CQRT TRAIN THE TRAINER
HANDOUTS
UPDATED 10/16/12

Clinical Quality Review Team (CQRT)

A Guide to the Authorization Process for Alameda County Behavioral Health Plan Members

CQRT Purpose

Providers are expected to attend a CQRT sponsored by the County in the first year of operation. And, then develop an internal process of chart review.

- The purpose of the CQRT is to review medical necessity, service necessity, quality review, and authorization.
- The BHCS CQRT committees meet a minimum of one time per month representing the Adult Outpatient, Children's Outpatient, Day Treatment and Outpatient EPSDT Expansion Programs in their first year of operation.
- Day Treatment Authorization is ongoing.

Learning Objectives

- Understand the purpose of the CQRT and its function in improving compliance with documentation standards.
- Understand the distinction between the Clinical & Quality Review.
- Understand the expectations of how to prepare and participate in Alameda County BHCS CQRT meetings.

Learning Objectives

- Understand the forms and paperwork necessary to participate in Alameda County BHCS CQRT meetings.
- Understand the Clinical Review Cycles of charts and how they guide clinical practices.
- Be able to facilitate and/or improve ongoing internal Clinical Quality Review Teams.

BHCS CQRT Process

Does not eliminate audit risk but assists the provider in reducing risk of audit disallowances.

- Is not a substitute for a provider's internal Quality Assurance (QA) process.
- The DHCS has the ultimate authority regarding Medi-Cal audits.

The Clinical Quality Review Teams will:

- Review the chart to ensure that adequate treatment and discharge planning are documented
- Approve the continuation of services

CQRT Members are:

- BHCS CQRT Chairpersons are licensed clinicians
- CQRT trained agency supervisors or their designees who provide their staff with direction regarding Quality Assurance requirements and issues/concerns identified by the CQRT
- Licensed clinicians, waivered psychologist candidates, or registered interns, Licensed Practitioners of the Healing Arts (LPHA)

The BHCS CQRT Meeting

- Representatives are apart of a team and review other's charts.
- Participants will be reviewing charts from other agencies.
- Agency representatives are to receive training and orientation to the CQRT procedures by their agency staff **Prior** to their actual participation in the CQRT meeting

Schedule for Treatment Chart Review

- Charts are reviewed based on the date of the case episode opening. The review cycle begins on the first of the month in which the episode was opened.
- Outpatient and Rehabilitative Day Treatment charts are reviewed every six months.
- Day Treatment Intensive charts are reviewed every three months.
- The review cycles will always remain the same!
- MHS Report 485 notifies providers that the UC Authorization is expiring and due for a reauthorization

Timeline Examples for Outpatient and Rehabilitative Day Treatment

Month Episode is **Opened**	**Period for Review**	Bring to the Chart to the CQRT **during** the month	With a revised or new TX plan to start **beginning**	And not signed **before** this date
January	Jan 1-June 30 July 1-Dec 31	June December	7/1 1/1	6/1 12/1
February	Feb 1-July 31 Aug 1-January 31	July January	8/1 2/1	7/1 1/1
March	Mar 1- Aug 31 Sept 1-Feb 28	August February	9/1 3/1	8/1 2/1

Chart Review Cycle Exercise

- What is the Episode Opening Date?
- What is the Review Cycle & Dates?
- When is the Assessment due?
- When is the Client Plan due?
- When is the Chart due in the CQRT?

Guide to Chart Content for CQRT

Charts must contain all of the elements required by Medi-Cal Documentation Guidelines.

Clinical Review

- The Clinical Review ensures that ongoing Medical & Service Necessity has been documented.
- Is there a Treatment Plan, included diagnosis, and corresponding Progress Notes?
- Is there evidence that progress is being made toward the goals/objectives and is the client is benefitting from treatment?
- Is there an appropriate discharge plan or tentative discharge plan?
- Are the required dated signatures, Community Function Evaluations, and Informing Materials present?

Quality Review

The Quality Review is more comprehensive:

- The chart is reviewed using the Regulatory Compliance checklist on the back of the CQRT Review Request Form
- It includes a Clinical Review
- There must be a continuity between the Assessment & Primary Diagnosis, the Treatment plan, and the treatment documented in the Progress notes

CQRT

Fifteen percent (15%) of all charts presented at CQRT meetings will be randomly chosen for Quality Review.

Deficient charts

In the BHCS CQRT, charts with deficiencies are given a month's authorization and must be corrected prior to return.

- Medical Necessity has not been established
- Service Necessity has not been established
  - Intervention Criteria
  - Impairment Criteria
- Client Plan Missing
- Progress Notes are found to be out of compliance.

Meeting Schedules

- BHCS CQRT meetings are organized by the type of provider or primary treatment mode.
- Meeting assignment is determined by the BHCS.
- Schedules are posted on the BHCS website at www.acbhcs.org

Final CQRT Advice

- Train and familiarize your staff with the CQRT process.
- Develop a written agency QA Policy & Procedure Manual.
- Supervisors reviewing charts and returning to staff for correction prior to reviews will reduce deficiencies and the need for time consuming 30 day returns.
- Reach out to other providers and develop a inter-agency CQRT process.

Questions and Answers

Questions

Post Training Questions?

QA Contact Information

For questions, limit 1 contact person per provider to maintain consistency of information at your agency.

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Alameda County Behavioral Health Services

CQRT Manual

Presented by the Quality Assurance Office

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Updated 5/23/2012

CQRT Overview

The Clinical Quality Review Team (CQRT) is a group that meets regularly to review clinical records for documented evidence of medical necessity for outpatient specialty mental health services (SMHS) that are provided to Alameda County beneficiaries of the Medi-Cal Mental Health Plan (MHP).[1] The purpose of these reviews is to provide payment authorization for ongoing SMHS and to ensure that clinical documentation standards are met. This Manual describes the BHCS-operated CQRT process.

Per DMH Information Notice 02-06, contracted organizations that provide the following services are required to obtain payment authorization through the BHCS-CQRT:

- Day treatment services
- Outpatient SMHS delivered concurrently to day treatment (supplemental authorization)
- Therapeutic Behavioral Services (TBS)

In addition, newly contracted organizational providers, providers with corrective action plans, or providers with additional contractual obligations are required to attend a BHCS-CQRT meeting for a period of time designated by the MHP.

Although BHCS authorization is not required for other providers of outpatient SMHS, those providers will perform an internal review process to assure they maintain compliance to any and all contractual requirements. A licensed, waivered, or registered LPHA will continue to approve Treatment/Client Plans, but will not submit them for BHCS authorization. Those providers are encouraged to model their internal review process after the review requirements in this Manual. Providers should maintain documentation of their internal review process.

Starting CQRT

New Programs

Organizational providers with previous CQRT experience in Alameda County do not participate in CQRT; if they develop new programs, they are incorporated into the provider's internal CQRT. It is the expectation that the existing, organizational provider has sufficient experience to train their new staff. The exception is when that CBO is adding a program with different/new documentation requirements with which they are unfamiliar, e.g., Day Treatment Intensive/Rehab or TBS.

New Programs that are not part of an existing, contracted organizational provider and that are not bringing beneficiaries from another program (slow start) will begin attending CQRT at 3 months. At that time they will:

- Review treatment plans and progress notes, etc., and will do complete, quality chart reviews for 3 months.
- At 6 months they begin attending the New Program CQRT with standard participation, bringing their own charts for 12 months.

Existing programs changing from Fee-for-Service to contracted CBO:

- At 3 months, QA will do an in-house CQRT where the provider reviews their own charts with QA staff present for 1 full day.
- At 6 months, they will attend the New Program CQRT with charts due each month for 12 months.

