

Alameda County Behavioral Health Care

MHP Provider Network Documentation Manual

This Section of the Quality Assurance Manual contains information about basic required chart management, and the minimum requirements for clinical documentation. This section applies to the Mental Health Plan Provider Network of Individual, Group and Organizational Providers that submit claims on the CMS 1500 form.*

December 1, 2016

*See Types of Providers on next page.

POLICY STATEMENT: MENTAL HEALTH

All service providers within the Alameda County Mental Health Services system shall follow the Clinical Record Documentation Standards Policy as set forth herein. This includes providers employed by BHCS and all contracted providers.

Types of Providers: The type of provider contract determines the documentation standards and method of claiming for reimbursement of services. Each provider's contract specifies which specialty mental health services they may claim; *not all provider contracts authorize claiming for all possible services.*

Level 1 Providers:

- County-owned and operated service providers of outpatient services.
- Master Contract Organizational providers (MCO, PKA: CBO) of outpatient services.

Level 3 Providers:

- MHP Provider Network (office-based individual & group clinicians)-addressed in this Manual.
- Organizational providers with fee-for-service contracts:
 - Those that claim through eCura on the CMS 1500 form are addressed in this Manual.
 - Those that claim through InSyst:
 - self-authorize services (with timeframes) with defined authorization packages of services as described in this manual, and
 - follow the documentation requirements per the ACBHCS Clinical Documentation Standards Manual (not this manual).

A Word about Terminology: ACBHCS providers and administrative offices have the intention to be inclusive in the language used to refer to beneficiaries of the Mental Health Plan (MHP) (e.g., consumers, clients, families, children, youth, transition-age youth, etc.). Depending on the language used, it is possible that some beneficiaries could feel excluded or secondary in importance. While it is the goal of ACBHCS to honor each individual's desire to be identified as they wish, this Quality Assurance Manual is bound by regulatory language that uses "beneficiary" and "client" in reference to documentation standards. Therefore, in the interest of clarity, inclusion, and consistency with regulatory language, all beneficiaries will be referred to as "clients".

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General Management of Clinical Records

(CFR2) (CC1) (CC2) (HS1) (CalOHI1) (DHCScontract2) (CCR23)

For the purposes of these documentation standards, charts containing documentation of mental health services are referred to as Clinical Records or Records.

General Record Maintenance:

Per BHCS, the “best practices” outlined below should be followed:

- Records should be organized and divided into sections according to a consistent standard allowing for ease of location and referencing. *(BHCS1)*
- Records should be sequential and date ordered. *(BHCS1)*
- Records should be fastened together to avoid loss or being misplaced. No loose papers or sticky-sheets in the chart (may staple). *(BHCS1)*
- Progress Notes must be filed in clinical records. Psychotherapy notes (process notes) should be kept separately. *(CalOHI1)*
- All entries must be legible (including signatures). (See “Clinical Documentation Standards” section, “Signature Requirements.”) *(CCR30) (DHCScontract)*
- Use only ink (black or blue). *(BHCS1)*
- Every page must have some form of client identification (name or identification number, etc.). *(BHCS1)*
- Do not use names of other clients in the record (may use relationship or similar method of preserving other clients’ identities). *(BHCS1)*
- Do not “rubber stamp” (or “cut and paste”) your record entries across service dates; tailor wording to the changing needs and circumstances of each individual for each intervention. *(BHCS1)*
- Correcting errors: Do not use correction tape/fluid, scribble over, etc. Instead, draw a single line through the error, and indicate “error”, initial, date, and then enter correct material. *(BHCS1)*
- Acronyms & Abbreviations: Use only universal and County-designated acronyms and abbreviations. A list is available at www.acbhcs.org/providers under the QA tab. *(BHCS1)*

Record Storage:

Clinical records contain Protected Health Information (PHI) and other Protected Information (PI) covered by both state and federal confidentiality laws. Providers are required to safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(CFR1) (CFR2) (CC1)

Alameda County BHCS requires that clinical records be stored at a minimum in a “double locked” manner (e.g., in a locked filing cabinet located within a locked office) and preferably in a “triple locked” manner (e.g., in a locked filing cabinet located within a locked room within a locked office). If records must be transported, maintain the “double locked” and safeguarding requirement (e.g., transported in a locked box in a locked vehicle trunk and never left in an unattended vehicle). *(BHCS1)*

The following record storage procedures are consistent with good clinical practice: *(HS2) (CC2)*

(CCR31) (CFR1) (CFR2)

- A controlled record check-out or retrieval system for access, accountability and tracking.
- Safe and confidential retrieval system for records that may be stored off-site or archived.

- Secure filing system (both physical plant and electronic safeguards used, when applicable). (See above regarding “double locked” storage.)

With respect to Electronic PHI/PI, providers must use appropriate administrative, physical and technical safeguards, and comply with the Security Rule and HIPAA Security Regulations. (BAEE) It is recommended that providers consult with an IT expert knowledgeable about HIPAA/HITECH requirements and NIST compliance standards for protection of PHI/PI. All workstations and laptops that store PHI/PI either directly or temporarily must be encrypted using a solution that provides Full Disk Encryption (FDE). All electronic files that contain PHI/PI must be encrypted when stored on any removable media or portable device per NIST standards.

Record Retention:

All Client Records must be retained as long as required by law, AND until ACBHCS has finalized that fiscal year’s cost settlement with CA Department of Health Care Services (DHCS), whichever is longer. Currently the last ACBHCS/DHCS finalized cost settlement was through 6/30/2008—this will be updated in future editions of this Clinical Documentation manual when needed. No records containing services beyond that date may be destroyed.

Clinical records must be preserved for a minimum of seven (7) years following discharge/termination of the client from services, with the following exceptions: (HS3) (CCR31)

- The records of un-emancipated minors must be kept until their 25th birthday and in any case, not less than seven (7) years.
- Third party: If a provider uses a third party to perform work related to their BHCS contract (such as off-site record retention), the provider must require the third party to follow these same standards. (BHCS1)
- Audit situations: Records shall be retained beyond the seven (7) year period (or youth’s 25th birthday, whichever is longer) if an audit involving those records is pending, until the audit findings are resolved. The obligation to insure the maintenance of records beyond the initial seven (7) year period for the audit period exists only if the MHP notifies Contractor of the commencement of an audit prior to the expiration of the seven (7) year period. (BHCS1)

Provider out of business: In the event a provider goes out of business or no longer provides mental health services, the provider is still obligated to make arrangements that will assure the accessibility, confidentiality, maintenance, and preservation of clinical records for the minimum retention time as described above. (CCR29) (HS3) As well, the Provider must notify the Quality Assurance office of who will be responsible for the maintenance of the records.

