member must take into account the resources available and notify the Clinic Director of the need for coverage. Epilepsy consults will all be referred to outpatient cases.

3.1.3 Work Load Expectations:

For students on required practicum, interns, fellows, and residents, Clinic days are full days and can last into early evening; interns, fellows and graduate students should not schedule other appointments (e.g., therapy, supervision, classes, research meetings) on their assessment Clinic day. The intensity of this experience helps focus the new Clinician on the importance of maintaining an organized approach to patient care.

3.2 Ongoing Treatment Services

3.2.1 Clinic Treatment: Outpatient

All new outpatients that are referred (by self or other professionals) as potential therapy cases will be scheduled for a “treatment evaluation.” This means that all new referrals for treatment (including self referrals) will be scheduled for “evaluation for treatment” at the next available Clinic team opening. Professional referrals to a specific faculty member by name will be scheduled when that member’s team is on duty. If this is a problem for the referring source, then Clinic staff will consult with the referral source to discuss the scheduling of the case. Treatment evaluations may be scheduled with the explicit and prior understanding

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that, in some cases, we may be unable to provide treatment through the Clinic. In such cases, all attempts will be made to make an appropriate referral for treatment outside of the Clinic. Intake "treatment evaluations" are scheduled as an assessment and are the first contact for a patient who may become an ongoing treatment case. Many of these will occur in the "Mental Health Clinic" which are appointment slots some faculty have spread throughout the week that are for traditional mental health cases. Faculty on specialty clinic have the option of accepting these 1 hour evaluations on their normal clinic day. Cases being referred for therapy should be emailed to Dr. Duane Dede (Therapy Case Coordinator) at therapycases@phhp.ufl.edu.

The patient financial eligibility should be determined by the front office as soon as the case is identified as a treatment case. At the very least, the patient financial status *must* be clarified prior to the first meeting with the therapist. Case assignment can be made prior to the financial assessment but the patient should be informed that treatment planning is pending the financial and insurance approvals.

A faculty member has two options; either supervising a trainee who carries out the treatment evaluation or conducting the evaluation themselves. A supervisor has the responsibility at the end of the treatment evaluation to give the patient general results and recommendations. The faculty member may also schedule treatment if he/she plans to see the patients in treatment themselves.

3.2.1.1 Financial Assessment and Training Cases: In some cases where the patient is unable to pay for ongoing Clinic services, the patient should **not** be informed that the Clinic will take them as a therapy case *until a training case determination is made*. Ideally, that decision should be made while the patient is in the Clinic or on the same day as the assessment. If the determination cannot be made immediately, the patient should be informed that they would be contacted regarding disposition.

For a case to be seen without financial resources or with Medicaid that does not reimburse us for our services, it must be determined that this case will serve an important training need in the Clinic in general or for a specific trainee in need of an experience with that type of treatment case. The Supervisor and Trainee, in conjunction with other faculty members, including the Clinic Director will make that "teaching case" determination and the treatment case assignment. This is accomplished through submission of a "Fee Waiver Request Form" found in the Clinic workroom. This form includes important information to be used to make this determination. If a reduction in fees, as opposed to a total waiver, is required for the patient to be seen, than this occurs only with *permission* of the Clinic Director. These requests must occur through written request.

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3.2.1.2 Referral Out of Clinic: If it is not possible for the patient to be seen in the Clinic (i.e. we do not provide the service the patient requires is the only reason to refer out), **it is imperative that an appropriate referral should be pursued** and the case is not closed to our Clinic until such a referral is given to the patient and documented in the patient chart. Prior to disposition, the patient should be informed that they may contact the Clinic in an emergency. While, as noted above, evaluation supervisors may elect to continue to see the case themselves, recommend treatment, recommend a therapist, or request to supervise the case in treatment, it is the responsibility of the faculty and the trainee to make the final therapy assignment and to follow up that the referral has been completed.

3.2.1.3 Therapy Recommendation: Whenever the outcome of the evaluation includes a recommendation for therapy, a THERAPIST/ SUPERVISOR ASSIGNMENT FORM (yellow sheet) must be filled out immediately by the trainee who has primary responsibility for the case (in conjunction with his/her supervisor). Therapists and other supervisors may be recommended. This THERAPIST/SUPERVISOR ASSIGNMENT FORM must also contain information regarding whether the patient has insurance that will cover therapy (plus amount of coverage and amount of co-payment required) or if the patient is not insured, the percent discount the patient qualifies for (as determined by the Clinic's sliding fee scale). This information can be obtained from the Office Manager (Janice Ogwada). *For uninsured patients who qualify for greater than a 75% discount, it will be necessary for the referring Clinician to clearly document the extent to which the case being referred for treatment represents a good case for training* (see paragraph above).

If the Clinic is unable to see a patient in treatment (when it has been recommended) for either a financial or Clinical reason, it will be the responsibility of the Supervisor, or his/her designee, to notify the patient and give appropriate referral information to assure adequate disposition.

If a patient is accepted into treatment in the Clinic, the Therapy Case Coordinator will assign a therapist and supervisor so that the patient can, in turn, be contacted as soon as possible (usually within one or two days). The faculty may request certain types of cases and/or specific students to supervise just as students may request certain types of cases and/or specific faculty to serve as supervisors. Such requests should be given to the Therapy Case Coordinator. It will often be possible to honor these requests and recommendations. Students and supervisors shall make certain that their master log of therapy cases is kept up to date, including new patients

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and terminations, so that assignments can be done with the maximum amount of information available.

The initial treatment evaluation will be charged at the full Clinic rate (for a minimum of one hour). As noted above, for patients entering treatment, information regarding insurance coverage or recommended charges based upon the patient's ability to pay will be available to the supervisor and therapist prior to the first scheduled treatment session. A minimum fee of \$12.80 will be charged to all patients for each therapy session.

3.2.1.4 Treatment case transfers: In order to assure proper continuity of care and adequate training experiences, **the supervisor of a treatment case is responsible for the assignment of a new therapist for those cases under his or her supervision** that must be transferred [for training reasons, Clinical reasons, end of a practicum or internship experience]. **The supervisor will complete** a Yellow Therapy Assignment Form with the changes and submit that form so that the Master Therapy Log can be updated.

3.2.2 Clinic Treatment: Inpatients

The range and type of treatment interventions for inpatients is great and requires different procedures from outpatients. The faculty member responding to the consult request will be responsible for brief intervention with inpatients as well as supervising any student or intern assigned to the case. When, in the opinion of the supervisor, the case becomes comparable to an outpatient case in either length or intensity, the Therapy Case Coordinator will be notified by the supervisor via the THERAPIST/SUPERVISOR ASSIGNMENT (Yellow) FORM for addition to the regular therapy data base as an ongoing treatment case.

3.2.3 Ongoing Treatment Services: General Information

The therapy system will not work without the prompt input of all required information. Prompt submission of the THERAPIST/SUPERVISOR ASSIGNMENT FORM is the professional responsibility of the faculty member and trainee assigned to the evaluation case. The prompt assignment of therapist(s) and supervisor(s) to the case is the professional responsibility of the Therapy Case Coordinator. Prompt response to the patient is the professional responsibility of the assigned therapist/supervisor.

Finally, and equally important, it is the professional responsibility of the therapist to submit a bill to the Clinic and to monitor the patient account. It is an economic and therapy issue when the patient does not pay. Patients are expected to pay their "copays" at the reception window prior to, or after, each ongoing

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treatment session. Both the front window personnel and therapist have the responsibility to assure that copays are collected. Supervisors will review trainee billing (when necessary) to make certain that the financial obligations of the patient are attended to by the trainee and discussed appropriately with the patient. It is the Financial Counselor's responsibility to report patient payment problems to trainee and supervisor.

3.2.3.1 Supervision. All student-conducted psychotherapy sessions should receive face-to-face supervision within seven business days of service delivery. When the student reports for therapy supervision, s/he should bring the clinic note written to document session activities for direct review by the therapy supervisor. By the end of the supervisory session, the faculty supervisor should affix their signature to the note. By the end of business on the day that supervision takes place; the student should submit the therapy note to the clinic for proper processing. In cases where the therapy note needs to be modified or edited, the student should complete revisions within 24 hours of the supervisory session and to secure faculty signature by that time. **The student and faculty bear equal responsibility for performing this task in a timely fashion.**

3.3 Clinic Specialty Services

The typical scenario is for each tenure-track faculty member to have a designated “training day” in the Clinic. Generally, Clinical faculty are “on clinic” most days. There are occasions, however, in which tenure-track faculty members come on for additional days to provide some specialty service not otherwise managed by their training day (e.g., WADA, Forensic Evaluations) Although these services are offered through the Psychology Clinic, these off-team Clinical activities are often relatively independent of the operations of the Clinic teams.

3.3.1: On Call Service: The Psychology Clinic operates a 24-hour emergency on call service for its patients throughout the year. Trainees and their supervisors can be contacted during usual business hours but the “on call” service is formally in operation when the Clinic is closed (i.e. 5pm-8am during normal business days, weekends, and holidays). The “on call” function is to provide emergency consultation/intervention in order to maintain patient, or other, safety. It is not to be used to provide routine services. It is a service for our established patients and not a general crisis hotline. For emergent calls coming from non-established patients, on call staff should refer them to the Alachua County Crisis Hotline (352-264-6785/6789)

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Schedule

The service consists of one licensed faculty member and one assigned intern. The schedule for each year [July through the next June] is published in early June. A new rotation starts every Monday at 8AM. The exception to this rule is when Monday is a Holiday in which case the switch does not occur until the next business day. The schedule for the on call service can be found on the Department’s intranet website. Both faculty and interns may switch their on call service dates with others. A notification of the switch must be sent to the Clinic Director and the Clinic Office Manager at least 7 days before the switch occurs. Breaking the week up for coverage among several people is strongly discouraged.