Please refer to the BHCS Quality Assurance Manual for a complete description of clinical record documentation standards. The BHCS-QA website (www.acbhcs.org/providers under the QA tab) is very informative and has documents, policies and manuals available to download.

Supporting regulations for requirements in this Manual are cited in the Appendix.

If you have questions that are not addressed in this Manual or at the BHCS-QA website, please first consult with your clinical supervisor or your organization's quality assurance staff. If your organization does not have someone responsible for quality assurance, please consider appointing one or two staff to receive and disseminate QA information so that it stays internally consistent and so that you are able to filter BHCS requirements through your own program's priorities & needs – in other words, you are able to create & enforce requirements that are more strict than BHCS's, but that may better suit your unique needs.

If questions remain unanswered, a provider's Quality Assurance staff or clinical supervisor may contact the BHCS Quality Assurance Office at (510) 567-8105.

Section I: How to Get Specialty Mental Health Services Reviewed for Reimbursement

Initial Review & Approval

The initial period of approval for reimbursement of services begins with the opening of a client's episode in the PSP system (see InSyst Manual) by data entry staff. That staff then enters an initial period of service authorization for either 30 or 60 days, 3 or 6 months, depending on the type of provider program (see below).

A program's clinical staff must complete the Initial Assessment within 30 days of a client's episode opening date (EOD; aka admission date).

Exceptions:

- Full Service Partnership (FSP) programs & BHCS-identified "Brief Service Programs" must complete the Initial Assessment within 60 days of a client's EOD.
- Time-limited programs under 3 months in duration (45 -89 days) must complete and sign the Assessment within 7 days from the Episode Opening Date.
- Time-limited Programs 3 -6 months in duration (90 - 179 days) must complete the sign the Assessment within 14 days of the Episode Opening Date.

The completed Initial Assessment determines whether there is medical necessity for ongoing services. If there is no medical necessity, the client's episode is closed. If medical necessity is documented and services will be provided, the client's episode remains open.

On 11/1/10, Alameda County BHCS instituted a 60-day deadline for the Initial Client/Treatment Plan, counted from the EOD. Providers receive an InSyst prompt for this deadline date, and prompts every 6 months thereafter, to create Initial and ongoing Client Plans. (Prior to 11/1/10, the Initial Client Plan deadline was 30 days from the EOD.)

Exceptions:

- Time-limited programs under 3 months in duration must complete and sign the Client/Treatment Plan within 14 days of the Episode Opening Date.
- Time limited programs 3-6 months in duration must complete and sign the Client/Treatment Plan within 30 days of the Episode Opening Date.

The length of the initial approval period depends on the type of provider program; charts are then reviewed for approval via the CQRT as follows:

- Outpatient Mental Health Services: Initial approval is done by the provider program for the first 6 months & every 6 months thereafter.
- Adult Day Treatment—Rehabilitative & Intensive:
  - *Programs more than 6 Months in Duration:* Initial approval is requested no later than 30 days from the episode opening date. The authorization will cover 6 months from the first day of the month that the episode was opened, e.g., start date 8/8/11; fax by 9/7/11; authorized 8/1/11 to 1/31/12.

- *Time-limited Programs 3 -6 Months in Duration:* Initial approval is requested no later than the 3rd full treatment day from the episode opening date. The authorization will cover 60 days from the first day of the month that the episode was opened. (e.g., start date 5/10/12; fax by 5/14/12 (this takes into consideration the weekend/non-treatment days; authorized 5/1/12 to 6/30/12)
- *Time-limited Programs under 3 Months in Duration (45 – 89 days):* Initial authorization is requested no later than the 3rd full treatment day from the episode opening date. The initial authorization will cover 30 days from the episode opening date, e.g., treatment start date 5/10/12; fax CQRT/Authorization Form before 5/14/12; authorized 5/10/12 to 6/8/12. The CQRT/re-authorization at 30 days will authorize for 30 days. (e.g., fax before 6/8/12; authorized from 6/9/12 to 7/8/12)

- *Children's Rehabilitative Day Treatment: CQRT provides initial approval at the first CQRT meeting after the expiration of the 60-day treatment plan approval date, then 6 months from the first day of the month that the episode was opened & every 6 months thereafter.*
- *Children's Intensive Day Treatment: Initial Placement Authorization of the first 3 months by BHCS Children's Specialized Service*s is required (see BHCS provider's website for more information); approval is required every 3 months thereafter. **Note:** Although these charts are reviewed every 3 months, Client/Treatment Plans are completed every 6 months.
- Full Service Partnerships: Authorization by the Crisis Response Program is required prior to a client's enrollment in the program. Thereafter, follow the process for your program type listed above.

This Manual will generally refer to 6-month approval periods to simplify the material; Intensive and Rehabilitative Day Treatment programs should keep in mind their respective time frames.

Chart Review Cycle

As just noted, the months in which a specific chart must be reviewed depends on 1) The type of provider program and 2) the month of the client's episode opening date (EOD). This timing of chart review is referred to as the chart's "CQRT Review Cycle." It is **essential** to understand how to determine review cycles for proper authorization of ongoing services. Use the calendar below while reading the following examples of chart cycles below.

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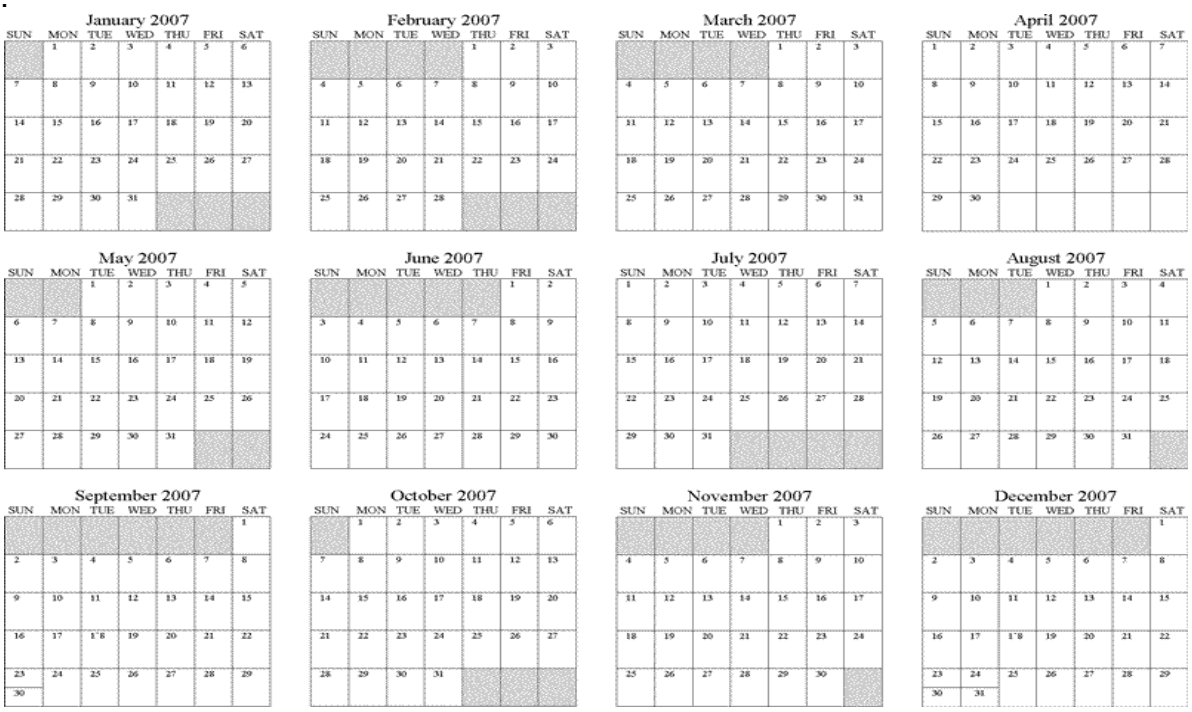


Example: Outpatient and Rehab Day Treatment (not time-limited) chart review cycle (every 6 months)
Episode Opening Date = February 17, 2007
First "review cycle" starts February 1 and goes through July 31 (the end of the 6th month).
This chart's first CQRT review is done in July & every 6 months thereafter (July, January, July, etc.), to allow for authorization starting on the 1st of the following months.
This chart's CQRT review cycle will <u>always</u> be January/July for authorization starting February 1 and August 1.