Record Destruction:

Clinical records are to be destroyed in a manner to preserve and assure client confidentiality. (CC1)

Eligibility, Referral, Authorization, and Payment of Services

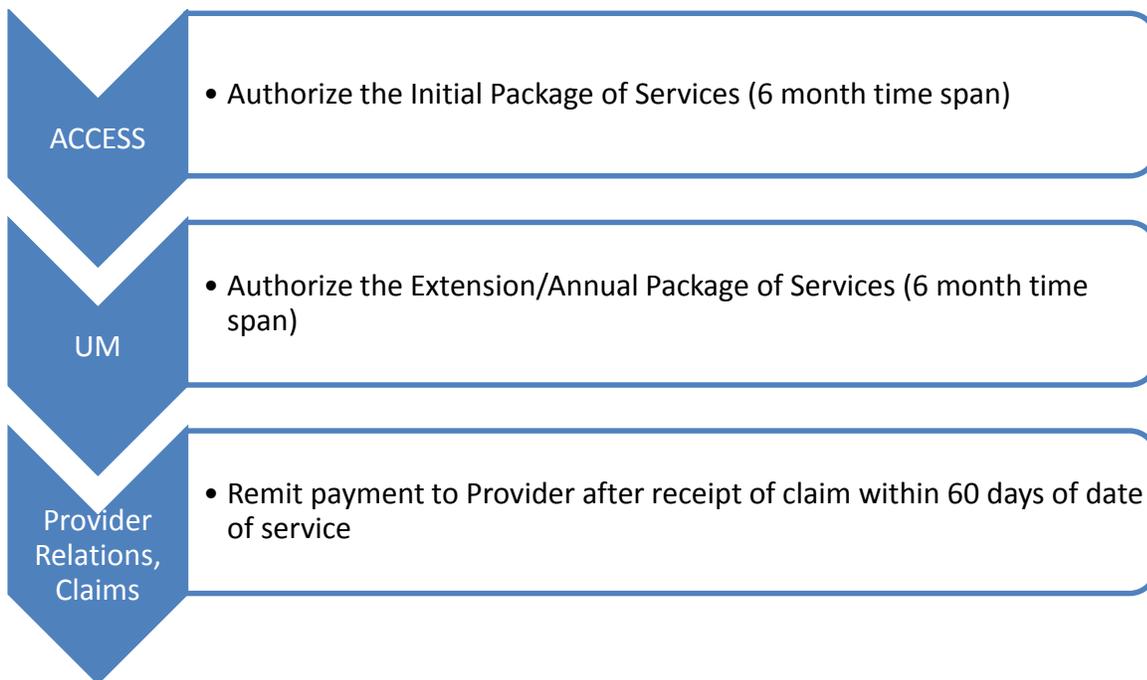
Introduction:

Utilization Management Program (UM) and the ACCESS Program serve as the BHCS Mental Health Plan (MHP) Points of Authorization (POA) for managed care outpatient Specialty Mental Health Services (SMHS). Under the Affordable Care Act, only beneficiaries who demonstrate functional impairments in the moderate-to-severe range due to their mental health condition are eligible for SMHS. Due to the current capitated managed care environment, brief therapy modalities are advised.

The Medi-Cal Managed Care Plans (MCPs), such as Alameda Alliance, and Primary Care Providers are expected to provide mental health services to those assessed to have mild-to-moderate functional impairment.

Alameda County is a retrospective payment authorization county. Service authorization is given for 6 months into the future but is not a guarantee of payment. Payment of claims is dependent on continued insurance eligibility, medical necessity, and timeliness of claim submission.

Overview of Authorization and Payment Process:



Package of Services:

Initial/Annual Package of Services (26 total services in 6 month time span):

- 2 sessions (120 minutes) - Assessment/Treatment Plan (in 60 min. increments)
- 20 Therapy sessions- Individual, Family &/or Group Therapy
 - Individual (60 min sessions) Family Therapy (60 or 90 min sessions); Group Therapy (90 min sessions)
- 2 hours- Brokerage/Linkage (30 and 60 min increments)
- 2 hours- Collateral (10 and 45 min increments)

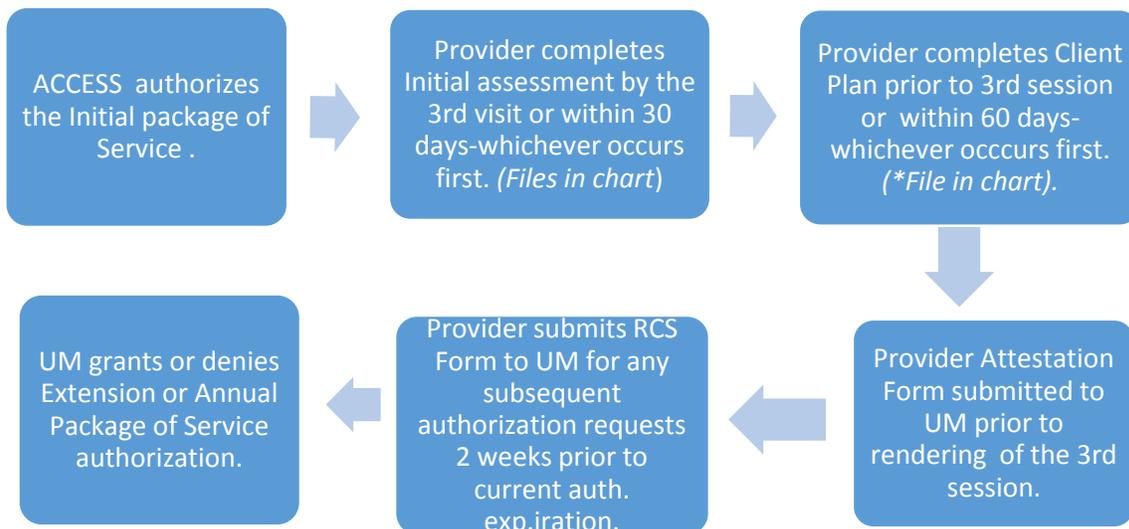
Extension Package (26 total services in 6 month time span):

- 1 session (60 minutes)- Assessment/Treatment Plan
- 20 Therapy sessions- Individual, Family &/or Group Therapy
 - Individual (60 min sessions) Family Therapy (60 or 90 min sessions); Group Therapy (90 min sessions)
- 3 hours- Brokerage/Linkage (30 and 60 min increments)
- 2 hours- Collateral (10 and 45 min increments)

Insurance Eligibility Verification:

- It is the Provider's responsibility to check insurance eligibility monthly and understand medical necessity criteria for SMHS.
- At the beginning of each calendar month, the Provider should verify on-going Medi-Cal eligibility for each client they serve. If Medi-Cal has been discontinued, alert the beneficiary to follow-up with the Medi-Cal Office so that hopefully their benefit will be reinstated (usually retroactively if alerted same/next month from discontinuation).
- It is strongly recommended for the Provider to know each of their beneficiary's Medi-Cal Managed Care Plan (MCP) to help ensure continuity of care as a beneficiary's condition improves from moderate-to-severe to mild-to-moderate. The three MCPs are as follows:
 1. Alameda Alliance/ Beacon Health Strategies: (855) 856-0577 (*Beacon manages the mental health services for Alameda Alliance Medi-Cal beneficiaries with mild-to-moderate impairment).
 2. Anthem Blue Cross: (888) 831-2246
 3. Kaiser: (510) 752-1075
- If a Provider is interested in continuing to work with a beneficiary whose condition improves to mild-to-moderate impairment, it is recommended that the Provider become a Beacon and/or Anthem Blue Cross provider.