Procedure

During the week on call, both the intern and faculty must be reachable by pager by the Shands operator. Neither is allowed to travel out of town and should be prepared to respond immediately to emergent situations. The intern on call will be provided with a cell phone by the Department to be used solely for the purpose of the on call service. In addition, the intern on call will have an “On Call” book in which to document every call received. Faculty will be required to initial each documented contact in the On Call book before the book is handed over to the next on call intern. All contacts with patients should be documented in the patient’s chart in our Clinic, signed by the intern and co-signed by the faculty member on call.

Therapy Patients: In instances where a therapist/supervisor have a patient who may require crisis intervention during the week, it is incumbent upon them to notify the intern and supervisor on call for that week and inform them of the nature of the patient’s concerns and offer instructions on how to handle crisis calls (e.g. should the on call service contact the licensed provider or therapist trainee of record after hours).

Types of Interventions: The On Call team is expected to use their clinical discretion to manage the case appropriately. This can include, as appropriate, an attempt to manage the crisis via telephone by counseling, contracting, etc. Under no circumstances are crisis patients to be met in the Psychology Clinic after hours. Patients can be referred to the emergency room at Shands Hospital for evaluation or potential admission. The on call team should contact the Psychiatry resident-on-call (380-3165) and/or the Emergency Room (265-0345) with the necessary information. It is up to the clinical discretion of the on call team, and the treating therapist & supervisor if they are involved, to meet the patient in the Emergency Department.

If the clinical decision calls for a law enforcement authority to be sent somewhere to assure the patient’s, or other’s, safety you can reach the Alachua County Sheriff’s Office at 367-4000 (if the patient resides in the unincorporated regions of Alachua County) or the Gainesville Police Department’s Communications Line at 955-1818 (if the patient resides within the city limits of Gainesville) and provide them with the necessary information.

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Some patient information (e.g. home address, home telephone number, etc) may be obtained through the Shands Hospital operator (265-0111) or as necessary, the on call team has access to all information about the patient in the patient's chart in the Clinic. Practitioners who expect that their patient(s) may use the on-call service are advised to keep such information handy but in a secure place that they can access after hours.

Inpatient Consults: The on call service for the Psychology Clinic is not a routine consultation service. Our on call service is an established intervention service for our established outpatients. **There are no inpatient emergency services available.** All emergent, inpatient consultation requests will be responded to the next business day during normal hours of operation.

Supervision

If the on-call contact involves simple triage (e.g., arrangement for the patient to follow up with their therapist at a later time, arranging for the patient's therapist to call the patient back), the intern should perform this action and inform their on call supervisor of the contact within a reasonable amount of time. Normally, the supervisor should be informed of the contact and triage that same day. In other cases an immediate clinical decision will need to be made. In such cases, the intern will evaluate the situation and consult immediately with the supervisor on call in order to decide on the action to be taken. The intern will then implement the action and will inform the on call supervisor of the outcome. Again, all decisions should be noted in the patient's chart and signed by intern and on call supervisor.

3.3.3 On Call as an Educational Activity: Interns are involved in the on call function to help provide front line assessment and interface between the on call faculty member and the patient in crisis. This is also an educational experience for the intern and the cases should be debriefed on the next business day at the time the notes are signed. This is an important teaching role for the supervisor, adds to the learning experience of the intern, and assures ongoing quality care.

4.0 PATIENT CLINICAL RECORDS

4.1 Psychological Record Contents: The therapist will insure that the Psychological Record for each therapy case contains the following information:

1. Patient's full name;
2. Patient's address;
3. Patient's date of birth;
4. Record number;
5. Marital status;
6. Ethnic/racial status;
7. Financial code; (Appendix)
8. Telephone numbers (home and work);
9. Best time to call;
10. Permission to contact at home/work/school;
11. Person to contact in an emergency;
12. Guardian information (if applicable);
13. Faculty supervisor;
14. Referral source;
15. Employer/School;
16. Type of therapy;
17. Completed Treatment Plan/Problem List;
18. Informed consent form (Informational Handout);
19. Consent for Audio taping/Videotaping;
20. Charges per session; and
21. Diagnostic code (ICD-9-CM) (Appendix - copy of billing form).

4.2 Chart Organization

4.2.1 Chart Tabs (In order based on frequency of use)

1. Progress Notes: There should be one entry in this section for each patient contact. Each note should be dated and counter-signed (if provider is unlicensed).
2. Treatment Plans: Each patient in treatment should have a treatment plan. Each plan should be tied to the "Problem List" with dates for when plan is "opened" and when "changed/closed".
3. Assessment Reports: Formal reports generated from our Clinic should be located in this section.
4. Database: This section includes all "assessment interview" notes, social/medical history questionnaires, "Program Specific" information forms (e.g. Pain Interview forms) and reports/data from other healthcare providers (e.g. Shands medical chart information). "Raw" notes (i.e. process notes) may also be kept in this section. If kept, they must be signed and dated by the supervising faculty member.

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- a. Raw notes may be transcribed into progress notes as long as they too are dated and signed. These should be filed under the Progress Notes tab.
5. Correspondence/Consent: This section should include letters from attorneys, therapy assignment forms, fee waiver forms, consent to video, etc, letters to patient terminating treatment, and HIS appointment records
6. Test Material: Place “raw” test materials including test forms and computer scored materials

4.3 Problem Oriented Medical Record (POMR)

The Department officially uses the POMR method of maintaining psychological charts. An overview of the POMR method can be found in Appendix M. All those working in the Clinic are expected to review Appendix M and to master the use of the POMR system and the various items to be included in each section. Quarterly quality improvement AUDITS are done for adherence to the required charting practices.

The three critical pieces of the POMR are the Problem List, Treatment Plan and Progress Note.

- 4.3.1.1 Problem List: The Problem List (PL) should appear on the front page of the chart on the right side. Thus, The PL is situated before the tabs and serves as a “table of contents”. Each problem identified should be titled and dated for when started, changed and terminated. The progress notes should also refer to the PL and tie together. Trainees may, at the supervisors’ discretion, “lump” or “split” problems. “Lumping” is to group problems (e.g. Problem #1 is Depression). “Splitting” is to break problems down into smaller parts (e.g. Problem #1 is weight loss, Problem #2 is loss of sleep, Problem # 3 dysphoric mood, etc.)
- 4.3.1.2 Treatment Plan: The Treatment Plan (TP) is filed under the “Treatment Plan” tab. Each problem in the PL will have a corresponding treatment plan. Each TP will have an opening date, modification date and termination date. Trainees may use the TP form provided by the Clinic or may use their own program specific form from the supervisors. TP details and progress should be indicated in the Progress Notes.
- 4.3.1.3 Progress Notes: For each session there will be a Progress Note which will include what problem was being addressed. Each note will be dated, include session number and countersigned by a licensed psychologist.
 - 4.3.1.3.1 Each note will be written in the Subjective, Objective, Assessment and Plan (SOAP) format. Subjective includes “what I heard”. Objective includes “what I saw, what I did and how they responded”. Assessment includes “what I think”. Plan includes “what I will do next time”.

4.4 Transfer of Cases

- 4.4.1 Each trainee who is transferring an ongoing treatment case must write a “Transfer Summary”. Minimally this report should include what problems were addressed, brief restatement of the “subjective” and “objective” of the problem, statement of

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what occurred during treatment, assessment of what did and did not work and discharge plan.

4.5 Telephone Contact With Patients

Brief telephone contact with patients regarding scheduling does not require that a billing sheet be completed. Therapy by phone is rarely appropriate or necessary, but there are exceptions. For these relatively rare events (>15 minutes), a billing sheet is required. Phone contacts should be charted and discussed with supervisor. Confidentiality issues may arise when leaving messages on answering machines, thus permission to leave such messages should be addressed with the patient. No message should be left without prior permission of the patient.

4.6 Termination of Therapy

The Supervisor and Financial Assistance Counselor must be given the name of the patient and date of last session with each termination. A final Clinical note summarizing treatment and disposition of the case must be included at termination. (In Appendix see Sample Report - Termination Summary.) Treatment summaries should include initial complaint and diagnosis, a summary of treatment(s) provided, treatment, outcome treatment and disposition (including termination).

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5.0 PROCEDURES FOR ROUTING OF OUTPATIENT AND INPATIENT ASSESSMENT CASES (INCLUDES CASES SEEN FOR THERAPY EVALUATION)

5.1 Information Needed Prior to Assessment. The appointment letter (see Appendix for copy), sent to assessment patients prior to the time of the evaluation, will provide information regarding Clinic policy related to financial issues. Included will be information indicating that:

1. There will be a \$231 minimum initial charge (payable at the time of the evaluation) for all patients not covered by a third party payer;
2. That patients will be financially responsible for any co-payment dictated by their insurance policy;
3. That these fees must be paid at the time of the evaluation.

Patients will also be sent an insurance information form, along with the appointment notice, which is to be filled out and returned to the Clinic prior to the appointment. (This will allow the Financial Counselor to verify coverage prior to the time of the patient's initial appointment.) Patients will also be requested to bring their insurance card with them to the evaluation so coverage can be verified.