Example: Children <u>Intensive</u> Day Treatment chart review cycle (every 3 months)
Episode Opening Date = February 17, 2007
First "review cycle" starts February 1 and goes through the end of the 3rd month (April 30). This chart's first CQRT review (by BHCS) is in April & every 3 months thereafter (July, October, January, April, July, etc.), to allow for authorization starting on the 1st of the following months.
This chart's CQRT review cycle will <u>always</u> be January/April/July/October for authorization starting February 1; May 1; August 1; October 1

Example: Day Treatment Rehab Time-limited 3-6 months (every 2 months)
Episode Opening Date = February 19, 2007
Initial Authorization requested no later than February 21, 2007.
First "review cycle" starts February 1 and goes through the end of the 2rd month (March 31). The chart is to be reviewed by ACBHCS every 2 months.

Example: Day Treatment Rehab Time-limited under 3 months (every month)
Episode Opening Date = February 19, 2007
Initial Authorization requested no later than the 3rd full treatment day, February 22, 2007.
First "review cycle" starts February 19th and goes to March 20th. The chart is to be reviewed by ACBHCS every month.

As shown in the examples, charts must be reviewed by the CQRT in the month before the next review cycle begins, so that services for the following period can be authorized. If a chart is brought to the CQRT or sent to Authorization Services later than its scheduled review, there is a risk of not getting authorization for the interim services.

- **Exception:** Time-limited programs may have review cycles set specifically to those programs.

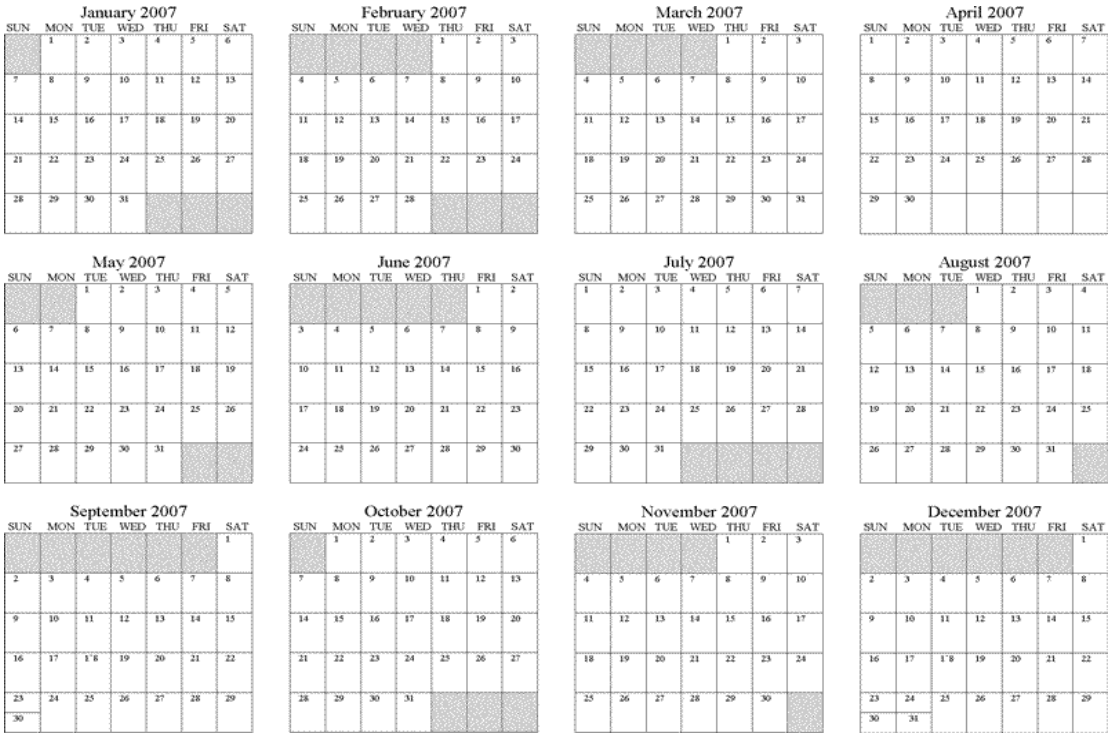
The review cycle for each chart always stays the same based on the EOD, regardless of the approval period. This is very important in order to ensure timely authorization of services and to ensure that InSyst prompts are correct. Therefore, the cycle stays the same even if a chart is given a 1-month authorization because of documentation deficiencies. If a chart is closed and then re-opened, the review cycle and the timing of treatment plans will change to follow the new episode opening date.

The review cycle is always calculated using the first day of the month in which the episode was opened, regardless of the actual start date – and it always stays the same for that chart.

(Exception: Time-limited programs may have review cycles set specifically to those programs.)

Client/Treatment Plan Cycles

The timing of when Client/Treatment Plans are done must be relative to the CQRT review cycle. This is because the CQRT must have a recently completed Client Plan in order to determine ongoing medical necessity. Again, it is helpful to view a calendar while reading an example.



Example: An Outpatient client's EOD is 10/29/07. The Initial Assessment is completed prior to 11/29/07. The Initial Client/Treatment Plan is completed by 12/27/07.

(BHCS changed to a 60-day deadline for the Initial Client Plan on Nov. 1, 2010; this example is based on that change but refers to the 2007 calendar as a sample). (Exception: *Day Treatment Intensive/Rehabilitative Programs with less than 3 months duration.* Assessments for these programs have a 7 day deadline and Client/Treatment Plans have a 14 day deadline, e.g. EOD is 10/25/07. The Initial Assessment is completed by 10/31/07. The Initial Client/Treatment Plan is completed by 11/7/07.)

The next Client Plan is the 6-month revision or a Client Plan Update. Though the Initial Client Plan is done in November or December, the Client Plan Update is completed 6 months from the episode opening **month** (October, in this example), **not** 6 months after the Initial Client Plan. Therefore, in this example, the Client Plan Update is completed just prior to 3/29/08.

The following Plan will be a new Annual Client Plan, done 6 months later in September, and every year thereafter just prior to the anniversary of the client's EOD month. Here is the Client Plan sequence: Initial Client Plan, Client Plan Update, Annual Client Plan, Client Plan Update, etc.

As the example on Page 5 notes, you must use the episode opening date (for the Initial Plan) and month (for all other Plans) to determine each Client plan's timing, so that future Plans will be completed in the month of the CQRT meeting. This is because it must be reviewed by the CQRT before the next approval period begins, therefore it must be in the chart and already approved by a licensed, waivered, or registered LPHA[2] when brought to the CQRT meeting.

- If episodes are closed and then re-opened, the Client Plan cycles must coordinate with the new EOD.
- If existing providers change their contract status with BHCS, client EOD's are re-set by the County. In this situation, a new Client Plan cycle must be initiated to coordinate with the new EOD.