Timeline for Authorization and Documentation Completion:



UM Authorization Process:

- Prior to rendering the 3rd session and within 60 days from the initial session, the Attestation Form must be completed, signed, and faxed to UM, attesting that a beneficiary currently meets medical necessity criteria for SMHS and that a full

assessment and client plan have been completed. The Attestation Form is available online at <http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm>

- Forms cannot be emailed to UM at this time. Please FAX to (510) 567-8148 or mail to Utilization Management, 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606.
- If additional services are needed beyond the Initial 6 month specified Package of Service authorization by ACCESS, submit to UM via FAX: (510) 567-8148 the Request for Continued Service (RCS form) fifteen days prior to the authorization expiration date. This is also true for any other subsequent RCSs. The RCS form is available online in two versions - one fillable and one printable at the UM Program Link: <http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm>
- The RCS must document medical necessity for SMHS. List an included diagnosis from the DHCS document “Medical Necessity for Specialty Mental Health Services” located in this handbook. Also list supporting symptoms and describe behaviorally significant impairments or risk of significant impairments in an important area of life functioning; or if the beneficiary is a child, describe the probability that developmental progress may be impaired. Impairment and Intervention Criteria are also described in the aforementioned CA DHCS document.
- The RCS has a screening form and algorithm to help you make impairment severity determinations (i.e. moderate-to-severe vs. mild-to-moderate).
- Four pages of the RCS are required, including the signature block, which requires a signature of a licensed, registered, or waived clinician. The RCS contains screening forms for all ages. Please send only the screening form which is age appropriate for your beneficiary.
- In response to the RCS, you will receive a letter of approval or denial by a Clinical Review Specialist (CRS). Notification will also be sent to the beneficiary. Authorization is usually for a 6 month time span unless otherwise specified.
- A CRS from ACBHCS UM may request responses for additional information that does not impact the current authorization, such as “For beneficiary’s current medications, please list dosage and frequency.” These requests will be highlighted in yellow on the approval letter; responses expected on the next RCS.
- A Provider will receive a phone call from a licensed Clinical Review Specialist (CRS) requesting case consultation if continued need for services is not clearly documented on the RCS. If, by the 14th calendar day, the Provider fails to respond to a telephone request to help determine medical necessity, the RCS will be considered withdrawn and no authorization will be processed. This will most likely result in returned claims.
- If the MHP is not the responsible payer, the Provider will receive a notice from a Health Information Technician (HIT) to this effect. Beneficiaries frequently lose their Medi-Cal benefits; go on another insurance; become Medicare eligible which is primary over Medi-Cal; or switch to another county’s Medi-Cal.
- If there has been a lapse in service or a new service is being added, indicate the start date for the requested 6-month authorization period.
- For any subsequent RCSs, document continued medical necessity for SMHS with current significant functional impairment(s) that directly relates to mental health symptoms. No duplicates of previously received RCSs will be acceptable.

Special Rules:

- A Medi-Cal Provider may NEVER bill a Medi-Cal client any amount—except for the rare instances when a beneficiary has a Medi-Cal Share of Cost.
- Missed appointments cannot be claimed or billed to the beneficiary or to BHCS.

- For family therapy, if there are multiple billable beneficiaries, only one service may be claimed.
- Child and Family Services (CFS) customized services require Child Welfare Worker (CWW) approval. An approval form must be sent to ACCESS by the CWW prior to delivery of the service. This includes CFS reports requested more frequently than 6 months or requiring more than 2 hours preparation time.
- Requests for reimbursement for non-treatment services provided at the request of other agencies should be directed to those agencies. This includes IEP's, court appearances, and child custody evaluations. Medi-Cal does not reimburse for non-treatment services.
- Assessments for purposes of evaluating for SSI are not covered by Medi-Cal except for beneficiaries using CalWORKs insurance.
- Services that do not require authorization:
 1. Supplemental bilingual services.
 2. Standard CFS court reports every 6 months.

Questions:

- CALL UM AT (510) 567-8141 from 8:30 to 4:30 M-F. The Daily Coordinator or another licensed Clinical Review Specialist will be available to speak to you or will return your call as soon as possible.

Medical Necessity: Providing the Rationale for Services
(CCR16) (CCR20)

The Mental Health Plan requires substantiation of the need for mental health services in order for those services to qualify for reimbursement. This is known as establishing Medical Necessity (MN). (CCR16)

All Level III providers use the following clinical document templates to document medical necessity for services:

- MH Initial Assessment – Short Form (used for initial assessment only) or Long Form.
- Annual Assessments – Long Form (may be used for the initial Assessment and MUST be used for any annual Assessments).
- Client Plan.
- MH Progress Note – or – equivalent with all the same elements.

The clinical documentation templates are posted on the ACBHCS Provider Website. See Forms/Clinical Templates/Provider Network:

<http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm>

Relevance of Medical Necessity for Documentation

- Initial Assessment documentation establishes Medical Necessity (MN).
- Initial client plans are based on the Initial Assessment.
- A signature of a licensed (or unlicensed LPHA-for MCO's only) on the Assessment and Plan is attestation that MN is met.
- Client plans serve as progress reports and support ongoing MN.
- Progress Notes must contain evidence that the services claimed for reimbursement meet Medical Necessity. Claim submission is attestation that this requirement is met.

Medical Necessity is determined by the following factors:

1. The client has an “included” DSM (currently DSM-IV and DSM-5 effective 4/1/17, and ICD-10 diagnosis that is substantiated by chart documentation. ^(CCR17)
 - a. A client’s excluded diagnosis may be noted, but there must be an “included” diagnosis noted that is the primary focus of treatment. (An “excluded” diagnosis may not be noted as primary.)
 - b. Identify and note the DSM diagnostic criteria for each diagnosis that is a focus of treatment.

2. As a result of the included diagnosis, it must be documented that the client meets at least one of the following criteria: ^(CCR18)
 - a. A significant impairment in an important area(s) of life functioning, OR
 - b. A probability of significant deterioration in an important area of life functioning, OR
 - c. For full-scope M-C beneficiaries under age 21, a probability that the child will not progress developmentally as individually appropriate, OR
 - d. For full-scope M-C beneficiaries under age 21, a condition as a result of the included diagnosis that can be corrected or ameliorated with mental health services.

3. Identify how the proposed service intervention(s) meets both of the following criteria: ^(CCR19)
 - a. The focus of the proposed intervention(s) is to address the condition identified in No. 2. (a-b) above; or for full-scope M-C beneficiaries under age 21, a condition identified in No. 2 (c-d) above.
 - b. The expectation that the proposed intervention(s) will do at least one of the following:
 - Significantly diminish the impairment, OR
 - Prevent significant deterioration in an important area of life functioning, OR
 - For full scope M-C beneficiaries under age 21, allow the child to progress developmentally as appropriate, OR
 - For full scope M-C beneficiaries under age 21, to correct or ameliorate the condition.

4. Documentation must support both of the following: ^(CCR19)
 - a. That the mental health condition could not be treated by a lower level of care.
 - b. That the mental health condition would not be responsive to physical health care treatment only.

EPSDT ONLY - Medical Necessity Criteria ^(CCR20)

If a youth does not meet the functional impairment criteria for MN, the services provided **MUST** correct or ameliorate at least one of the following:

- A documented mental illness or condition, and/or
- The documented risk of developing a mental illness or condition, or of not progressing developmentally as expected.

(Note: EPSDT clients must still have an included DSM and/or ICD-10 diagnosis that is a focus of treatment.)