5.1.1 At a minimum of three days before scheduled appointment, a Clinic staff member contacts the patient. The patient will be informed of the percentage of the total charges or co-pays they will be expected to pay at the end of the evaluation.

5.1.2 First Time Appointments. As the patient or guardian comes to the Clinic for the first time, he/she will provide the Clinic staff with completed forms that were mailed prior to appointment. At this time the receptionist will check-in the patient by use of the scheduling software and notify supervising faculty member that the patient has arrived by paging them with a code of "999".

New patients are typically instructed to register with the hospital Outpatient Registration by phone prior to their appointment in the Psychology Clinic and to check in at the Clinic window 15 minutes prior to the time they are to be seen for assessment. (This is to allow time for the patient or their guardian to meet with the Financial Assistance Counselor and register if necessary.)

An overview of Clinic procedures involved in the registration of new patients is provided in the following sections.

If the patient is sponsored by third party payer such as Children's Medical Services or Workers Compensation which cover some of the total costs of the evaluation they will be directed to the waiting room to wait for the Clinician. If services are

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not entirely covered by a third party payer, the patient will be advised by the receptionist of the payment or co-pay due. If the patient requires additional financial information, they will be directed to the Financial Counselor.

- 5.1.3 Payment Entry.** The Financial Counselor will record and initial the percent (and/or total amount) the patient or guardian is expected to pay for the evaluation on the Financial Routing Sheet attached to the patient's bill. (The Financial Counselor will also routinely calculate the percent discount the patient would be qualified for [non-insured patients] or the amount of insurance coverage available along with the patient's co-payment [insured patients] should the patient enter into treatment. This information can be obtained from the Financial Counselor to include on the Therapy Referral Form at the time a recommendation for therapy is made.)
- 5.1.4 Receptionist Duties.** The receptionist will page faculty and/or trainees on the pager system when their patient has arrived. This system is in place for the convenience of the provider. **It is the trainee/faculty's responsibility for their patient's appointment.** At the appointment time, if you have not received a page it is **STRONGLY** recommended that you walk down to the Clinic to see if your patient has actually arrived. Other miscellaneous duties include taking messages, ordering supplies (not tests), providing HIPPA information, etc
- 5.1.5 Clinician's Duties.** The patient will be met in the waiting room by the Clinician and subsequently seen for evaluation. It is the Clinician's responsibility to determine whether their patient has checked in and to meet the patient in the waiting room for the evaluation at the time they are scheduled.
- 5.1.6 Conclusion of Visit.** After the conclusion of the patient's visit, the Clinician or supervisor may submit the billing for all services rendered.. Prior to the bill being submitted, **the bill must include the name of supervisor (and the name of the trainee seeing the case included as well).** The licensed psychologist name should appear at the top followed by any of the following (in order): Unlicensed Doctoral Level Psychologist, Post Doctoral Fellow, Intern, and Graduate Student. All bills must include both Diagnosis codes and CPT codes
- 5.1.7 Check Out.** **After the evaluation is completed the trainee should inform the receptionist that the patient is ready to be checked out and the patient should be directed to the Clinic registration desk where the appropriate fee for services will be collected and a next appointment (if necessary) is made.**
- 5.1.8 Medical Records.** If the patient has been seen at Shands before, the Medical Record will be available for review in the student's workroom the day before the appointment when possible. This record will be returned to the Medical Record office the day after the patient is seen in the Clinic.

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5.1.9 Patient's Psychology Clinic Record. The Psychology Clinic staff prepares a file folder with referral information when an appointment notice is sent to a client. This will become the Psychological Record (see Section 8.0).

5.2 Special Procedures: Transplant

5.2.1 Transplant Reports. In order to maintain a high level of clinical quality customer service, a special procedure is needed for providing psychological information to the transplant teams.

In order for the transplant coordinators, and other team members, to receive timely information from the Department of Clinical and Health Psychology, the Transplant Reports sent to these respective teams will be of limited length (i.e., typically one-page reports). The report will begin with a very brief description of the referral question and procedures used (i.e., Data Evaluation). Finally, the report must end with a numbered listing of the action plan recommended in order to manage any barriers to successful transplantation (i.e., Treatment Plan). A copy of a sample report is attached.

5.2.2 Routing Reports. In order to maintain an efficient continuum of care, Transplant Reports need to be sent to the appropriate transplant coordinators within 24 hours in advance of the transplant team meeting.

Once a one-page report has been reviewed and signed by the appropriate supervisor, it is to be placed into a routing box specifically for Transplant Reports. This box will be maintained next to the routing box in the clinic used for other types of reports.

Before being placed into the box, the report must receive a date/time stamp. This machine will be located next to the routing box. If the report is placed in the box before 4PM, it will be delivered by courier to the appropriate transplant coordinator that same day. If placed after 4PM, it will be delivered the following day.

In order to assist in an efficient tracking system, a sign-up sheet will be placed beside the routing box. This sheet will indicate the transplant patient's name, the transplant service involved, and the Clinical and Health Psychology faculty supervising the report. The faculty member who is assigned the case is responsible for completing the Tracking Sheet after the morning assignments are distributed. If a consult comes into the clinic later in the day, the faculty member receiving the consult must complete the Tracking Log.

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5.2.A Special Procedures: Epilepsy

Background

The Neuropsychology Service is part of a multidisciplinary team (Neurology, Neurosurgery, Neuroradiology) that evaluates epilepsy patients, both children and adults. We receive consults from Adult Neurology and Child Neurology to evaluate patients who are admitted to the Epilepsy Monitoring Unit for an intensive inpatient workup. A variety of different types of patients are seen and may include: (a) those who are seizure surgery candidates (very common); (b) those who are being evaluated for medication management; and (c) others presenting with non-epileptic seizures (also known as pseudo-seizures). Inpatients on the Epilepsy Monitoring Unit remain hospitalized for 3 to 7 days and undergo video-EEG monitoring, volumetric Magnetic Resonance Imaging (MRI), and Neuropsychological testing.

Seizure Surgery Candidates

For seizure surgery candidates, the results of their inpatient evaluation are presented and discussed during a weekly Epilepsy Management Conference that is held every Tuesday morning at the McKnight Brain Institute. The role of neuropsychology is to provide information about: (a) laterality of findings (left versus right brain); (b) localization (frontal, temporal, etc.); (c) factors that might influence interpretation of findings (e.g., education, primary language, pain, etc); (d) mood and psychological status; and (d) other factors that might affect the patient's well being in relationship to surgery (e.g., social support, ability to understand surgery, compliance, etc.). The neuropsychological test findings provided by our service represent one of three critical data points for making patient care decisions about seizure surgery and other treatment options.

Decisions about whether a patient moves forward with seizure surgery are based on three "independent" sources of information: EEG, MRI, and Neuropsychological Findings. Two of these three sources of data must converge if the patient is to move directly to surgery (known as a skip or Phase I patient). If there is lack of convergence among EEG, MRI, and Neuropsychology, then the patient may have to undergo additional invasive procedures. These may include placement of extradural grid electrodes over the surface of the brain, or insertion of depth electrodes into the medial temporal region (hippocampus). These procedures (grids, depths) pose additional risks to the patient, but are often necessary to fine tune lateralization/localization.

It is critical that Neuropsychology's decisions about laterality and localization be made SOLELY on patterns of neuropsychological findings derived from our testing. Our interpretation should be made blindly and independent of knowledge about the result of EEG and MRI findings. Otherwise, our contributions to the EMC decision making process are contaminated by other streams of information. This type of approach is clearly

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different from what transpires with other types of cases in Neuropsychology Clinic, where we attempt to integrate all sources of information about our patients.

Procedure: The procedure below should be followed for any epilepsy inpatient (adult or child) who is being evaluated for potential seizure surgery.

1. By Monday noon of the week after the workup, place the following information in the Clinic's Epilepsy Routing Box: (a) COMPLETED NEUROPSYCHOLOGICAL SUMMARY SHEET and (b) PINK COVER SHEET (which provides information about laterality, location, mood, social/compliance issues). The final neuropsychological report IS NOT necessary, although it is welcomed. Importantly, the neuropsychological report does not substitute for the Summary sheet and Pink Cover Sheet.

This information will be orally presented during the Epilepsy Management Conference that is held every Tuesday 8:30 AM at the McKnight Brain Institute (3rd floor Neurology Conference Room, located to the right as you emerge from the elevators). You are welcomed and encouraged to attend this meeting to see how decisions are made within a multidisciplinary context. In attendance are faculty from Neurology (Eisenschenk, Uthman, Sackelarres, Meador), Neurosurgery (Roper), Pediatric Neurology (Carney), Neuroradiology (Schmalfus, Quisling), and Neuropsychology (Bowers). The support staff for adult epilepsy service are Donna Lilly and Debra Thomas-Saltzer, both ARNP's.

2. The final neuropsychological report on all epilepsy inpatients should be routed to the Epilepsy Monitoring Unit (PO Box 100365), the medical chart, and the referring physician. Although additional copies may be routed elsewhere, it is important to always send a copy to the EMU which maintains a backup data file on all patients who have been evaluated on the unit. A copy of the summary sheet should also be attached to the report routed to the EMU.