Date of Client Plan Signatures

Client Plans are written and finalized "just prior to" a date determined by the client's EOD. The LPHA (licensed, waivered, or registered) signature date is what determines whether a Client Plan was finalized on time. A Client Plan may be developed and written prior to its due date, but the Plan's information must be up-to-date at its due date.

- If a Plan is amended after signatures are obtained, the signatures are invalidated and must be obtained again.

(See the next section for more information about Client Plan signatures; also see QA Manual, Documentation Standards for complete requirements at www.acbhcs.org/providers, under the QA tab.)

Client Plan Addendums

A Client Plan Addendum must be written whenever there is a significant change in services provided, treatment focus, diagnosis, objectives, etc. and can be just a sentence or two added to an existing Plan. Regardless of when an Addendum is done, an Annual Client Plan and Update must still be done according to that chart's CQRT review cycle.

> **Example**: An Outpatient Services chart with a January/July review cycle needs an addendum to the Client Plan in June due to a significant change in the primary focus of treatment. Even though the addendum is done in June, a Client Plan Update will still need to be done in July in order to stay on cycle.

The next page shows an example of one outpatient chart's CQRT review cycle, along with its Client Plan cycle, to demonstrate how the EOD affects both processes. Pages 8 and 9 show annual timetables by month of episode opening for different program types.

Outpatient Example of a CQRT Review Cycle & its Client Plan Cycle

Client's episode opening date:	August 29
Initial Review by Program Initial Client Plan completed within 60 days of the episode opening date, or by:	October 27
First 6-month authorization period:	***August 1 – January 31***

1st CQRT Review Client Plan Update completed in	January
CQRT review done in	January
For service authorization of the 2nd period	***February 1 – July 31***

This particular chart's CQRT review cycle will always be:
July: for August 1 - Jan. 31 approval
January: for Feb. 1 - July 31 approval

2nd CQRT Review New Annual Client Plan completed in	July
CQRT review done in	July
For service authorization of the 3rd period	***August 1 – January 31***

Outpatient & Rehabilitative Day Treatment (not for Time-Limited Programs):

CQRT Review/Client Plan Cycles

(Not including the Initial Client Plan)

EPISODE OPENING MONTH	AUTHORIZATION PERIODS	CQRT REVIEW MONTHS	CLIENT PLAN CREATED & SIGNED IN:	CLIENT PLAN CREATED FOR:
January	Jan. 1 - June 30 July 1 - Dec. 31	June December	June Dec.	July 1st January 1st
February	Feb. 1 - July 31 Aug.1 - Jan. 31	July January	July Jan.	August 1st February 1st
March	Mar. 1 - Aug. 31 Sept. 1 - Feb. 28	August February	Aug. Feb.	Sept. 1st March 1st
April	April 1 - Sept. 30 Oct. 1 - Mar. 31	September March	Sept. March	October 1st April 1st
May	May 1 - Oct. 31 Nov. 1 -Apr. 30	October April	Oct. April	Nov. 1st May 1st
June	June 1- Nov. 30 Dec. 1- May 31	November May	Nov. May	Dec. 1st June 1st
July	July 1 - Dec. 31 Jan. 1 - June 30	December June	Dec. June	January 1st July 1st
August	Aug. 1 - Jan. 31 Feb. 1 - July 31	January July	Jan. July	February 1st August 1st
September	Sept. 1 - Feb.28 Mar. 1 - Aug.31	February August	Feb. Aug.	March 1st Sept. 1st
October	Oct. 1 - Mar. 31 Apr. 1 - Sept. 30	March September	March Sept.	April 1st October 1st
November	Nov. 1 - Apr. 30 May 1 - Oct. 31	April October	April Oct.	May 1st Nov. 1st
December	Dec. 1 - May 31 June 1 - Nov. 30	May November	May Nov.	June 1st Dec. 1st

Intensive Day Treatment: CQRT Review/Client Plan Cycles

(Not including the Initial Client Plan and Not for Time-Limited Programs)

EPISODE OPENING MONTH	AUTHORIZATION PERIODS	CQRT REVIEW CYCLE	CLIENT PLAN CREATED & SIGNED IN:	CLIENT PLAN CREATED FOR:
January	Jan. 1 – March 31 April 1 - June 30 July 1 – Sept. 30 Oct. 1 - Dec 31	March June September December	June December	July 1st January 1st
February	Feb. 1 – April 30 May 1 – July 31 Aug. 1 – Oct. 31 Nov. 1 – Jan. 31	April July October January	July January	August 1st February 1st
March	March 1 – May 31 June 1 – Aug. 31 Sept. 1 – Nov. 30 Dec. 1 – Feb 28/29	May August November February	August February	September 1st March 1st
April	April 1 – June 30 July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31	June September December March	September March	October 1st April 1st
May	May 1 – July 31 Aug. 1 – Oct. 31 Nov. 1 – Jan. 31 Feb. 1 - April 30	July October January April	October April	November 1st May 1st
June	June 1 – Aug. 31 Sept. 1 - Nov. 30 Dec. 1 – Feb 28/29 March 1 – May 31	August November February May	November May	December 1st June 1st
July	July 1 - Sept. 30 Oct. 1 – Dec. 31 Jan. 1 - March 31 April 1 – June 30	September December March June	December June	January 1st July 1st
August	Aug. 1 - Oct. 31 Nov. 1 - Jan. 31 Feb. 1 - April 30 May 1 - July 31	October January April July	January July	February 1st August 1st
September	Sept. 1 - Nov. 30 Dec. 1 - Feb 28/29 March 1 - May 31 June 1 - Aug. 31	November February May August	February August	March 1st September 1st
October	Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30 July 1 – Sept. 30	December March June September	March September	April 1st October 1st
November	Nov. 1 – Jan. 31 Feb. 1 – April 30 May 1 – July 31 Aug. 1 – Oct. 31	January April July October	April October	May 1st November 1st
December	Dec. 1 – Feb 28/29 March 1 – May 31 June 1 – Aug. 31 Sept. 1 – Nov. 30	February May August November	May November	June 1st December 1st

Section 2: Chart Documentation & Preparing for the CQRT

The following is a list of items that should be easily located in any chart brought to the CQRT; it follows the Quality Review checklist located on the reverse side of the CQRT Review Form (see Appendix for both Children's & Adult versions; also available www.acbhcs.org/providers under the QA tab). The list is intended to assist clinicians to create and maintain a well-documented chart that meets the criteria for approval of ongoing services. This is a simplified guide to chart contents; all staff should refer to their program's policies and procedures for complete chart requirements and the BHCS QA Manual, Section 8 Policy on Documentation Standards (see above website).

- Contracted providers may modify BHCS document/form templates (see website), however it is the provider's responsibility to ensure that their forms contain, at a minimum, the elements listed in the Documentation Standards.
- County-operated programs must use the BHCS templates for all documents.

Evaluations & Consents:

All charts must contain the following forms for CQRT review, with all required signatures:

- Initial Assessment[3] (completed within 30 days of episode opening date)
- Annual Community Functioning Evaluation* (at admission & annually thereafter)
- Informing Materials Packet's signature page (at admission & annually thereafter). This was distributed by BHCS to all providers in 2010 and addresses all required informing materials published by BHCS (see website).
- Consents for Release of Information, if applicable
- Medication Consents, if applicable

For clients under age 18, the chart must contain a comprehensive developmental history (including pre/perinatal), with an emphasis on social, emotional, psychological & cognitive development, and an assessment of the child's resiliency. The developmental history does not need to be located on the Assessment form; if that history is unavailable to the clinician, indicate this and the plan to obtain it, if possible. Also indicate factors that impair normal development, for example, trauma, illness or environmental/family stressors.