Clinical Documentation Standards for Specialty Mental Health Services
[Citations noted under each subject.]

This section describes signature requirements for all providers, as noted. It also describes the required contents of the following clinical documents, per type of provider or service, as noted below:

1. **Signature Requirements**
2. **Mental Health Assessments**
3. **Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.)**
4. **Progress Notes**
5. **Discharge/Termination/Transition Documentation**

1. Signature Requirements: All providers ^(DHCscontract2)

- **Complete Signature:** Every clinical document must be followed by a “complete signature,” which includes the writer's signature, M/C credential and date of signature. ^(BHCS1)
- **Legibility:** Signatures should be legible: If signatures are illegible, the associated document may be subject to disallowance. Therefore, the MHP recommends that the name and appropriate credential (see below) be typed under signature lines. MCO providers may also have an administrative “signature page” containing staff signatures with their typed names and credentials. ^{(CCR30) (DHCscontract)}
- **Credentials:**
 - **For all providers:** Professional licensure (e.g., LCSW, MFT, LPCC, PhD, NP, or MD,) must accompany the signature.
 - **For Level III Master Contract Organizations (MCO aka CBO) who claim through eCura on the CMS 1500 Form:** Waivered or Registered Status (e.g., ASW, MFT-Intern, PhD-Waivered, or PCC-Intern) or Graduate Student/Trainee status (currently in a MH degree program) is required to accompany the signature. (Only MCO's may supervise registered or waivered interns and/or student/trainees.) ^(DHCscontract)
- **Dates:** All progress notes must indicate the Date(s) of Signature as well as the Date of Service. ^(BHCS1)
- **Timeline for Completion:** It is best practice that providers of mental health services complete, sign, and finalize progress notes the same day, and no later than within five (5) business days of the Date of Service (DOS). Required signatures include the staff providing the service, and if applicable, the supervisor(s) who are required to co-sign progress notes as Licensed Practitioner of the Healing Arts (LPHA) as well as the dates of the signatures. ^(BHCS1)
- **Late entries:** Progress notes written after five (5) business days from the Date of Service (DOS) shall be documented as a “late entry” and signed the day of that entry. ^(BHCS1) Note, that if the Progress Note is created in a non-EHR database (such as Word); each Note must be printed out when written and then signed. One should not print out multiple notes (of different dates) and then sign each as it will result in all but the last note being a “late note”.
- **Notes for non-billable services and informational notes** shall be documented within five (5) business days of the Date of Service (DOS) ^(BHCS1)

- **Situations where it is clinically indicated to document a service before five (5) days:** All providers of mental health services shall document services the same day, or as soon as reasonably possible, when the service is provided for a client who is at imminent or potential risk. The objective is to ensure continuity of care by providing a written record that will be used to inform all relevant mental health providers. ^(BHCS1)
- **Completion Line:** Nothing may be added within a document after it is signed. To indicate the end of an entry, draw a line from the end of the body of the note, down to the signature (n/a for electronic signatures). If additional information must be added, write an addendum. ^(BHCS1)
- **Addendums:** Include complete signature (see above). ^(BHCS1)
- **E-signatures:** There are extensive rules and regulations governing the use and security involved in e-signatures. DMH and the MHP accept only those e-signatures that meet the guidelines set out in DMH Letter 08-10. ^(DMH06)

2. Assessments ^(DHCScontract)

Definition: Assessments are a collection of information and clinical analysis of the history and the current status of a client's mental, emotional and/or behavioral health. Documentation must support the Medical Necessity criteria defined above if the Initial Assessment determines that ongoing mental health services will be provided. ^(CCR04)

Assessment information must be in a specific document per MHP requirements. ^(BHCS1) The assessment templates are posted on the ACBHCS Provider Website. See Forms/Clinical Templates/Provider Network: <http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm>

❖ **Timeliness & Frequency of Initial Assessments** ^(BHCS1)

Initial Assessment

All Providers: Per the MHP requirements, a completed and filed Initial Assessment is required within 30 days of the opening episode date AND prior to the third client visit.

- See most recent versions of the required *Initial Assessment-Short Form* and *Initial and Annual Assessment – Long Form* on the ACBHCS Provider Website. Either may be used for the Initial Assessment. If client needs to be seen beyond 12 months, the *Initial and Annual Assessment – Long Form* must be completed within 30 days (no sooner) of the first day of the anniversary episode opening month.
- The Initial Assessment (Short or Long Form) must be completed prior to the third client session.
- If it is not possible to address all required elements due to issues of client participation or inability to obtain a full history within the required time-frame, but medical necessity has been established, the Assessment should be completed with notations of when addendums with missing information are expected.
- If the case is closed before the 4th session, best practice is to complete the Initial Assessment as much as possible.
- Progress Notes for every billed Assessment service must be in the clinical record.
- Effective 4/1/16, the only Mental Health services that may be provided before completion of the MH Assessment AND Client Plan are: Assessment, Plan Development and Crisis Intervention (coded as Crisis Psychotherapy).

Annual Assessments

The Initial Assessment is required prior to the third client visit and the 2nd (Annual) Assessment is due approximately 11 months after the Initial Assessment by the first day of the Episode Opening Month (EOM). Example, EOD is 1/15/16—Annual Assessment is due by 1/1/17 and should be written no early than 12/1/16. Every Assessment thereafter would be due on a 12 month cycle. Previous history can be carried forward from a previous assessment, but all new information gathered and interim history must be updated and a newly written Assessment form is required.

Returning Clients: If a beneficiary's episode is closed but he/she returns to the provider for additional services within 12 months of an *Assessment's completion, that Assessment may be updated with new clinical information in an addendum and re-used for the new episode opening. This addendum must be clearly linked to the previous Assessment and completed/signed prior to the third client visit.*

If the beneficiary returns for services after 12 months of an Assessment's completion, the Assessment must be re-done as a new Initial Assessment.

❖ Minimum Requirements for Assessment Content

The following areas must be included in the Initial Assessment, as appropriate, as part of a comprehensive clinical record. *(DHCScontract)*

- a. **Identifying information:** Unless included in another document in the record (e.g., a face sheet or admission note), the Assessment must include: *(BHCS1)*
 - The date of initial contact and admission date.
 - The client's name and contact information (including address/phone and emergency contact information).
 - The client's age, self-identified gender & ethnicity, marital/domestic partnership status, and sexual orientation as developmentally appropriate.
 - Information about significant others in the client's life including parents, caretakers, guardian, conservator or other legal representatives.
 - The client's school and/or employment information.
 - Other identifying information, as applicable.
- b. **Communication needs** are assessed for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter services, etc.). If required, indicate whether it was/will be provided, and document any linkage of the client to culture-specific and/or linguistic services in the community. Providers are required to offer linguistic services and document the offer was made; if the client prefers a family member as interpreter, document that preference. Service-related correspondence with the client must be in their preferred language/format. It is the preference of BHCS that family members not be used as interpreters due to the potential for conflicting needs. Because of this, it is to be strongly discouraged. *(BHCS1)*
- c. **Relevant physical health conditions** reported by the client or by other report must be prominently identified and updated, as appropriate. *(DHCScontract)*
- d. **Presenting problem/referral reason & relevant conditions** affecting the client's physical health, mental health status and psychosocial conditions (e.g. living situation, daily activities, social support, etc.). Includes problem definitions by the client, significant others and referral sources, as relevant. *(DHCScontract)*