Finally, many patients who undergo seizure surgery will be seen for repeat neuropsychological evaluation approximately six months following their surgery. This typically occurs during an outpatient visit. The report of this post-operative neuropsychological evaluation should be compared with their presurgical workup and also routed to the EMU.

Patients with Non-Epileptic Seizures (pseudo-seizures)

Occasionally we receive referrals for assistance with inpatients on the EMU who have been determined, based on video-EEG monitoring, to have seizures or non-epileptic origin (aka pseudo-seizures). For these referrals, it is important to contact the epilepsy ARNP's (Donna Lilly, Debra Salter-Johnson) or the physician consultant regarding what is specifically wanted from us. You should be aware that patients with "real" seizures can also have pseudo-seizures as well.

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Patients being Evaluated for Medication Management

Sometimes epilepsy patients are admitted to the EMU in order to be closely monitored regarding their medication management. Although rare, an epilepsy patient may go into “status”, meaning they develop uncontrolled prolonged seizures. Such patients are usually seen emergently in the ER and admitted to the neurology service in order to be stabilized. It is less common for the Neuropsychology Service to receive consultation for neuropsychological workups on medication management cases. Should this occur, there is no “press” for you to route summary sheets, etc., as these patients will not be presented at the EMC meeting.

Frequently Asked Questions

1. Where is the Epilepsy Monitoring Unit? The adult Epilepsy Monitoring Unit is located on the 6th floor of Shands Teaching Hospital. It consists of 4 inpatient rooms located on the 65 hallway and one “control” room. The control room consists of EEG and video monitors that are directly linked to each inpatient room. The pediatric Epilepsy Monitor consists of 4 inpatient rooms located on the 4th floor (pediatric floor). Children are monitored by EEG personnel from the 6th floor control room. You are free to visit the “control room”. Introduce yourself as being from the Neuropsychology Service.

2. Where is the neuropsychological testing administered? All testing is carried out in the patient’s hospital room. Put a sign on the door that says “testing underway”. Family members are asked to leave during testing.

3. What if the patient has a seizure during testing? The *goal* is for the patient to have seizures, so that the seizure focus (if present) can be localized on EEG. To facilitate this occurrence, patients are tapered or removed from their epilepsy medications as they enter the hospital. This increases the risk of seizures. If a patient should have a seizure, immediately push the red alert button. This will alert the nursing and the EMU staff who will “rush in” and possibly administer medication. While you’re waiting, make sure the patient is safe on the bed and isn’t going to fall. Otherwise, do not attempt to restrain the patient.

4. Is there a set neuropsychology epilepsy protocol? For Adults, there is a recommended testing protocol that was selected by the Neuropsychology Service. This protocol will take approximately 3 hours, including the interview and mood measures (STAI, BDI). Depending on the patient and any questions that arise during testing, you may wish to alter or modify this protocol. The summary sheet for the Epilepsy Protocol is located in the Neuropsychology Testing Shelves in the Clinic.

5. Who are the epilepsy “attendings”? For **adult epilepsy patients**, the neurology attendings are Drs. *Stephan Eisenshenk*, *George Ghacibeh*, and *Kim Meador*. These neurologists typically rotate on a monthly basis and are responsible for epilepsy inpatients on the EMU. For children, the neurology attending is Dr. *Paul Carney*, a pediatric neurologist with a primary appointment in Pediatrics. The neurosurgeons who perform

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resections or other procedures on appropriate surgical candidates are Dr. *Steve Roper* (adult) and *Dr. David Pincus* (children). Their contact information is listed below. Finally, two key individuals of the Epilepsy Team are Donna Lilly, ARNP, and Debra Thomas-Salter, ARNP. They are up to date on all patients in the program.

Important Numbers Related to Epilepsy Consultations

Name	Phone	Box	Pager	Fax
Eisenshenk, Stephan, M.D.	273-5550	100236	413-5050	273-5573
Ghacibeh, Georges, M.D.	273-5550	100236	413-7570	273-5573
Meador, Kim, M.D.	273-5550	100236	413-1086	273-5573
Sackellarres, Chris, M.D.	273-5550	100236	413-7555	273-5573
Uthman, Bassim, M.D.	273-5550	100236	413-6637	273-5573
Carney, Paul, M.D.	392-6442			
Roper, Steve, M.D.	392-4331	100265		392-8413
Donna Lilly, ARNP	273-5550	100236	413-9459	
Debra Thomas-Salter, ARNP	273-5550	100236	413-9460	
Epilepsy Monitoring Unit	5-0061	100236	n/a	
EEG Suite		100236	n/a	
Neurology OP Clinic	265-8408		n/a	265-8409
Neurology Office	273-5550	100236	n/a	273-5573

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5.3 Inpatient Services

Inpatients are usually seen on the medical unit floor on which they are hospitalized. Arrangements can often be made with unit staff for testing and consultation rooms. Bedside interviews are often required, however, patients can also be brought down to the Psychology Clinic and it is preferable if possible.

Medical inpatients that are to be seen in the Clinic may be brought by a courier who also brings the Medical Record. Psychiatric inpatients are to be seen on the 8th floor Psychiatric Unit rather than in the Psychology Clinic. (Rooms for conducting evaluations will be provided on the Psychiatric Unit.)

When an evaluation on an inpatient is completed in the Clinic, the courier service is contacted, or we escort the patient back to the floor ourselves. It is essential that the floor staff be notified that the patient has returned to the floor AND THAT THE VISIT IS DOCUMENTED IN THE MEDICAL RECORD AND RETURNED TO THE REFERRING UNIT.

5.4 Initiation of Therapy

When agreement has been reached after an assessment to undertake treatment, the therapist must notify the Financial Assistant Counselor of the agreed upon arrangements.

Trainees who will be seeing patients in the Clinic rooms should check for the availability of a room before scheduling the patient for a specific day and time of therapy. It is the trainee's responsibility to maintain the accuracy of their room use scheduling on the master listing of rooms in the Clinic.

An overview of Clinic check-in and registration procedures for ongoing therapy cases is presented in the following sections.

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6.0 PROCEDURES FOR ROUTING NEW OUTPATIENT THERAPY CASES

All patients seen in outpatient psychotherapy will have been seen for prior evaluation in the Clinic. Thus, information on the patient's financial status will be available from the Financial Counselor. This information will include whether the patient has insurance coverage and, if so, the amount of coverage for mental health services available and the amount of co-payment the patient would be responsible for. If some third party payer does not cover the patient, information will be available regarding the percent discount for which the patient would qualify if the patient entered into therapy. This information must be included on the Therapist/Supervisor Assignment Form when the case is referred to the Team Leader for assignment. The Therapy Assignment Form is then returned to the patient's Clinic file.

6.1 Initial Therapy Appointment. When the therapist calls the patient to schedule the first psychotherapy appointment he/she should communicate to the patient that it will be necessary for the patient to speak with the Clinic's Financial Counselor prior to this initial appointment if this has not been done at the time of the initial assessment. If unable to do so, the patient would be instructed to meet with the Financial Counselor fifteen (15) minutes prior to the first therapy appointment. The therapist should then communicate the time of the appointment to the Financial Counselor. (If the first session is scheduled after hours, that is, before 8:00 a.m. or after 5:00 p.m.) it will be necessary for the patient to schedule an appointment to meet with the Financial Counselor on some other occasion prior to the time of the first appointment.) Assuming that the patient is to see the Financial Counselor prior to the first therapy session, the typical sequence of events would be as follows:

6.1.1 Check In. At the time of the first appointment, the patient will check in at the Clinic window. The receptionist will then call the Financial Counselor to inform her that the patient is ready to be seen (if this has not already been done previously) and the patient will either be directed to the Financial Counselor's office (if she is ready to see the patient) or to the waiting room.

6.1.2 Financial Counselor Meeting. During the meeting with the Financial Counselor, the costs of therapy (basic cost per session, amount covered by insurance and patient co-payment, percent discount if no insurance, etc.) will be discussed with the patient or guardian and this information will be recorded on the Financial Routing Sheet. (Along with any special notes regarding individual payment plans that have been agreed upon). The patient will be told that it will be necessary that they pay their required co-payment (in the case of those who have insurance) or their fee per session (in the case of those paying for therapy themselves) at the time they are seen for each therapy session. The therapist and supervisor can request a modification of this fee. **Only the Clinic Director has the authority to actually adjust these fees.**

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6.1.3 Waiting Room. After this meeting, the patient will be instructed to wait in the waiting room for the therapist. **No patient is to be seen without having checked in at the Clinic front window.** EAP patients or faculty or employees wishing anonymity can make other arrangements with therapist.

6.1.4 Conclusion of Visit. At the conclusion of the patient visit, a bill will be completed by the therapist to indicate those therapy services rendered. The therapist should inform the Clinic staff that the patient is ready to check out and the date and time of the next scheduled therapy session (so the next appointment can be scheduled in advance). At this point, the appropriate fee will be collected. **A similar sequence will be followed on subsequent visits except that the patient will not need to see the Financial Counselor on these occasions, except in the event of a billing or other financial problem.**

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7.0 BILLING

7.1 Payment. All patients are expected to pay some portion, or their entire, bill at the point of service unless CMS, Vocational Rehabilitation, and Worker’s Compensation sponsors them or they have (100%) insurance coverage for mental health services. **(Those with insurance coverage will be expected to make any required co-payment at the time services for each session is rendered, whether this is for assessment or therapy.)** For those without sufficient third party coverage, the minimal amount of this initial payment is \$231.00 (for assessments). Self-pay therapy patients, without third party coverage, will be expected to pay for services rendered **(as determined by the percent discount they qualify for according to the Clinic’s sliding fee scale)** at the time of each treatment session. This discount will, in no case, be greater than 90%. As noted earlier, for therapy patients qualifying for discounts greater than 75% it will be necessary to document (see Appendix for form) the degree to which the case serves a significant training function.