Client Plans:

All charts must contain Client/Treatment Plans[4] that are based on the program's Assessment. The LPHA (licensed, waivered, registered) signature date determines whether the Plan was finalized per that chart's cycle, as identified in the previous Section. If a client receives services from multiple programs within one provider agency, please see Section 4 of this manual for more information regarding Client Plans.

Initial/Annual Client Plan: Only selected plan elements are described below, as most are self-explanatory on the current BHCS template of this form. (Please check the www.acbhcs.org/providers site regularly for updated versions).

- DSM (current edition) Diagnosis[5]: A complete 5-axes diagnosis must be provided and substantiated by chart documentation. List each diagnosis separately and indicate the

primary diagnosis being treated. Indicate the name and credential of the clinician who determined the diagnoses and the date the diagnoses were established. In order to be covered by the MHP, the primary diagnosis must be an included diagnosis per the Specialty Mental Health Medical Necessity Guidelines (see Appendix; also www.acbhcs.org/providers, under the QA tab).

- Impairment Criteria and Service Necessity[6]: Document the signs and symptoms to support Axis I and Axis II diagnoses for treatment, as described by the DSM (current edition). The description must support impairment criteria -- how each identified impairment is a result of the primary diagnosis AND how the client's clinical presentation meets at least one of the following criteria:
  - Significant impairment in important area(s) of life functioning, or
  - Probability of significant deterioration in important area(s) of life functioning; or
  - Probability that a child will not progress developmentally as individually appropriate **AND** that the mental disorder can be corrected or ameliorated.

  The documentation should also support service necessity by describing the client's level of current risk/stability/impairment in order to justify the type, frequency, and duration of the services currently being provided.

  If a client is not making progress or has regressed in functioning, an explanation should be provided and treatment objectives should reflect interventions to address the identified issues.

  If a client is stable but there is still risk of impairment, provide an explanation of the type and potential severity of the risk(s).

- Client Risk Assessment: Identify areas of risk associated with the client (i.e., danger to self/others, health, etc.) and what interventions are planned to reduce those risks, or reference the specific Client Plan objectives that address them. Data in this section should be consistent with descriptions of current areas of risk documented elsewhere in the clinical record. If there are no identified risks, note "N/A" to indicate that risk situations were assessed.

- Client Strengths & Resources: Describe these and, if applicable, how they are utilized in treatment to help achieve treatment objectives. This section should be updated annually.

- Special Needs: A client's cultural/linguistic and special visual/hearing needs should be identified and addressed in both the Initial Assessment and all Client Plans, including information provided and accommodations offered to address these needs. If there are no identified special needs, note "N/A" to indicate that an assessment was done.

- Medication Support Services: This section should contain complete information and be updated annually or whenever there is a change in psychotropic medications or service provision. Clients who **only** receive treatment from the program's psychiatrist must

have a "Medication Visit Only Treatment Plan" (template at www.acbhcs.org/providers), instead of the usual Client Plan, to be completed at the same prescribed intervals.

- Intervention Criteria: List the professional disciplines of program staff who provide services, the frequency of those services and the specific treatment modality, if applicable. For example, "Psychiatrist provides medication support 1x/month" or "Registered MSW provides individual therapy 1x/week".

  If a client receives services from more than one program, indicate which program staff provides each service (and document any collaborative efforts in progress notes). Service duplication will be *carefully* reviewed. See also Section 3 of this Manual about multiple providers.

  If a client receives Therapeutic Behavioral Services (TBS), collaboration with the mental health provider of TBS must be indicated in each Client Plan as an Intervention, e.g., "Clinician will collaborate with TBS provider weekly". Details of the collaboration will also be documented in the Progress Notes.

- Tentative Discharge Plan: Provide a month/year by which the client is expected to terminate services at your program. Indicate the clinical aftercare plan & referrals anticipated, given the expected improvements in functioning by that time.

- Client Goals: This section should reflect ongoing discussions with clients regarding their own goals, in their own words. It is expected that this section could change and impact the Client Plan objectives.

- Objectives[7]: These must be client-focused, measurable or observable, with timeframes, and must relate to the signs, symptoms and impairments that support the primary diagnosis for treatment. Specific interventions designed to help meet objectives should be included. Situational objectives (i.e., reunification, academic performance or job searches) should be framed from a clinical perspective related to the client's symptoms/impairments. There may be objectives that are not clinical in nature, such as court-ordered activities, but the majority must be objectives relating directly to symptoms and impairments that are the focus of treatment. It is considered "best practice" to include the current baseline for each objective, as this provides easy identification of progress or the lack thereof, which may warrant modification of the Client Plan.

For example: "Area of Need: Client runs from the classroom when unable to tolerate increased anxiety. Objective: Within 6 months, Client will ask teacher for permission to take 2-minute break from classroom in 3/5 instances of escalating anxiety; currently does so in 1/5 instances."

In this example, one intervention may involve helping the client identify early indicators of anxiety.

- Participation & Agreement with the Client Plan[8]: Demonstrated by the client and/or parent/guardian signatures on the Client Plan. If these signatures are not present, provide an explanation and describe the plan to obtain them (a notation of "unavailable" is not sufficient). Reference to a dated progress note which provides the explanation is acceptable. Please note that, because the Client Plan is not a legal document, the parent/guardian's signature is only required if the client is unable to represent themselves. A minor client who is able to understand the concept of ownership (e.g., they know their "x" on a ball means the ball is theirs) is expected to sign the Client Plan regardless of their age.

- Clinician Signatures[9]: Required signatures include the treating clinician who wrote the Client Plan, the provider agency's psychiatrist if medications are prescribed by that person, co-signature by a licensed, waivered, or registered LPHA. If the clinician who wrote the Plan is licensed, a co-signature is not required. If the psychiatrist's signature is provided, an additional LPHA signature is not required.

Client Plan Update: Done in the 6th month from the episode opening date and summarizes the client's clinical status, progress toward meeting objectives, new objectives, and updates to any other Plan element. The BHCS template includes a section at the end for the Update (same signature rules apply).

Client Plan Addendum: A Client Plan Addendum must be written whenever there is a significant change in services provided, treatment focus, diagnosis, objectives, etc. and can be just a sentence or two added to an existing Plan. It may be a handwritten signed/dated paragraph added to a current Plan.

- If simply adding updated information about a client's status, only the person writing the Addendum must sign.
- If making a change in the services provided, treatment focus, or Client Plan objectives, the client and other clinicians must re-sign. (Such a change invalidates previous signatures.)

Regardless of when an Addendum is done, an Annual Client Plan and Update must still be done according to that chart's CQRT review cycle.

Progress Notes

Each progress note[10] should indicate what has been done to assist the client toward the objectives identified in their Client Plan and should indicate ongoing medical & service necessity. Progress notes should be succinct, describe the clinically relevant service provided and how it relates to the objectives. There must be a progress note in the chart for each billable service. (Please see samples of acceptable and disallowed progress notes in the Appendix.)

A progress note should include, at minimum, the client's presenting problem or current status, interventions made by staff and the client's responses, clinical decisions, new assessment information, and the follow-up care (i.e., continue to address issue in ongoing sessions, collateral with residence staff, linkage to socialization group, etc.). A legible, dated signature must also be present, along with procedure code, diagnosis, location and amount of service time (face-to-face and total time). (Go to www.acbhcs.org/providers for progress note templates; QA Manual Policy on Documentation Standards, and the Mini-Insyst Manual.)

Listed below are the specific requirements for progress notes by program type:

- Outpatient Mental Health Services: All notes must indicate procedure, diagnosis, location, date, and amount of time; and must include the treating clinician's signature, title, and the date. Group service notes must include the total count of ALL clients served (whether Medi-Cal or not); service time is the addition of group time plus the documentation time for ALL clients in the group (whether Medi-Cal or not).