- e. **Special status situations** that present a risk to the client or to others must be prominently documented and updated, as appropriate. If a risk situation is identified as present within the past 90 days (or at any time with a likelihood of recurrence), the Client Plan and a specific Safety Plan must include how it is being managed.
(DHCScontract)
- f. **Client, and/or Family strengths** in achieving anticipated treatment goals (e.g., client's skills and interests, family involvement and resources, community and social supports, etc.). (DHCScontract)
- g. **Medications:**
- List medications prescribed by a Medical Provider (prescriber) employed by the provider, including dose/frequency of each, date of initial prescriptions & refills. Documentation of informed consent for each medication prescribed is required and may be located in a different section of the record. See the ACBHCS Provider Website for a sample Medication Consent with all the required components. A general medication consent is not sufficient.
(DHCScontract)
 - Medications prescribed by an outside Medical Provider must be listed as above, per client or MD/NP's report; provide the MD/NP's name, address and telephone number. (BHCS1)
- h. **Allergies & adverse reactions/sensitivities**, per client or by report, to any substances or items, or the lack thereof, must be noted in the Initial Assessment (DHCScontract) and prominently noted on the front of the chart. (BHCS1)
- i. **Substance use**, current, past & last use: Tobacco, Alcohol, Caffeine, Complementary & Alternative Medications (CAM), Prescribed (not to them or using different than prescribed), Over-the-Counter, and Illicit drugs. (DHCScontract)
- j. **Mental health history**, including previous treatment dates and providers; therapeutic interventions and responses; sources of clinical data; relevant family information; and results of relevant lab tests and consultation reports (as applicable to scope of practice). (DHCScontract)
- k. **Other history:** As relevant, include developmental history; social history; histories of employment/work, living situation, etc. (BHCS1)
- l. **For clients under age 18:** Include (or document efforts to obtain) pre-natal/ perinatal events, and significant developmental milestones (physical, intellectual, psychological, social & academic). (DHCScontract)
- m. **Relevant Mental Status Examination:** Includes signs and symptoms relevant to determine diagnosis and plan of treatment. (DHCScontract)
- n. **Complete Diagnosis (DSM & ICD-10)** with primary diagnosis from the CA DHCS Medi-Cal Included Diagnosis List, consistent with presenting problem, history, mental status examination, and/or other assessment data. (DHCScontract)
- o. The **Primary Included Diagnosis** must be the focus of treatment. (CCR16)
- p. Only a licensed clinician may assign a psychiatric diagnosis. For MCO's: a waived or registered intern may assign a diagnosis only if it is co-signed by a Licensed LPHA. The MH Assessment (with Dx) may be co-signed or indicate the Licensed LPHA who made the current (not historical) Diagnosis (and date) alongside the diagnosis within the body of the Assessment.
- q. For MCO's only: when a diagnosis is made by a waived or registered LPHA they must obtain the co-signature of a licensed LPHA.
- r. For MCO's only: A Graduate Trainee/Student may not make a diagnosis, and the client will need to be seen face-to-face by a licensed LPHA (or waived or registered LPHA with licensed LPHA co-signature) with their signature for this purpose.

- s. **Five-axis diagnosis** (while DSM-IV is in effect through 4/1/17) or complete Dx from the most current DSM and/or ICD-10 Dx consistent with presenting problem, history, mental status examination, and/or other assessment data. ^(DHCScontract)
- At least one diagnosis must be the primary focus of treatment and must be on the “included” Medical Necessity criteria list. ^(CCR16)
 - Per the MHP requirements, only a licensed clinician may assign a psychiatric diagnosis (see exception for MCO’s above).
- t. **Complete signature** of the person completing the Assessment and the signature of a licensed or for MCO’s: a registered/waivered LPHA, or MH Trainee with a licensed co-signature ^{(CCR21) (CCR11) (BP1) (CCR01)}

Clinical Analysis: “Best practice” is to also provide a clinical analysis (aka clinical impression or formulation) of how the client’s mental health issues impact life functioning, based on the Assessment information. ^(BHCS1)

3. Medication Consents (For Medical Provider’s Prescribing Medications)

The process of obtaining Informed Consent is invaluable to assist the medical provider in educating and empowering their clients about the course of their treatment.

All of the following requirements must be included and discussed on the Consent Form or attached documentation-such as a Medication Information Sheet (simply having a checkbox attesting to a verbal discussion is not adequate). **A compliant Informed Medication Consent Form may be found on the ACBHCS Provider website (in English and ACBHCS Threshold Languages):** <http://www.acbhcs.org/meddir/consent.htm>.

- The nature of the client’s mental condition must be included and discussed on the Consent Form or attached documentation (simply having a checkbox attesting to a verbal discussion is not adequate).
- The reason that the medical provider has for prescribing the medication, including the likelihood of the condition improving or not improving without the medicine must be included and discussed on the Consent Form or attached documentation (simply having a checkbox attesting to a verbal discussion is not adequate).
- That a client may refuse to take the medications at any time if he/she tells any member of the treating staff must be indicated on the Consent Form.
- Reasonable alternative treatments available for the client’s condition must be included and discussed on the Consent Form or attached documentation (simply having a checkbox attesting to a verbal discussion is not adequate).
- The type of medication that the client will be receiving, the frequency and range of dosages, the method by which the client will take the medication, and duration of such treatment must be included on the Consent Form.
- Common short term, and long term (3 months) side effects must be described. The side effects of these drugs known to commonly occur, any particular side effects likely to occur in their particular case, and any possible side effects which may occur to the client taking such medications beyond three (3) months must be included and discussed on the Consent Form or attached documentation (simply having a checkbox attesting to a verbal discussion is not adequate).
- A new Consent Form must be completed when a new medication is being prescribed or after an end date is noted on a previous Informed consent.

- A change in medication dosage may be indicated on the existing Consent Form, if initialed and dated by provider and client.
- The Consent Form must be signed and dated by the client (*unless the client is willing to take the medication but unwilling to sign. In this case, this should be documented in the space available with the clinical reason the client refuses to sign.*)
- The Consent Form must be signed and dated by the prescribing medical practitioner.
- All writing must be legible.

4. **Client Plans** (DHCScontract) (CCR12)

The Client Plan is now posted on the Provider Website. If filled out completely, it will meet the following requirements.

Definition: Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.) are plans for the provision of mental health services to clients who meet the Medical Necessity criteria. Strength-based and recovery/resiliency oriented treatment planning is strongly encouraged. (BHCS1) Services must address identified mental health barriers to goals/objectives. Client Plans are developed from the Initial Assessment and must substantiate ongoing Medical Necessity and be consistent with the diagnosis(es) that is the focus of mental health treatment. (CCR05) (BHCS1)

Strength-based and recovery/resiliency oriented treatment planning is strongly encouraged. (BHCS1)

The minimum required content areas of any Client Plan may not be left blank; instead, indicate on the plan when you will complete those elements or indicate when they are not applicable. (BHCS1)

Timeliness & Frequency of Client Plans, applies to all providers

Initial Client Plan:

If you are authorized by UM to provide MH services beyond 12 months, a completed and filed Initial Client Plan is required prior to the third client visit. If the case is closed before the third visit, a completed Plan is not required. The Initial Client Plan may be completed before the deadline. (BHCS1) The only Mental Health services that may be provided before completion of the Client Plan are: Assessment, Plan Development and Crisis Intervention (coded as Crisis Psychotherapy).