7.2 Using “NERVE”. “NERVE” is the scheduling and billing software used in the Clinic. Following each patient contact a bill must be submitted that includes: the place of service, the CPT codes best describing the services rendered, the Diagnoses codes (ICD-9) that best describe the patients present status (chief complaints), the providers participating in the contact and the date services rendered. Every month, licensed providers will be provided with a monthly summary of the preceding months billing activity. Licensed providers should review these summaries and when satisfied with their accuracy submit them signed to the Back-end Office Manager (Billing Manager)

7.2.1 Missing Charges. The Financial Assistance Counselor and Back-end Billing Manager will review a missing charge report every few weeks. The report will identify the patient, date of service, billing provider (supervisor), scheduling provider (therapist), and missing charge.

Everyone with a missing charge will receive an email from the Clinic Director detailing his or her missing charges. Faculty will receive a copy of the report that shows them as the listed billing provider (if available). Trainees will receive a copy of the missing charges that list them as the scheduled provider.

The Back-end Office Manager will be available to discuss any concerns regarding missing charges from faculty or trainees.

The missing charges, or an explanation of why the bill cannot be submitted at this time, should be in the Clinic office within 1 week of this notification.

The Clinic Director will review the responses and account for all missing bills. The Clinic Director will seek out the trainees who have not responded first. The Clinic Director will coordinate with the Office Manager and Financial Assistance Counselor for edits to the missing charge report.

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Faculty supervisors will be kept current on the status of missing trainee bills. If necessary, chronic lateness in turning bills in will be reported to the Director of Clinical Training and the Internship Director.

- 7.3 Assessment Charges.** Charges for assessment are computed according to a standard fee for service schedule, which can be found in Appendix A. **Charges for assessment should not be discounted.** As indicated earlier, charges for therapy may be modified according to the Clinic's Sliding Fee Scale (as recommended by the Financial Assistance Counselor) or otherwise modified at the discretion of the Clinic Director. **All trainee conducted Clinic assessments should receive face-to-face supervision within 24 hours of service delivery. Reports for all assessment services should be completed within 48 hours of the service date.** It is the trainee's responsibility to see to it that the bill is properly submitted to the Clinic for processing. The trainee and faculty bear equal responsibility for performing this task in a timely fashion.
- 7.4 Billing Information.** The following information must be indicated on the billing page in NERVE for all patients:
1. Patient name;
 2. Service Type;
 3. Date seen;
 4. Service Location;
 5. Procedures (CPT);
 6. Diagnosis (ICD-9);
 7. Length of time seen;
 8. Licensed Supervisor
 9. Trainee name(s) and initials
- 7.5 Inpatient Information.** For inpatients, the billing page in NERVE needs to be completed AFTER the provider of service sees the patient.
- 7.6 Special Diagnostic Procedure Codes.** In certain cases (e.g., pre-transplant evaluations to be paid for by the Kidney Acquisition Fund) special diagnostic procedure codes are required for billing. Information regarding these codes can be obtained from the Clinic staff.
- 7.7 Discounting Bills.** No discounting on bills prior to billing commercial insurance.

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8.0 RECORD KEEPING

8.1 Record Documentation. ADEQUATE RECORD KEEPING AND DOCUMENTATION ARE ESSENTIAL. In addition to legal requirements, each patient has a right to an accurate, up-to-date record of services rendered. In the Psychology Clinic we work with two charts for each patient: (1) the Medical Record (filed in the Medical Records Department of the Shands Hospital) and (2) the Psychological Record (filed in the Psychology Clinic of the Shands Hospital).

8.1.1 Reasons the Psychological Record is Important. The kind of information recorded in the patient's Psychological Record is extremely important for a number of reasons:

1. It is the primary instrument for recording the patient's problem and the treatment planned. (If the service provider were to disappear suddenly, the record should be sufficiently detailed to permit continuation of care.)
2. It is the only real defense against malpractice and liability suits. ("In court, the medical record is the care rendered. *If it isn't in the record, it didn't happen.*")
3. It is necessary to obtain reimbursement for services from third party payers. (Before bills are approved for payment, records are often scrutinized.)
4. It is a document that can be reviewed by the patient. (General guidelines for information that should and should not be in the patient's psychological record can be found in Appendix B.)

8.2 Filing of Records. Records must be filed appropriately and available at all times. They should never be out of sight in drawers, etc. Medical Records must never be removed from the Health Center. **WORKING MATERIALS FROM THE PSYCHOLOGICAL RECORD MUST NEVER LEAVE THE HEALTH CENTER WITHOUT THE SUPERVISOR'S PERMISSION.** To highlight the significance of this, the following statement from the Shands Hospital Rules and Regulations is relevant: "Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the chief executive officer. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the Medical Staff."

1. The Medical Record for outpatients must be placed in the appropriate box in the Clinic workroom at the end of the day. These records will be available in the Clinic workroom on the day the patient is seen and will be sent back to the Medical

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Records Department on the following day. Inpatient records for patients seen on medical units should never leave the floor. Should a medical patient, accompanied by the medical record, be seen in the Clinic the appropriately documented record must accompany the patient when the patient is returned to the floor.

Faculty will make arrangements with the Medical Records Dept. (265-0479) to complete all incomplete records on their clinic day. This **MUST** be done weekly. Faculty can arrange a set time on their clinic day and the Medical Records Dept. will have all incomplete records ready for the faculty member to complete (see Appendix).

2. The Psychological Record must be filed as an open chart in the trainee's pendoflex file, or in the Psychological Clinic files. **An "out" notice specifying where it can be found MUST replace any chart not in the Psychology Clinic master file. It should be possible for Clinic staff to find the patient's record AT ANY TIME.**

8.3 Class Teaching and Supervision Material. We must be sure to discriminate teaching/supervisory material from that which is the "Psychological Record." Class teaching and supervision material must be kept in a manner that preserves the anonymity of the patient and the confidentiality of the material and should be destroyed at the completion of the training experience. *It must be kept in the trainee's pendoflex folder in the Clinic, but is not a part of the Psychological Record.*

8.4 General Charting Guidelines. The following guidelines are an attempt to integrate and comply with the Rules & Regulations of the Shands Hospital, the JCAHO Accreditation Criteria (for both medical records and ambulatory care), the Standards for Delivery of Psychological Services, Florida Statute (Chapter 21U-22) and common sense. They are minimalist in nature and thus do not in any way substitute for the supervision required in order to develop professional reports. These general guidelines apply to both the Psychological Record and the Medical Record, of which our record is a part.

1. The patient's full name and medical record number must appear on every page in the upper right corner.
2. Write in black ink.
3. Do not skip lines.
4. Write legibly.
5. Do not use abbreviations unless they are listed on the STH List of Approved Abbreviations.

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6. Cross off errors with a single line, ensuring that the original entry is still legible. Date and initial the correction. Never obliterate an entry.
7. Write your note immediately after seeing the patient. Do not **ever** postdate notes. Note should be titled "Psychology Clinic Consultation Note" with clinic phone number listed.
8. Include date, service, signature, and title for each entry. Time of entry (24 hour time) is required for all inpatient records.
9. Choose your words carefully; the record is not the place to joust with other professionals.
10. Be specific, concise and objective.
11. All trainee entries must be countersigned by the licensed psychologist supervising the work.
12. Be sure to directly address any sensitive issues such as suicide potential, dangerousness, suspected child abuse.
13. *In addition to documenting each and every patient contact be sure to document skipped appointments, telephone calls, contacts with significant others, and consultations you have obtained as appropriate. Copies of correspondence related to the case must also be a part of the record.*
14. Mark every psychological report "CONFIDENTIAL."
15. Specifically relevant to inpatient record keeping, Shands Rules and Regulations note that non-physicians will limit their medical record entries to those within their area of expertise. While this statement is obvious and clearly part of our ethical standards, it is mentioned here, as it is part of Shands policy.
16. **Note: As it is assumed that trainees will have always discussed the case with their supervisor prior to rendering a chart note, chart notes should in all cases contain a statement indicating that the case was discussed with the supervisor (e.g., Case formulation discussed with Dr. _____). This sort of documentation is often essential to obtain reimbursement from those providing third party coverage.**
17. Include beeper number of attending on the consult sheet.
18. Using a Tertiary Code Modifier (22T Modifier) for Billing: We utilize a tertiary code modifier to indicate to the insurance company (as payer) that the clinical

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procedure or service being billed is not widely available in the community and is "tertiary" in nature. Tertiary can be defined as "not available in the community", based upon a "referral from another specialist", and/or based upon the "complicated nature" or "extraordinary nature" of the disorder, disease, or the diagnostic question at hand. It is up to the provider (the attending psychologist) to define the service as "tertiary" in order to determine the portion of the service that sets us, and this particular service, apart from the community.

We are required to designate on the claim form that such procedures and services are "tertiary" and to record the appropriate modifier (22T) under the CPT code for that procedure.

The formal assessment report or the clinic note can provide sufficient documentation of the tertiary nature of the service.