  Rehabilitative Day Treatment/Residential: Weekly Summary, including each day of service must be signed by the writer.
- Intensive Day Treatment/Crisis Residential: Daily Progress Notes must be signed and dated by the writer (LVN/RN, PT, MHRS, or a licensed, waivered or registered LPHA). Weekly Summary must be signed by the writer with co-sign/date by a licensed, waivered or registered LPHA.

Medication Progress Notes: Written by the program's psychiatrist and, at minimum, addresses medical necessity for services, signs and symptoms, efficacy/compliance/ adverse effects of prescribed psychotropic medications, lab results and planned interventions. A legible, dated signature must also be present, along with the procedure code, diagnosis, location, amount of face-to-face time, and total time. More information regarding documentation requirements are located in the "BHCS Psychotropic Medication Practice Guidelines", available from the BHCS Office of the Medical Director and in the BHCS Documentation Standards, located on the Provider Website. (www.acbhcs.org/providers)

While the treating psychiatrist determines the frequency of medication support visits, the "Guidelines" call for face-to-face visits at a minimum of 3-month intervals.

Legibility & Signatures[11]: All writing must be legible and in ink. Signatures must include professional disciplines and, where noted, be dated. If licensed, a staff person must sign with their license designation.

Forms Required for the CQRT Meeting

CQRT Request Form: Each chart brought to the CQRT must include a form called the CQRT Request Form. There are adult and children's versions of this form (see website).

CQRT Minutes: The program representative also brings a list of the charts brought for review, called the CQRT Minutes – this must be filled out PRIOR to the CQRT meeting.

(Both forms are on the BHCS provider website, and in the Appendix of this Manual.)

The CQRT Request Form is an official request for approval to authorize reimbursement for ongoing services. Approval decisions and CQRT feedback to programs will be noted on this form. Do not complete any information below the Clinical Supervisor's signature line; that area is reserved for the CQRT reviewer and Chairpersons. ***The form must be a double-sided document and must not contain any markings or hole-punches that obliterate information.***

The treating clinician usually completes this form and signs with their title or credentials on their signature line. The LPHA Clinical Supervisor signs on their signature line, with LPHA credential and date, ***after*** reviewing the chart and CQRT Request Form to ensure that all CQRT documentation standards are met. If the treating clinician is licensed, he/she signs both lines.

If the Supervisor checks "Yes" in the Recommended Approval box, he/she is certifying that the chart has been reviewed & found to be in compliance. If the "No" box is checked, the chart has been found to be out of compliance and may receive a provisional 1-month return by the CQRT Chair. However, it is expected that charts and forms would be returned to the clinician for correction prior to the CQRT meeting.

Most elements on the CQRT Request Form are self-explanatory, therefore only certain elements are described below:

1-Month Provisional Return: Check this box if the chart had been given a provisional 1-month authorization and is being returned for re-review. In this case, also attach the previous CQRT Request Form which notes the needed corrections. (Otherwise, CQRT Request Forms should be kept in the program's administrative file.)

Admission Date and Next Cycle: The admission date is usually the same as the episode opening date.

- If an existing provider changes their BHCS contract status, client episode opening dates are re-set to a date determined by the County. In these cases, please use the new EOD but note the original admission date as well.

"Next Cycle" indicates the period of time being requested for approval. Typically, the dates will be from the 1st of the following month to the end of the 3- or 6-month timeframe, per

program type (i.e., from 3/1/07 to 8/31/07). Remember that the approval period always stays the same for each chart, based on the episode opening month.

Program Type/Services: Indicate your program type and check all services being requested for approval.

Tentative Discharge Date & Aftercare Plan: Provide a month/year by which the client is expected to terminate services at your program. Indicate the clinical aftercare plan & referrals anticipated, given expected improvements in functioning by that time.

SECTION 3: THE CQRT PROCESS

CQRT Function & Staffing Requirements

The CQRT is comprised of one of the following:

- BHCS administrative staff and qualified representatives of providers required to either attend a BHCS-operated CQRT or submit CQRT reviews to BHCS; or
- Qualified staff of contracted providers performing an internal review of their clinical records; or
- Qualified staff of several contracted provider programs that have agreed to review each others' clinical records (all participating providers must be contracted with Alameda County in order to preserve the privacy protection afforded to business partners of the County …or per HIPAA regulations?)

Clinical records that meet documentation standards will receive a provisional authorization for the next period of mental health services. A chart with documentation deficiencies may be given a provisional 1-month authorization in which to address deficiencies and be re-reviewed the next month. All authorizations are considered "provisional" depending on such factors as a client's ongoing eligibility for services or a program's compliance with their contract.

The CQRT procedure is a required review of client charts. For providers identified on page 1, the CQRT procedure is required in order to receive ongoing authorization of Medi-Cal services. The review focus is on chart documentation that supports medical & service necessity for ongoing treatment with that provider. The CQRT procedure is in accordance with the California Department of Mental Health and the MHP policies and standards, and with policies established by the BHCS QA Office.

There are several BHCS CQRT meetings which meet a minimum of one time per month. The meetings are organized by type of program, primary treatment mode and/or populations served. Programs are assigned to their CQRT meeting by the MHP. If you are uncertain which meeting your program should attend, please contact the BHCS QA Office.

The CQRT consists of Chairpersons (BHCS supervisors/staff) and qualified representatives appointed by programs to bring their charts for review. Representatives must be trained in the CQRT procedures by their program **prior** to participation. Programs are strongly encouraged to designate a consistent person(s) to regularly attend the CQRT and report findings to the program. Reviewers do not review their own program's charts.

Once at the meeting, a representative has two roles – to address questions raised about their program's charts by other reviewer, and to act as reviewers of other program charts. Reviewers may identify documentation issues, make recommendations for corrective action and give positive feedback. The CQRT Chairs provide final approval for ongoing services.

Criteria for CQRT Agency Representatives:

- Must be program supervisors/or their designees, trained in the CQRT process, authorized to represent/provide feedback to their program.
- Must be licensed, waivered, or registered LPHA's (Licensed Practitioner of the Healing Arts) staff (see the Glossary of Terms in this Manual).
- **Must know their County staff identification number**.
- Must be prepared to stay until ALL charts have been reviewed.
- Must provide 1 qualified representative for every 10 charts brought (i.e., 11-20 charts = 2 reps.; 21-30 charts = 3 reps.). Any exception to this ratio requires advance approval from the CQRT Chairperson.

The CQRT Meeting

In order for the BHCS CQRT meetings to operate efficiently, please follow these guidelines:

- Arrive at least 5 minutes before the start time. Representatives who bring charts more than 15 minutes late will not have charts reviewed at that meeting. They will need to contact the QA Office to arrange chart review by a different CQRT meeting that month, if possible. If not possible, the representative's tardiness may result in costly unauthorized services.

- Bring the required CQRT forms already completed: 1) CQRT Request Form for each chart; 2) the CQRT Minutes (list of charts for review).

- Sign the Attendance Sheet and place program charts in the designated area.

- Show the CQRT Minutes to the Chairpersons who keep a total count of charts to be reviewed. The Minutes also serve as a log of approval decisions per chart and must be completed during the meeting by the representatives.

Fifteen percent (15%) of the total number of charts receive an in-depth review, called a Quality Review. This Quality Review uses the reverse side of the CQRT Request Form which lists questions regarding basic chart documentation standards. All Quality Review charts should be reviewed first. The other 85% of charts receive a limited review, called a Clinical Review, which focuses on substantiating medical necessity and confirming the information on the front of the CQRT Request Form. Both the Clinical and Quality Reviews are explained in more detail below.