Annual Client Plan: Treatment Plan updates are required on an annual basis. The cycle must be kept in sync with the Episode Opening Date (EOD). The 2nd Client Plan is due approximately 11 months after the first Client Plan deadline during the month prior to the EOD. Every Treatment Plan after that would be on a 12 month cycle (e.g., opened in March, so due every February); in other words, it must be completed in the month prior to the next authorization/utilization review period. If the case is closed before that month, a completed Plan is not required. (DHCScontract) (BHCSQA)

Providers MUST be attentive to the need to update changes in the treatment plan throughout the year. DHCS (and QA) will disallow notes if the Treatment Plan has not been updated to

reflect new client goals and mental health objectives. Examples of events requiring a change to the Client Plan include, but are not limited to: hospitalization, new thoughts or behaviors of self-harm or dangerousness to others, and additions of new treatment modalities (i.e. group therapy, case management brokerage, etc.). It would be expected that there might be a new MSE, new goals, interventions, etc. All updated Client Plans require a Brief Screening (completed as part of the RCS Form).

- a. If unable to fully address each component of a Client Plan within the specified timeframe, the Plan must be finalized by the deadline date and indicate when the missing information will be added. ^(BHCS1)

❖ **Minimum Requirements for Client Plan and Updates**

- a. The following elements must be fully addressed in the Initial and Annual Client Plans, as appropriate, as part of the clinical record. Client Plan Updates must provide updated information, as applicable, for each element. **Client's goals** (stated in own words, when possible) ^{(DHCScontract) (BHCS1)}
- b. **Mental health goals/objectives** that are specific and observable or measurable, and that are linked to the Assessment's clinical analysis and diagnosis (i.e. must be related to mental health barriers to reaching client's goals). Provide estimated timeframes for attainment of goals/objective. ^{(DHCScontract) (BHCS1)}
- c. **Service Modalities & Interventions: Their focus** must be consistent with the mental health objectives and must meet the medical necessity requirement that the proposed intervention(s) will have a positive impact on the identified impairments (Item 3.b. in the Medical Necessity section of this Policy). ^{(DHCScontract) (BHCS1)} **CA DHCS requires that the following be listed in the Client Plan:**
 - Service Modalities, which are the planned mental health services **MUST** be listed in the Client Plan (along with proposed frequency and duration) in order to be claimed. This includes: Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, Collateral, Case Management Linkage Brokerage, and Medication Management (for prescribers).
 - Detailed Clinician Interventions for each Service Modality, which are the proposed provider's actions during services to support the client's progress toward mental health objectives (e.g., "Offer stress reduction techniques to reduce anxiety" or "Support client to express unresolved grief to reduce depression"). ^{DHCScontract1) (BHCS1)}
- d. **Coordination of care:** If applicable, it is "**best practice**" to include an objective in the Client Plan regarding coordination of a client's care with other identified providers AND that this is expected to diminish the mental health symptoms or impairments of the client's included diagnosis. ^(BHCS1) This objective is required if case management will be claimed. For Adult Clients the record must indicate which of the MH symptoms/impairments of the client's included Medi-Cal diagnosis are preventing them from accessing and utilizing community support services on their own. As well, it must indicate that the successful Case Management service is expected to allow the client to meet their specific MH Objectives—that is decrease their symptomology of the Included Dx.

e. Tentative Discharge Plan (what signs will be present to indicate discharge readiness, estimated time frame, and termination/transition plan). ^(BHCS1)

f. **“Complete Signature”** (see also “Clinical Documentation Standards” section, “Signature Requirements”) or the electronic equivalent by at least one of the following: ^(CCR13)

- Person providing the service(s).
- For MCO’s, if psychiatric medication is prescribed by an organizational provider’s Medical Provider, they must also sign the Client Plan. ^(BHCS1)
- For MCO’s, if the above person providing the service(s) is not licensed, registered, or waived, a complete co-signature is required by a Licensed LPHA.

If the above person providing the service(s) (at the MCO) is not licensed or registered/waivered, a complete co-signature is required by at least one of the following:

- Physician or Nurse Practitioner
- Licensed psychologist
- Licensed social worker
- Licensed marriage and family therapist,
- Licensed Professional Clinical Counselor, or
- Registered nurse

a. **Evidence of the client’s degree of participation and agreement** with the Client Plan must be addressed in the following ways: ^{(CCR14) (BHCS1)}

- The client’s (or legal representative’s) dated signature on the Client Plan is required.
- If the client (or legal representative) is unavailable or refuses to sign the Client Plan, the Plan must include the provider’s dated/initialed explanation of why the signature could not be obtained, or refer to a specific Progress Note that explains why. In either case, include evidence on the Plan or in Progress Notes of follow-up efforts to obtain the signature.
- If the provider believes that including the client in treatment planning would be clinically contraindicated, the Plan must include the provider’s dated/initialed explanation or refer to a specific Progress Note that explains why, and the reason must be supported by the clinical record’s documentation.
- It is best practice to indicate above the client/legal representative’s signature that they participated in, and agree with, the Client Plan.
- **A copy of the Client Plan** must be offered to the client (or legal representative). This must be indicated in the Medical Record (Client Plan or Progress Note for the Client Plan) and is best practice to have a statement whereby the client acknowledges this, on the Plan above the client’s signature. ^(DHCScontract)
- **The client must participate in the creation of, and agree with, the Client Plan.** This must be indicated in the Medical Record (Client Plan or Progress Note for the Client Plan) and is best practice to have a statement whereby the client acknowledges this, on the Plan above the client’s signature. ^(DHCScontract)

5. Progress Notes

Definition: Progress Notes are the evidence of a provider's services to or on behalf of a client and relate to the client's progress in treatment. Notes are filed in the clinical record and must contain the clinical details to support the medical necessity of each claimed service and its relevance to the Client Plan. ^(BHCS1)

In order to submit a service for reimbursement, there must be a complete and filed Progress Note for that service. Reimbursement submission is attestation that these criteria are met:

- Progress Notes must clearly relate to the mental health objectives & goals of the client as established in the Client Plan (versus, for example, a Progress Note that focuses on the mental health needs of a depressed mother in a family session, without addressing how her depression impacts the client/child's mental health needs). ^(CCR23)

❖ **Progress Notes vs. Psychotherapy/Process Notes** ^(CFR3)

Progress Notes, as noted generally above, relate to the client's progress in treatment and include only the information required by the MHP (described later in this Progress Note section). Progress Notes become part of the clinical record, which may be requested by the client at any time.

Alameda County BHCS expects that all providers will understand the content difference between Progress Notes and Psychotherapy Notes (also known as Process Notes) and the differences in privacy protection as described below. If a provider chooses to write Psychotherapy Notes, they should maintain them in a separate file to protect the privacy of those notes.

Psychotherapy Notes (aka Process Notes) are defined by HIPAA CFR 45, Part 164.501 as: "...notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." ^(CFR4)

Examples of Psychotherapy Notes (aka Process Notes) are a description of dream content, specific memories of child abuse, a clinician's thought process about the client's issues, a clinician's personal feelings or counter-transference, etc.