Documentation must actually state that the present care "is tertiary care". For example, "The present tertiary care evaluation of Mr. Standish, as referred by John Smith, M.D., his cardiologist, and seen as part of a multidisciplinary team approach to treatment, was carried out on July 4, 1776." Where the assessment is part of a specialized treatment approach that should be stated.

Please use the 22T modifier on all appropriate CPT codes, regardless of payer. When in doubt, utilize the modifier, as there are no penalties for using the modifier. All documentation should support the tertiary nature of the claim.

Please attach documentation (the initial assessment note) to the patient's bill when submitting it to the Clinic Front Office in order to expedite the filing of the claim.

8.5 Consultation. In addition to adhering to the general guidelines listed above, the following information **must** be present in each consultation report. (Formats of reports may vary, and should be discussed with the supervisor.)

1. Name of requesting attending physician;
2. Reason for consultation;
3. Evidence of a review of the patient's record;
4. Nature of assessment procedures and pertinent findings; and
5. Impressions and recommendations.

According to Shands Hospital Medical Staff Rules and Regulations, inpatient consultations by health care professionals are to be responded to in one of the following two methods:

- A.) The consultation form is to be completed, or**

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B.) The consultation is to be documented in the progress notes in the patient’s medical record and labeled “Consultation.”

Shands Rules and Regulations can be found in the Clinic and all faculty and trainees are encouraged to review that document.

8.5.1 Follow-up consultations must be designated as such and signed/countersigned by the consultant.

8.6 Progress Notes. In addition to adhering to the general guidelines listed above, *the following information must be present in each Clinic progress note.*

1. Purpose of visit. (Why the patient came to the Clinic [for assessment feedback, for ongoing psychotherapy session, etc.])
2. Objective findings. (What you observed while they were here [nature of test findings, the major issues patient chose to deal with in therapy session, etc.])
3. Services/interventions rendered. (What you did in the session [dealt with specific issues in therapy, continued relaxation training, etc.])
4. Response to treatment. (How the patient reacted to what was done [responded well to interpretations, was able to successfully approach feared situation after desensitization, etc.])
5. Plan. (What you expect to do next [see for next session in one week, terminate therapy, refer elsewhere, etc.])

For ongoing psychotherapy charts, there must be evidence of ongoing supervision of the case (e.g., countersignatures). Every inpatient progress note must be countersigned.

6. Signature Block. Signatures should include name of trainee, degree and title and name of faculty, degree and title, (including Board certification and specialty).

8.7 Time Line for outpatient consults and diagnostic evaluations.. Initial drafts of reports of outpatient consultations and diagnostic evaluations should be completed within 48 hours by trainees and be placed within the chart as final drafts at least by the next week depending on number of rewrites and supervisory needs.

8.8 Time Line for inpatient consults. Inpatient consultation reports can be handwritten in the progress notes section or on the consultation request form. **Copies need to be made for the Psychological Record in the Clinic.** Preliminary results must be recorded immediately. **Additional reports should be on the chart within 24 hours.** Verbal feedback does not supplant the need for a written document.

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8.9 Final Reports. Due to the availability of computer equipment, most reports are composed at the computer, thus eliminating the need for a Clinic typist. **When the final report is completed and placed in the chart, computer files containing the report should be erased or modified so that all identifying information is deleted.**

8.10 Routing of Reports. When turning in reports, be sure to complete a routing slip for each report to indicate where copies should be distributed. Be sure to include complete addresses and information for each person to whom the report is to be mailed. If a patient is sponsored by Children’s Medical Services, Vocational Rehabilitation or a Worker’s Compensation carrier, then be sure that they are mailed a copy of the written report. (For Worker’s Compensation cases, a copy of the report should automatically be routed to our Financial Assistance Counselor at the time the report is sent to the referral source.)

Transplant Reports – In order to maintain a high level of clinical quality customer service, a special procedure is needed for providing psychological information to the transplant teams.

In order for the transplant coordinators, and other team members, to receive timely information from the Department of Clinical and Health Psychology, the Transplant Reports sent to these respective teams will be of limited length (i.e. typically one-page reports). The report will begin with a very brief description of the referral question and procedures used (i.e. Data Collection). Next, the report will focus on the evaluation of the data collected and impressions gleaned (i.e. Data Evaluation). Finally, the report must end with a numbered listing of the action plan recommended in order to manage any barriers to successful transplantation (i.e. Treatment Plan). A copy of a sample report is attached.

8.11.1 Recording of Contacts. While every contact with a patient must be recorded, the place of recording will vary. **Every contact with *inpatients* must be noted in the inpatient Medical Record. Every contact with *outpatients* must be noted in the Psychological Record and must include information listed in Section 9.4; Purpose of visit, Objective findings, Service/interventions rendered, Response to treatment, Plan.**

8.12 Changing or Canceling Appointments

The support staffs are responsible for entering all initial and therapy appointments into the scheduling software (NERVE). Therapy appointments are entered by the trainee themselves or via Clinic staff via e-mail (clinicapps@phhp.ufl.edu)

Therapists may change or cancel return appointments at any time via NERVE or clinicapps@phhp.ufl.edu. Support staff must notify therapists/supervisors if patients call to cancel an appointment.

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In the information distributed to patients, it is stated that patients are expected to give 24-hour notice of cancelled appointments, except in emergency situations, or they may be billed at the therapist/supervisor’s discretion. **Therapists should re-iterate our policy to all patients.**

When patients do not show for their appointment, and no notification is given, therapists/supervisors are required to discuss and document discussion in the patient’s chart. Documentation should include date of no show, reason (if any) given by the patient and a specific plan to handle the no show. Patient’s chart should have documentation on therapists/supervisor’s decision to call patient, or not, and the billing decision with explanation. Documentation should occur within 24 hours for non-urgent cases and immediately for emergent, potentially emergent or actively suicidal cases.

After two (2) consecutive recorded no shows, all therapists/supervisors MUST consider termination. Reason for termination, or not, should be included in the patients chart. **Once the decision to terminate is made, the patient must be contacted by registered mail with a copy of the letter and receipt to be kept in the chart.**

8.13 Clinic Policy on Charts Transferred from HPNP to JHMHSC

The Psychology Clinic is committed to the confidentiality of the patient records we maintain. There are legitimate reasons for some patient records to move from the Psychology Clinic to the HPNP building. No patient charts with protected health information (PHI) may be kept in the HPNP building overnight. They must be transferred back to the Psychology Clinic for proper maintenance and storage.

The Psychology Clinic will manage two key-locked bags for transporting patient charts back and forth between the Psychology Clinic and the HPNP building.

The Psychology Clinic Office Manager will keep one set of keys. The Department of Clinical and Health Psychology Administrative Assistant will keep the other set.

Trainees who have charts in the HPNP building, and are leaving the building for any reason before 5:00PM, are expected to bring the charts back to the Psychology Clinic and file those charts themselves or allow staff to file them later. If the trainee is not expecting to leave the HPNP building at all before 5:00PM, then they should follow the faculty procedure below.

Faculty who have charts in the HPNP building must return those charts to the Administrative Assistant in the Department’s administrative office by no later than 4:30PM Monday through Friday. The chart **MUST** be delivered to only this person. In the event the Administrative Assistant is away from the office, the Assistant Director for Medical Health Administration (ADMHA) will be the designee. If both are absent the

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ADMHA will identify the appropriate person responsible and notify the Department via email.

When the staff member receives a chart, they must immediately place the chart in a locked bag. The bag will be located in a secure area inside the administrative office. A log sheet will be placed in the bag. Each patient chart in the bag should be listed on the log sheet.

At 4:30PM each day, the locked bag will be transported and delivered to the Clinic Front Office Manager or their designee. If there is a designee assigned for that day, the Administrative Assistant and the Director for Medical Health Administration will be notified 24 hours in advance or at the earliest possible time that the information is known. The log sheet will indicate whose charts are in the bag. The transporter and the Clinic Front Office Manager will initial the log sheet to indicate agreement on the bag's contents. An empty bag will then be taken back with them to the HPNP building.

The Clinic Office Manager will either leave the charts in the locked bag until the Clinic opens the next day or re-file the charts.

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9.0 GENERAL INFORMATION

- 9.1 **Phone Numbers.** Be sure to give your phone number to Clinic staff and keep this current.
- 9.2 **Messages.** Faculty and trainees are responsible for being aware of messages received by Clinic staff and should check their e-mail and voicemail on a daily basis.
- 9.3 **Travel.** If you are traveling on “comp” or your own grant dollars, you are asked to avoid your clinic day. If it is unavoidable, then a coverage plan must be submitted that explains how business/training will be covered in your absence or when cases will be rescheduled. Be sure to let the Clinic staff know when you will be away, who will be covering your clients in case of emergency and how you might be reached if we had to contact you. **Trainees are also responsible for obtaining the approval, at least three weeks in advance, from the appropriate team leader(s) when they must be absent on a day they are assigned to the Clinic** (leave forms can be obtained from the Clinic office and must be turned in at least three weeks in advance and preferably sooner in order to be considered). A request by one student and one intern (or two trainees) will ordinarily be granted, but absences beyond that number will depend upon the Clinic patient schedule. **The Faculty effected by the absence must adjust their intake schedule for these scheduled absences so that scheduling for that day will be based on trainee resources available.** Students in core practice begin in the Fall Semester and continue through the end of Summer Semester. A total of four days off clinic, with prior approval, can be obtained.
- 9.4 **Dress Code.** The dress code for the Clinic can best be described as “conservative but casual.” That is, shirts and ties — but not necessarily coats — for men; and dresses or dress pants for women. No jeans, shorts, cut-offs, t-shirts are allowed in Clinic areas. This code applies at all times, whether or not you are scheduled to see patients. The code is required by the Chief of Staff of Shands Hospital and applies to all employees, faculty and students. **When clients come to the Clinic, they are looking for professional help. Dressing appropriately as a professional clinician aids in giving the client confidence that you can be of help.**
- 9.5 **Clinic Supplies.** Clinic supplies and the Clinic copy machine are to be used for patient care only. Any research supplies or copies must come from other sources. All materials must be returned in a orderly fashion with accidental pencil marks erased. Trainees should let the Clinic Director or their Team Leaders know of damaged or missing test materials.
- 9.6 **Room Reservations for Therapy.** All room reservations can be conducted via NERVE
- 9.7 **Ongoing Therapy Cases.** All therapy appointments **MUST** be in NERVE prior to patient arrival.