If a chart is being returned with corrections after a provisional 1-month authorization, it is reviewed only for those corrections. If the correction has been made but a new issue is noticed, that issue is only noted by the reviewer on the CQRT Request Form; full authorization is provided by the Chairperson.

HIPAA Note: All client-related material is confidential and must be handled appropriately per HIPAA guidelines. Please give any waste papers with identifying client data to the Chairs for shredding.

Chart Reviews: Clinical Review

The Clinical Review is a general review to establish medical and service necessity criteria. Reviewers first read the CQRT Request Form for basic substantiation of those criteria and to orient themselves to the client's treatment.

Reviewers also evaluate the following documentation:

- Discharge Plan noted on the CQRT Request Form & reasons for continued treatment and ensures that the required signatures are on the Form.
- Client/Treatment Plan and Progress Notes for further substantiation of the criteria and timeliness of completion (per that chart's cycle). An emphasis is placed on the relationship between the Plan's goals/objectives and Progress Note documentation. Progress Notes must describe current symptoms/behaviors that reflect the primary diagnoses for treatment as well as relate to specific objectives.
- Overall client progress toward Client Plan objectives in consideration of the type and level of services provided.

Reviewers doing a Clinical Review sign the CQRT Request Form on the "CQRT Reviewer" signature line (below the program's Clinical Supervisor's signature line).

Chart Reviews: Quality Review

A Quality Review is a more comprehensive review of the chart. In addition to the elements of a Clinical Review described above, reviewers utilize the back of the CQRT Request Form (the Regulatory Compliance Checklist) to review the chart for all Checklist items, including proof of client notification of informing materials.

Reviewers doing a Quality Review sign the CQRT Request Form in the "Quality Review" signature box located in the bottom right corner of the form. They must provide their County designated staff number. A record is kept of all charts which received a Quality Review.

Chart Reviews: General Procedures

Each CQRT meeting may differ slightly in the way charts are reviewed, depending on the group and Chairperson. However, the following is a general guideline:

As clinical and/or quality issues are identified, it is suggested that they be noted on a separate sheet while the review continues. When the review is completed consult with that chart's program representative. Very often, representatives can answer questions and find documents or information that resolves the issue. If the representative cannot help, then bring the chart to the Chair for consultation.

Complete the CQRT Request Form after reviewing each chart:

- Sign the form in the appropriate section;
- Indicate the status of documentation standards by checking the "Yes" or "Needs Discussion" box;
- Check one or more of the appropriate boxes in the Rationale for Continuation of Services section; and
- Provide comments to the program in the Committee Comments section. Note any positive aspects of the chart, state concerns or deficiencies and give constructive feedback. Committee comments should always indicate the specific chart deficiency if a 1-month authorization is recommended.
- Do not complete the back of the CQRT Request Form unless you are doing a Quality Review.

The Chairs review the Committee Comments section and give **Provisional Authorizations** for the requested timeframes if medical and service necessity criteria are met. (Remember, authorizations are always considered "provisional".)

The Chairs complete the lower left authorization/signature box. The authorization **Start Date** entered by the Chairperson will be the beginning of the next approval period (or the date of that CQRT meeting, if the chart was submitted out of its review cycle: *Chairpersons may only backdate an approval with the permission of the QA Office).* The authorization **End Date** will be the end of that chart's approval cycle, unless a 1-month authorization is given.

Copies of the completed forms are made for the program representatives to take back for their program's files. Original forms are maintained in QA Office files. The Chair also maintains a list of charts receiving a provisional 1-month authorization with the main reason for return indicated. Programs receive feedback via the QA Office if a significant number of charts in a 6-month period are given a 1-month authorization.

Section 4: Special Situations

Multiple Providers & Multiple Reporting Units

Multiple Provider Agencies Serving One Client

The MHP accepts that in some situations, a client may receive services by more than one program because their needs cannot be met by one provider. Some examples may include:

- A client receiving monthly medication support services provided by a psychiatric clinic while also receiving weekly individual or family treatment from an outpatient services provider.
- A client in an Intensive Day Treatment program while also receiving wraparound case management services as a result of out-of-home placement.

It is the MHP policy that duplication of mental health services is to be avoided. If multiple service providers are treating a client, the mental health charts at each provider site must document evidence of treatment collaboration, clear explanations of which provider is providing which service, and demonstrate that medical and service necessity for all services are met.

If other Alameda County agencies (i.e. Child & Family Services or Probation) are involved in the development of treatment goals for the client, this should be clearly documented in the chart as it impacts the mental health treatment. If you have any questions regarding this policy, please contact the Child & Youth Services Director, Alameda County Behavioral Health Care Services.

Multiple Reporting Units of One Provider

At times, clients receive services from multiple Reporting Units (RU's) of a single provider program; this does impact the CQRT and Client Plan cycles. The options below may be used by providers, depending on the specific circumstances.

When the services are started simultaneously, or within the same month of admission, a provider agency has two options regarding Client Plans:

1. Multiple Client Plans – one for each program's RU; or
2. Single Client Plan -- completed by the RU program with the earliest episode opening & which includes treatment objectives for each additional RU.

   If a single Client Plan is used by more than one RU and the service that established the Initial Client Plan is discontinued, the remaining program RU's must complete a Client Plan to cover the current approval period. As above, the provider has the following options:

i) Complete a single Revised Client Plan, noting the change in services; or
ii) Change to multiple Revised Client Plans – one for each remaining program RU, noting the change in services and charting.

When the different RU services are <u>not</u> opened in the same month:
Providers must receive approval to authorize services based on the episode opening dates of **each** RU – therefore, each RU program will have its own CQRT Review and Client Plan cycles.

Some provider agencies create a separate client chart for each program RU, with copies of documents required to be in each chart (identifying which chart contains the originals). Other providers create a single, combined chart with clearly identified sections for each program RU so that CQRT reviewers can easily locate the documentation to be reviewed in any given cycle.

Sample Progress Notes

Four most common reasons for disallowed progress notes:

- **Missing notes**
- **Does not address mental health condition**
- **Note is solely clerical**
- **No client contact/participation**

(Acceptable) Collateral 7/20/06 311 Phone 25 mins. 30 (total)
Returned call to caregiver. Talked to mother regarding a recent incident at the school for which client was suspended. She is very concerned about his behavior and the impact on the younger children in the home. Discussed safety issues in the home and reminded her of interventions practiced in sessions to help de-escalate client's aggressive behavior. Plan: Will meet at our regular time next week.
-Juan Perez, MFT

(Disallowed – No client contact) Collateral 7/20/06 311 Phone 25 mins. 30 (total)
Returned call to caregiver who had left urgent message to contact her regarding client's behavior last night. Tried several times but phone was busy. Then caregiver's boyfriend answered phone; left message with him to let caregiver know writer had tried to call many times. Plan: Will await caregiver's return call.
-Juan Perez, MFT

(Acceptable) Assessment 6/15/06 331 Office 70 mins. 90 (total)
Met with client and caregiver for first appointment. Caregiver is monolingual Hmong speaking, writer is bi-lingual. Client is a 13-year-old Hmong male who was referred due to truancy and aggressive behavior at school. He is also failing several courses. Father is deceased. Client denies any gang affiliation but mother is still concerned about his peers. Explained how services will be provided, problem resolution, confidentiality, etc. Plan: Continue to assess and develop a plan with the client and mom.
-Mai Vang, MFT