Psychotherapy Notes (aka Process Notes) differ from regular clinical records and receive special protection under HIPAA (CFR 45, Part 164.524) from other clinical records which may be exchanged between providers and the MHP without specific permission from the client. Physically integrating the excluded information and protected information into one document does not make the excluded information protected. ^(CFR5)

Psychotherapy Notes (aka Process Notes) that are not filed separately from the clinical record, or that contain excluded information, no longer receive special protection under HIPAA. Those notes are subject to review by the MHP and would be seen by the client if he/she so requested. Psychotherapy Notes that are maintained separately and do not contain excluded information would only be disclosed via legal action or with the client's release.

❖ **Timeliness & Frequency of Progress Notes**

Timeliness

Applies to All Providers

It is best practice that Progress Notes be entered in to the clinical record within one (1) business day of the date of service (DOS). Approval by the supervisor and clinician finalization of the Progress Note must be completed within five (5) working days or the PN is considered "late". If an entry is late, the beginning of the Progress Note must clearly identify the note as a late entry for the Date of Service (DOS) with "Late Entry for XX/XX/XXXX" at the beginning of the Progress Note. **All Signatures must include the date the note was written whether the note was written on the same date of service or on a later date.** The note must be filed chronologically in the clinical record per the date it was written, not per the date of service.

❖ **Minimum Requirements for Progress Note Contents**

Progress notes are documentation of services provided to or on behalf of clients. Services may or may not include direct contact with clients. *Not all providers are contracted to provide all of the services described in this section.* (BHCS1)

➤ **Minimum requirements for Progress Notes:**

- a. **Date of service** (00/00/00) and date of signature (whether same day or not). (DHCScontract)
- b. **Service Modality by code and/or specific ACBHCS label of the specific code** (e.g. assessment, plan development, individual psychotherapy, case management linkage brokerage, group psychotherapy, family psychotherapy, etc.). must be indicated in the PN. (DHCScontract)
- c. **Location** of the service provided. (BHCS1)
MHP Network providers: Location is required only if location is other than office. (Service is expected to be office-based; approval from Authorization Services is required for other locations.)
- d. **Time** spent providing a *billable* service. Varies per provider type, as below: (CCR26)
 - MHP Network providers: The time spent to provide a service determines which code is selected for claiming (e.g., Individual Psychotherapy for 30 minutes requires a different service code than for 60 minutes). This type of contract allows for the inclusion of the "community standard" of 10 minutes for documentation with a 50 minute session. This type of contract does not provide for reimbursement of travel time.
- e. **Documentation of specific services/interventions:** Succinct description of clinically relevant information. (BHCS1) (DHCScontract)
In general, the P/BIRP format (Problem/Behavior, Intervention, Response, Plan) meets this standard:
 - When a service includes client contact, minimum requirements are description of the following, as applicable:

- Reason for the contact.
- Assessment of client's current clinical presentation.
- Relevant history.
- Specific mental health/clinical interventions by provider, per type of service and scope of practice.
- Client's response to interventions.
- Unresolved issues from previous contacts.
- Plans, next steps, and/or clinical decisions. If little or no progress toward goals/objectives is being made, describe why. Include date of next planned contact and/or next clinician action. Indicate referrals made. Address any issues of risk.
- When a service does not include client contact, minimum requirements are description of:
 - Problem or need for the service.
 - Specific interventions by provider, per type of service and scope of practice.
 - Response from collateral contacts.
 - Unresolved issues from previous contacts, if applicable.
 - Address any issues of risk.
 - Plans, next steps, and/or clinical decisions. Include date of next planned contact, clinician actions and referrals made, if applicable.
- **f. Signature:** The person who provided the service must write and sign all notes; and obtain a Licensed LPHA co-signature, if required (see **Staff Qualifications for Service Delivery and Documentation** in this Policy). (See also "Clinical Documentation Standards" section, "Signature Requirements.") (DHCScontract)

❖ **Special Situations: Progress Note Documentation Requirements** (BHCS1) [Other citations noted at specific lines]

Group Services: A note must be written for each client participating or represented in a therapy or rehabilitation group if the service is claimed to ACHBCS. These notes must include the minimum requirements above, as well as: (CCR25)

- Summary of the group's behavioral health goals/purpose.
- Primary focus on the client's specific group interaction & involvement, as relevant to their Client Plan.
 - The total number of clients served (regardless of insurance plan/status).
 - Total service time: The addition of group time to the time it takes to write progress notes for all clients served (regardless of insurance plan/status).

Crisis (Psychotherapy) Services: Crisis services may be necessary when a client is in a mental health crisis requiring more intensive services to prevent the necessity of a higher level of care. This means the client is at eminent risk of hospitalization due to danger to self, danger to other, or grave disability. Providers must document the need for such services in the clinical record.

- MHP Network providers may provide services in excess of the current authorization when warranted. These providers must Authorization Services for authorization of the amended treatment plan for an estimated period of crisis. Each service provided during the period of crisis must be documented as crisis

services. MCO's may self-authorize with documentation of the crisis need in the chart.

- Progress Notes for crisis services must include the minimum requirements already described, as well as:
 - Relevant clinical details leading to the crisis
 - The identified crisis must be the client's crisis, not a significant support person's crisis. (CCR24)
 - The urgency & immediacy of the situation must be clearly documented and describe each of the following medical necessity requirements: (CCR06) (CCR10) (CCR15)
 - How the crisis is related to a mental health condition
 - ***How the client is imminently or currently a danger to self or to others or is gravely disabled***
 - Why the client either requires psychiatric inpatient hospitalization or psychiatric health facility services or that without timely intervention, why the client is highly likely to develop an immediate emergency psychiatric condition.
 - Interventions done to decrease or eliminate or alleviate danger, reduce trauma and/or ameliorate the crisis.
 - The aftercare safety plan.
 - Collateral and community contacts that will participate in follow-up. (CCR06) (CCR10) (CCR15)
 - Interventions done to decrease, eliminate, alleviate danger, reduce trauma, and/or ameliorate the crisis.
 - The aftercare safety plan.
 - Collateral and community contacts that will participate in follow-up. (CCR06) (CCR10) (CCR15)

Documenting Missed Appointments: It is not permissible to submit a claim or charge clients for missed appointments; however, the missed appointment should be noted in the clinical record. The MHP suggests that providers follow up in a timely manner with clients when appointments are missed and document the findings. (DMH05) (BHCS1)

Documenting Lockout Situations: When a mental health service is provided to a client in a lockout situation (when Medi-Cal is suspended or when a client is in a facility that provides "bundled" mental health services) the service may not be claimed, a Progress Note for that service should still be written and noted to be "non-billable" so that the clinical record documents all services provided. (CCR22) (CCR28) (DMH01)

Note: If a minor client is residing in Juvenile Hall, services are not billable to Medi-Cal **unless** the client has been adjudicated (client is only awaiting placement in a group home or other non-institutional setting). Due to risk of disallowance, evidence of a placement order must be obtained and filed in the clinical record prior to providing services. A copy of the court ordered placement or another document indicating the date of adjudication will serve as proof. If that proof is not available prior to providing necessary services, the clinician may use a Progress Note to document a client's adjudication status as reported by a reliable source that is identified in the Note. "Best practice" is to make ongoing efforts to obtain paper evidence of adjudication. (BHCS1)

For more information, see the Lock-out Grid on the Provider Website:
http://www.acbhcs.org/providers/QA/docs/2013/TR_Lockout_Situations_Grid.pdf

Documenting the Creation of Clinical Documents: When claiming for the time spent writing clinical documents, a Progress Note must be written to substantiate the claim. Examples of such documents are: Assessment, Client Plan, a clinical summary to Social Services/court that is required for treatment purposes, psychological testing report, etc. A copy of the dated clinical document must be filed in the record as evidence of the activity. Progress Notes for these claimed activities must briefly describe the purpose/mental health relevance of creating the clinical document, the time it took to complete, and reference where the copy is located in the clinical record.