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- 9.8 Telephone Usage.** Telephones in the Clinic are for Clinic use only, thus outgoing calls should deal with Clinic business only. Likewise, the Clinic number should not be given as a place to call for other than official Clinic business.
- 9.9 Clinic Work Room Security.** The Clinic Work Room has been provided for use by interns, students on practicum and others working in the Clinic. In addition to providing working space, this area contains patient charts, testing materials, computers, and Clinic mailboxes for students, interns and faculty (that often contain confidential patient-related materials). It is necessary that every effort be made to insure confidentiality of patient data and to insure that other items contained in this area are safe. In this regard it is essential that this area be kept locked at all times, when unoccupied, after 5:00 p.m. and on weekends.
- 9.10 Seeing Patients After Normal Working Hours.** The hours during which the Psychology Clinic is open are from 8:00 a.m. until 5:00 p.m. (Monday, Wednesday, Thursday and Friday) and 8:00 a.m. to 8:00 p.m. Tuesday. Attempts should be made to see patients during normal working hours. In all cases patients seen after hours should be seen prior to 7:00 p.m. and in the Clinic proper as opposed to rooms located some distance from the Clinic. In any case, therapists who see patients after the Clinic office is closed must arrive their patients in NERVE the following day. Trainees **must** have onsite faculty coverage at **all times** when patients are seen.
- 9.11 After Hours Call.** The Psychology Clinic provides after-hours on call services for dealing with Clinical emergencies involving Clinic patients. This service is available for patients between the hours of 5:00 p.m. and 8:00 a.m. on a daily basis and on weekends and holidays. This on call system involves interns and faculty who take call on a rotating basis for a period of one week at a time. (The current call schedule for both interns and faculty is available on the Department’s intranet Website) It is essential that the Clinic staff (including the Clinic Director) know in advance of any substitutions or other changes made in the call schedule by either interns or faculty so that the paging operator is given accurate information regarding whom to contact in case of a patient emergency. It must be possible to contact the intern (on first call) and the faculty (on back up call) by either phone or beeper at all times while on call. A separate on call schedule for carbon-monoxide poisoning cases is run by the Neuropsychology faculty during cold weather months (typically October through March). Carbon Monoxide calls during the day are handled by the Neuropsychological faculty on that clinic day. On Fridays, the intern on call will respond to Carbon Monoxide referrals during the day with one of the NP faculty supervising.
- 9.11.1 On Call Mobile Phone:** A Department sponsored cell phone will be provided to the intern on call for the week of their call service. Each intern will pass the phone from the current on call intern to the next. Due to University regulations each call placed by this phone must be logged onto a log sheet which the Clinic will provide with the phone. This log sheet will be reconciled with the mobile phone bill every

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month.. Personal calls should not be made on the clinic's cell phone. Any personal calls that result in charges will be reimbursable to the University of Florida.

9.12 Professional Demeanor. When in the halls outside the Clinic or around the Clinic office area, please keep in mind that clients may very well be within your view or earshot. Observing the following guidelines will help you avoid inadvertently upsetting the client who may think you could be talking about them.

- Do not discuss clients or even clinical material from courses in the halls.
- Do not discuss clients in any public place.
- When you are in the clinic workroom, remember that clients may be checking in next door, and be sensitive not to yell or laugh.
- BE RESPECTFUL
- Always place “Do Not Disturb” sign on door and remove when done
- Keep smelly garbage out of rooms
- Schedule therapy cases on the hour, not half-hour

9.13 Timeliness

Promptness in attending all Clinic meetings is expected of all Clinic staff.

- If you are ill on your clinical assessment day and cannot attend, or find that you cannot avoid being late (e.g. your car blew up, Godzilla attacked your apartment) please leave a message with the Clinic Director or faculty supervisor.
- Punctuality is also especially important in ending therapy and assessment sessions on time. Other clients or therapists may be waiting and deserve to be able to have a full session.
- Getting your reports done on time and keeping case notes up to date are often very important professional responsibilities. Failure to do so can adversely affect the client’s treatment in an emergency.
- Part of your clinical responsibility is to respond promptly to any and all memos or e-mails sent to you by Clinic staff. Please check your Clinic mailbox and e-mail at least once a day to make sure to stay current with information and questions relevant to your clinical cases.

9.14 Maintain Clinic Rooms and Equipment

Each client has the right to expect a therapeutic environment that is neat and consistent:

- It is critical to return all therapy and assessment rooms to their original condition before leaving the room. This includes moving assessment tables back where they were initially positioned, throwing away used Kleenex and other trash, etc.

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- Eating and drinking in the therapy rooms is strongly discouraged. If by chance, something spills, please clean it up immediately and notify the Office Manager.
- Kleenex is an integral tool needed in the therapy process. If a sobbing client comes up empty-handed when reaching into the Kleenex box, they feel uncared for and the therapy may be negatively affected. Therefore, if you notice that Kleenex is running low, please replace the box before it is empty. Please ask Clinic Staff to obtain them for you.
- Keeping the play area in the Child Play Room neat and in order is also especially important, since child clients often depend on the stability of the sameness of the playroom. Do not let clients take toys out of the playroom and play in the hallway; replace blank paper if you use the last of it, etc. If you or your client undress the dolls, please put their clothes back on to assure that they present a well-groomed appearance to the next child client. If you move furniture around in the playroom, please make sure that the tables and chairs are returned to their original upright position.
- Please return all assessment material or other items borrowed immediately following their use so that others may have access to them. It is vital that all components of the assessment material be kept together and returned. There is nothing worse than reaching for the blocks for the Block Design and finding eight rather than nine.
- Note any problems with your therapy room (e.g. wall clock time is wrong, etc) and report them to the Office Manager.
- REPORT PROBLEMS IMMEDIATELY.

10.0 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Clinic has a separate manual for Policies and Procedures regarding confidentiality of patients personal health information (PHI). All trainees are required to review the manual. In addition, all trainees are required to sign a Health Information Policy and Confidentiality Statement (<http://privacy.health.ufl.edu>) and complete an on-line HIPAA training test (<http://privacy.health.ufl.edu>). Both must be completed and provided to the Chair's office before starting on Clinic.

10.1 Guidelines for Release of Clinic Reports for Internship/Post Doctoral/Employment Applications

APPIC applications and Post Doctoral/Employment positions often request a copy of an evaluation or treatment report. In order for students/interns/post doc clinicians to fulfill this request while maintaining compliance with HIPAA regulations, we have adopted the following policy.

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A trainee may submit a clinic report with the approval of:

1. the case supervisor, and
2. the Graduate Training Director, Internship Director, or Post Doc mentor.

Their signatures on the form titled “Clinic Report Release for Internship/Post Doctoral/Employment Applications evidence this approval.” (see below)

Trainees are directed to the following procedure:

1. Consult with the clinical supervisor who supervised the report you would like to use.
2. The supervisor will review the report and agree or disagree that this is an appropriate report for the trainee to use.
3. If the supervisor agrees that this is an appropriate report to use, the trainee will prepare a revised report that is
 - a. clearly labeled **“Modified Sample Report”** in bold print on the first page; and
 - b. de-identified in order to protect client confidentiality.

De-identifying or “sanitizing” a report may include more than changing the client’s name and disguising readily identifiable information (e.g., place of employment). HIPAA specifies an exact list of information that it considers to be identifying (see HIPAA Identifiers List). Trainees will refer to this list to de-identify the report.

4. The trainee will submit the Modified Sample Report to the supervisor for approval, and secure the supervisor’s signature on the Clinic Report Release form.

The signature of the case supervisor ensures that s/he approves of the report

- a. as an exemplar of the student’s work;
- b. as being consistent with the internship /post doctoral/employment site request; and
- c. that the report has been adequately de-identified.

5. The trainee will submit the Modified Sample Report and the Clinic Report Release form to the Graduate Training Director. The signature of the Graduate Training Director ensures that
 - a. s/he is aware that the report will be utilized for the internship/post Doctoral/Employment application process, and
 - b. that the de-identification is consistent with HIPAA requirements.

No audio or videotapes will be released from the Clinic for any applications. Trainees are advised to inform potential sites that their program will not allow such materials to be used, given the impossibility of adequately protecting client confidentiality. Violation of any of these recommended procedures for handling program/employer requests for sample reports would be considered a breach of ethical conduct and the Department would consider such a violation a very serious matter.

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Clinical Report Release for Internship/Post Doctoral/Employment Applications

APPIC applications, as well as Post Doctoral positions and potential employers, often request a copy of an evaluation or treatment report. Signatures on this form permit student clinicians to fulfill this request while maintaining compliance with HIPAA regulations.

Trainee Name (print): _____

Signatures on this form indicate that the trainee has followed CHP Psychology Clinic policy and procedures.

Checkmarks indicate that the student has

- _____ 1. Consulted with the clinical supervisor who supervised the report;
- _____ 2. The supervisor reviewed the report and agreed that this is an appropriate report for the student to use; and
- _____ 3. The student has prepared a revised report that is
 - a. clearly labeled **“Modified Sample Report”** in bold print on the first page; and
 - b. is de-identified in order to protect client confidentiality. Trainees will refer to the HIPAA Identifiers List.
- _____ 4. The trainee has submitted the Modified Sample Report to the supervisor for approval. The signature of the supervisor ensures that s/he approves of the report
 - a. as an exemplar of the student’s work;as being consistent with the internship site/post doc/employer request; and that the report has been adequately de-identified.

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HIPAA DE-IDENTIFICATION LIST

What is PHI?

Protected health information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment.

What is not PHI?

In contrast, some research studies use data that is person-identifiable because it includes personal identifiers such as name, address, but it is not considered to be PHI because the data are not associated with or derived from a healthcare service event (treatment, payment, operations, medical records) not entered into the medical records, nor will the subject/patient be informed of the results. Research health information that is kept only in the researcher's records is not subject to HIPAA but is regulated by other human subjects protection regulations.

HIPAA Identifiers

1. Names
2. ALL geographic subdivisions smaller than the state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. All elements of dates smaller than a year directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers
5. Fax numbers
6. E-mail addresses
7. Social Security numbers
8. Medical record number

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9. Health plan beneficiaries/numbers
 10. Any other account numbers
 11. Certificate/license numbers
 12. Vehicle Identification Number (VIN)
 13. License Plate Numbers
 14. Device identification numbers
 15. Names of relatives
 16. WEB URL's
 17. Internet IP address numbers
 18. Biometric identifiers. The examples given in the regulations are fingerprints and voice prints – i.e., identifiers for which there is some database or comparison upon which to check (probably includes retinal scans and dental x-rays too). In other words the data is the identifier. MRIs or CTs are not in the same category for two reasons. 1) While ‘unique’ these do change over time (unlike fingerprints) and 2) unless you had the original MRI for comparison, it would be next to impossible to identify a person. So, MRIs are in the category of health information, which can be de-identified with the removal of the 18 items on the list.
 19. Full face photographs or comparable images
 20. Any other unique number, characteristic or code.

There are also additional standards and criteria to protect individual's privacy from re-identification. Any code used to replace the identifiers in datasets cannot be derived from any information related to the individual and the master codes, nor can the method to derive the codes be disclosed. For example, a subject's initials cannot be used to code their data because the initials are derived from their name. Additionally, the researcher must not have actual knowledge that the research subject could be re-identified from the remaining identifiers in the PHI used in the research study. In other words, the information would still be considered identifiable if there was a way to identify the individual even though all of the 18 identifiers were removed.

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11.0 UNIVERSITY POLICY ON “SHADOWING” OF PATIENTS

The University of Florida Privacy Office, in partnership with Shands Health Care, agreed to change the process for student "shadowing" and patient care observation. This process applies not only to student shadowing, but also to resident applicants, visiting professors, or others who wish to observe patient care; it also applies to vendors demonstrating medical-dental equipment as part of patient treatment.

The Shands' Volunteer Office will no longer screen or train students who only wish to observe medical-dental procedures and patient care. However, student volunteers will continue to be sponsored and trained by the Shands' volunteer staff. Those individuals who wish to observe patient care will be trained by the UF Privacy Office; online training will be available to observers and visitors.

For student and other observers, the process now requires that HSC faculty members screen and sponsor the observers. Attached you will find the "Request for Permission to Observe Patient Care" form, which is to be completed by the faculty member who will be accountable for the observer's activities. The Chief of Staff for Shands at UF, will sign all requests that involve observation of patients or procedures at Shands' facilities.

While this form was designed for the UFP clinics and Shands' Health Care facilities, it can be amended for other HSC colleges that wish to sponsor patient care observers. The approval process for HSC Colleges, other than the College of Medicine, requires the College Dean's or designee signature. If the visitor wishes to observe procedures at Shands facilities, The Chief of Staff will also sign the form. To receive approval, the observers must complete at minimum HIPAA 101: General Awareness Training and review the Confidentiality policies. The observer is also required to sign the Confidentiality Statement. Please note the special restrictions regarding liability and student age. Additionally, observation of procedures in some health care areas, like the operating rooms, will require infection control training.

Because the Privacy Office does not yet offer infection control training, the faculty member must address this issue with the observer before entering patient care areas; in the future, online infection control training will be available. If in doubt, please call the

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Privacy Office who will help make arrangements for specialty training. Once the Request to Observe form is approved, the form and supporting compliance documentation must be forwarded to the Privacy Office (N1-008).

12.0 HOLIDAY DECORATIONS

Guidelines for holiday decorations:

1. No decorations shall be placed to obstruct exits.
2. Combustible decorations shall be prohibited unless flame retardant. These decorations shall always be separate from the ignition sources (i.e. light fixtures, electrical receptacles, etc.)
3. Decorations of an explosive or highly flammable character shall not be used. Christmas trees not effectively flame retardant treated, ordinary crêpe paper decorations, and pyrolyin decorations may be classified as highly flammable.
4. Holiday wrapper paper covering doors shall not be permitted.
5. Natural cut and live Christmas tree shall not be permitted.
6. Artificial Christmas tree shall be labeled or otherwise identified or certified and is flame retardant or flame resistant.
7. No decorations that impair the visibility of an exit sign or portable fire extinguisher shall be permitted.
8. No decorations that impair the proper operation of the fire sprinkler system shall be permitted.
9. Electrical or battery-operated lights and devices of any kind or prohibited for use as decorations.
10. Attaching decorations depended services with tape is prohibited. Hanging of decorations from ceiling grid is preferable.
11. Limit wall decorations to 15% of wall surface area so as not to substantially increase the fuel load.
12. Handrails must remain unobstructed for use by our patients, visitors and staff.

13.0 Billing Compliance Plan

I. Billing Compliance Administrative Policies and Procedures

13.1 COMPLIANCE ASSURANCE

13.1.1 This Department of Clinical and Health Psychology Compliance Policy has been drafted to ensure that our billing procedures are conducted in accordance with all applicable federal, state and local laws and regulations relating to professional fee reimbursement.

13.1.2 The Department will bill for faculty services in accordance with regulations and guidelines established by the applicable third party payers.

13.1.3 The Department will strive to maintain policies and procedures that provide both narrative and flow-charting of the billing process for the Department of Clinical and Health Psychology. These policies will be kept by the Departmental Compliance Representative and are available to any interested person.

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13.1.3.1 The Department encourages participation and helpful comments on its policies and procedures. Questions and comments on this Policy should be addressed to the Departmental Compliance Representative.

13.2 REPORTING OF COMPLIANCE CONCERNS

The College of Public Health and Health Professions of the University of Florida (PHHP) is committed to providing an environment of honesty, integrity and trust. If you have concerns about legal or ethical issues speak with your departmental compliance leader or you may call the Gator Hotline at 1-866-574-2867.

The Gator Compliance Hotline is a resource for all employees who may be confronted with ethical issues in areas such as Billing Issues, Proper Accounting and Record Keeping, and Relations with Government Officials and Regulatory Agencies

Anonymous reports are accepted. You may use this number to follow up or learn the results of the investigation process.

13.0 A FINAL NOTE

While these guidelines cover major issues of importance related to the functioning of the Psychology Clinic and common and acceptable guidelines for Clinical practice, it is likely that issues may arise which are not fully addressed in this procedures manual. In this event it is important for such issues to be brought to the attention of those responsible for the ongoing operations of the Clinic so that appropriate additions and/or changes can be considered. APA's Code of Ethics and Guidelines for Psychological Records and appropriate state laws should be reviewed routinely by all those who work in our Clinic.

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APPENDICES

APPENDIX A

General Guidelines for Providers of Psychological Services

APPENDIX B

Appropriate Information for Inclusion in Clinic Files

APPENDIX C

Infection Control and Standard Precautions in Working With Medical Patients

APPENDIX D

Shands Change in Medical Record Completion Enforcement

APPENDIX E

Confidential Therapist/Supervisor Assignment Form

APPENDIX F

Shands at UF Campus Rules and Regulations of the Medical Staff

APPENDIX G

Shands at AGH/UF Medical Staff Bylaws

APPENDIX H

Guidelines for Documenting Outpatient Clinic Contacts

APPENDIX I

Record Retention and Management Policy

APPENDIX J

Therapy Room Assignment Book (TRAB)

APPENDIX K

Quality Assurance

APPENDIX L

Shands Hospital Disaster Preparedness Plan Clinical Psychology Response for Casualty Management

APPENDIX M

Medicare B Medical Record Documentation Alert

APPENDIX N

Consult Service's Mission

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APPENDIX O
Baker Act

APPENDIX P
Carbon Monoxide Protocol

APPENDIX Q
"Go Team" Plan

APPENDIX R
Sample Termination Letter

APPENDIX S
UF Administrative Disaster Preparedness Policy