6. Discharge / Termination / Transition Documentation.

Definitions: Discharge documentation describes the termination and/or transition of services. It provides closure for a service episode and referrals, as appropriate. There are two (2) types of clinical discharge documentation – one (1) of the following must be completed: (BHCS1)

- Discharge Note: A brief Progress Note to indicate that the case is closed, per the Minimum Requirements below. (This is considered an administrative activity and is not billable to Medi-Cal, *unless it is part of a final billable service with the client present.*)
- Discharge Summary: A comprehensive document that is **clinically necessary** in order to provide continuity of care for the next service provider, per the Minimum Requirements below. The MHP considers this to be a billable Plan Development service, unless provided as part of the last psychotherapy face-to-face visit with the client. (BHCS1)

Timeliness of Discharge Summary & Discharge Note

Cases/episodes must be closed within 90 days (3 months) after the client's last service, unless the rationale for maintaining an open case is written in the clinical record. A quarterly written rationale must be provided if the case will be kept open during continued non-contact. (BHCS1) Discharge documentation must be entered into the clinical record within one (1) working day of the discharge decision, but prior to closing the episode, and must be clearly labeled as either "Discharge Summary" or "Discharge Note". (BHCS1)

❖ Minimum Requirements

Discharge Note: A Progress Note that includes brief documentation of the following: (DHCScontract) (BHCS1)

- Reason for discharge/transfer.
- Date of discharge/transfer.
- Referrals made, if applicable.
- Follow-up care plan.

This is considered an administrative activity and is not billable to Medi-Cal, *unless it is part of a final billable service with the client present.*)

Discharge Summary: A document that must meet the requirements of a Discharge Note **plus a summary of the following:** (BHCS1)

- Treatment provided.
- Overall efficacy of interventions (including – if prescribed - medications, their side effects/sensitivities and dosage schedules).
- Progress made toward the mental health goals/objectives.
- Clinical decisions/interventions:
- Treatment planning recommendations for future services relevant to the final Client Plan; and
- Referral(s) for aftercare services/community support services.

The MHP considers this a billable Plan Development service when **clinically necessary for continuity of care.**)

Citations

Citations for documentation standards and requirements are included with each subject heading, and for specific items, if warranted:

| | |
|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BHCS | Behavioral Health Care Services |
| BHCS1 | BHCS Requirement |
| BHCSQA | Behavioral Health Care Services, Quality Assurance can be found at http://www.acbhcs.org , in tab “Quality Assurance” |
| BP | Business and Professions Code can be found at http://www.leginfo.ca.gov |
| BP1 | BP, Section 4996.9, Section 4996.15, Section 4996.18(e) |
| CaIOHI | California Office of HIPAA Implementation can be found at http://www.ohi.ca.gov under California Implementation |
| CC | California Civil Code can be found at http://www.leginfo.ca.gov |
| CC1 | CC 56.10 |
| CC2 | CC 1798.48 |
| CCR | California Code of Regulations, Title 9 and Title 22 can be found at the DMH (Department of Mental Health) website http://www.dmh.ca.gov |
| CCR01 | CCR, Title 9, Chapter 3, Section 550 |
| CCR04 | CCR, Title 9, Chapter 11, Section 1810.204 |
| CCR05 | CCR, Title 9, Chapter 11, Section 1810.205.2 |
| CCR06 | CCR, Title 9, Chapter 11, Section 1810.216 |
| CCR10 | CCR, Title 9, Chapter 11, Section 1810.253 |
| CCR11 | CCR, Title 9, Chapter 11, Section 1810.254 |
| CCR12 | CCR, Title 9, Chapter 11, Section 1810.440 |
| CCR13 | CCR, Title 9, Chapter 11, Section 1810.440(c)(1) |
| CCR14 | CCR, Title 9, Chapter 11, Section 1810.440(c)(2) |
| CCR15 | CCR, Title 9, Chapter 11, Section 1820.205 |
| CCR16 | CCR, Title 9, Chapter 11, Section 1830.205 |
| CCR17 | CCR, Title 9, Chapter 11, Section 1830.205(b)(1) |
| CCR18 | CCR, Title 9, Chapter 11, Section 1830.205(b)(2) |
| CCR19 | CCR, Title 9, Chapter 11, Section 1830.205(b)(3) |
| CCR20 | CCR, Title 9, Chapter 11, Section 1830.210 |
| CCR21 | CCR, Title 9, Chapter 11, Section 1830.215 |
| CCR22 | CCR, Title 9, Chapter 11, Section 1840.312 |
| CCR23 | CCR, Title 9, Chapter 11, Section 1840.314 |
| CCR24 | CCR, Title 9, Chapter 11, Section 1840.314(b) |
| CCR25 | CCR, Title 9, Chapter 11, Section 1840.314(c) |
| CCR26 | CCR, Title 9, Chapter 11, Section 1840.316 |
| CCR28 | CCR, Title 9, Chapter 11, Section 1840.360 - 374 |
| CCR29 | CCR, Title 22, Chapter 2, Section 71551(c) |
| CCR30 | CCR, Title 22, Chapter 7.2, Section 75343 |
| CCR31 | CCR, Title 22, Chapter 9, Section 77143 |
| CFR | Code of Federal Regulations can be found at http://www.gpoaccess.gov/cfr |
| CFR1 | CFR, Title 45, Parts 160 and 164 (HIPAA) |
| CFR2 | CFR, Title 45, Parts 160, 162 and 164 (HIPAA) |
| CFR3 | CFR, Title 45, Part 164 |
| CFR4 | CFR, Title 45, Part 164.501 |
| CFR5 | CFR, Title 45, Part 164.524 |

Policy Title: CLINICAL RECORD DOCUMENTATION STANDARDS – MENTAL HEALTH

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|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DMH | Department of Mental Health Information Notices & Letters can be found at http://www.dmh.ca.gov |
| DMH01 | DMH Information Notice No. 02-06, page 3 |
| DMH02 | DMH Information Notice No. 06-07DMH05DMH Letter No. 02-07 |
| DMH06 | DMH Letter No. 08-10 |
| DHCScontract | Department of Mental Health Contract with the Mental Health Plan; the boilerplate contract with DMH can be found at http://www.dmh.ca.gov |
| HS | Health and Safety Code can be found at http://www.leginfo.ca.gov |
| HS1 | H&S, 123105, 123145 and 123149 |
| HS2 | H&S, 123105(b) and 123149 |
| HS3 | H&S, 123145 |