(Acceptable) Individual Therapy 6/22/06 341 Office 50 mins. 65 (total)
Met with client for individual session. Discussed progress toward treatment goals. She is still concerned about her reactions in social settings but states that she is less depressed and anxious and may start taking a dance class after school. Client shared journal entries relating to abuse she suffered three years ago. Explored feelings and thoughts triggered by those memories. Role-played coping skills to contain anxiety about peer pressure at school. Encouraged client to continue practicing coping skills and praised her for continuing to use her feelings journal.
-Carmen Miranda, MFT

(Disallowed – Solely clerical) Individual Therapy 6/22/06 341 Office 20 mins. 65 (total)
Goal: client will increase sleeping from 2-3 hours a night to 6-8 hours. Impairment: symptoms of adjustment d/o with mixed anxiety and depressed reportedly interfere with client's functioning ability at home, school & community. Intervention: received t/c from client's mother regarding client's scheduled therapy session for today. Mother told writer she & client can't make it to appointment due to has another appointment for client's doctors to check his diabetes. Mother requested to reschedule. This writer was able to coordinate another time to meet w/ family.
-Carmen Miranda, MFT
(Acceptable) Group Therapy 8/13/06 351 Office Co-staff Jason Thomas, LCSW

(2 staff, 110 min. total, 10 clients)
This writer co-facilitated a mixed gender social skills group emphasizing peer relationships. Client participated in today's group activity which involved role playing with peers in various social situations. She stated that she enjoyed the activity and stated that it actually helped to alleviate some of her anxiety in dealing with social situations. Writer and the co-facilitator split the group into male and female and role played several examples within the groups and then brought them back together for discussion and more role playing.
-Jim Randolph, MFT

(Disallowed – Nothing about specific client) Group Therapy 8/13/06 351 Office Co-staff Jason Thomas, LCSW (2 staff, 110 min., 10 clients)
This writer co-facilitated a mixed gender social skills group emphasizing peer relationships. All clients participated in the group activity which involved role playing with peers in various social situations. They stated they enjoyed the activity and that it was especially helpful to alleviate anxiety – each member shared what type of social situation made them most anxious. The group was then split into males & females for discussion about traditional vs. current gender roles and where they believe they fit in. The whole group then met & shared the main points of the smaller group discussions.
-Jim Randolph, MFT

(Acceptable) Individual Rehabilitation 4/29/06 381 Field 45 mins. (f-t-f) 70 (Total)
Worked with client on hygiene skills which are impacted by his depression and social isolation behaviors. He has not taken a shower this week. Created a chart with him to help keep track of his ADLs and his feelings so that he can see how they impact one another. He was willing to do this activity. Client was talkative and maintained eye contact during the session. He responded well to praise and seemed hopeful at the end of the session. Plan: Monitor progress with chart at the next session.
-Cindy Lu, MHAII

(Disallowed – No mental health intervention) Individual Rehabilitation 4/29/06 381 Field 45 mins. 70 (total)
Writer picked up client and took her to her podiatrist's office where she had an appointment. The client told me about her previous day's activities and how stressed out she'd been. Writer went into the doctor's office with the client and waited for the doctor to examine her foot, then returned the client to her B&C. Plan: Monitor client's health needs in next sessions.
-Cindy Lu, MHAII

(Acceptable) Plan Development 3/3/07 581 Office 70 mins. 120 (total)
Met with client and caregiver to develop a treatment plan that will help the client reduce aggressive, acting out behaviors, which include self harm and cruelty to animals. Discussed goals and objectives with them. Received input from both of them. Developed a safety plan with crisis numbers and alternative behaviors to practice when client begins to be agitated. Plan: to provide individual and family therapy weekly.
-Miriam Smith, LCSW

(Disallowed – Doesn't address mental health condition) Plan Development 3/3/07 581 Office 70 mins.
This writer researched studies on the internet which have been done on babies who were born with methamphetamines in their systems. Found website on study which started in 1999 in Hawaii with mothers & babies in this situation. The grant was also given to UCLA & Brown. At this point, this writer left messages for researchers at UCLA & Brown to request a copy of the study to find out more

information about “evidence based practice” interventions being used. Plan: to provide this information to client in next session.
-Miriam Smith, LCSW

(Acceptable) Case Management 9/14/06 571 Phone 30 mins.
Spoke with CPS Social Worker regarding the foster parents concern with client’s increasingly violent behaviors and their inability to keep her in their home since they also have three other foster children. CPS worker will discuss options with the foster family at her next visit. Worker asked that this writer continue to meet with the client weekly to monitor behaviors. Will continue to provide case management with client and include caregivers as appropriate.
-Amar Sarat, MHRS

(Disallowed – Doesn’t address mental health condition) Case Management 9/14/06 571 Phone 30 mins.
Spoke with attorney representing client’s father. Attorney said he & opposing counsel had a “hearing with the judge” and that Dr. XXX is bringing her files with her to court hearing. Writer reminded attorney that nothing has changed since her letter to him dated 7/2/06. Writer reminded attorney that the records sought are confidential and privileged and that the clinic cannot legally or ethically release such records unless the client’s mother authorizes release of them or the clinic receives a court order. Attorney recommended writer contact mother’s attorney to further discuss the issue.
Plan: contact mother’s attorney.
-Amar Sarat, MHRS

(Acceptable) Crisis Intervention 12/17/06 371 Office 180 mins. 200 (total)
Mother phoned and client can be heard screaming profanity in the background. Mother is afraid for the safety of others in the home. Client is threatening bodily harm to mother and a younger sibling. Mother asked for help in dealing with this situation. Worker will go out to the home to intervene. Gave mom worker’s mobile phone number. Recommended calling the police immediately or taking client to MERT for an evaluation if she feels safe in transporting the client. Client refused to speak to this writer.
-Yoshiko Sumi, MFT

(Disallowed – No imminent psychiatric risk to client) Crisis Intervention 12/17/06 371 Office 60 mins. 70 (total)
Mother brought client into office for an emergency appointment because she did not know how to respond to the client’s request for information regarding her biological father. Mother was very distraught but the client was surprisingly calm and said “I was just asking a question; I don’t know why she’s so upset. I know my dad’s in jail and has done some bad things.” Worked with mother to calm down and recognize that it was her own feelings that had created the upset & that it would be a great topic to discuss in her own individual therapy. We then provided the information about her father to the client which was that he was born in Detroit and didn’t have any siblings.
Plan: f/u with mother in next session re. if she spoke about this in her own therapy.

Glossary of Terms

ACBHCS: Alameda County Behavioral Health Care Services.

Authorization: Approval action provided by County-designated staff that allows for a provider agency to bill for mental health services provided to eligible clients; provided in 1-, 3- or 6-month intervals.

CDMH: California Department of Mental Health.

Clinical Review: Brief review of client chart documentation. See pg. 19 of this manual.

CQRT: Clinical Quality Review Team; Committee that reviews provider agency's client charts for Medical & Service Necessity criteria and authorizes reimbursement for services provided.

CQRT Request Form: Official request for approval to request reimbursement of mental health services provided by a contracted provider program; cover sheet for each chart brought to the CQRT for review; reverse side contains Regulatory Compliance checklist for chart documentation. See completed sample/blank form in the Appendix of the manual; see also Pgs.15 & 20 for how to fill out this form.

CQRT Minutes: Form filled out by provider agency staff listing all client charts brought to the CQRT for review; form is completed with each chart's approval decision during the CQRT meeting. See completed sample/blank form in the Appendix of this manual; see also Pg.15.

Episode Opening Date (EOD): Date of the first billable service for a client; sets the CQRT Review & Treatment Plan Cycles.

FSP: Full Service Partnership programs funded by the Mental Health Services Act (MHSA).

HIPAA: Health Information Portability & Protection Act; Federal law regulating documentation practices to protect client confidentiality.

LPHA: Licensed Practitioner of the Healing Arts; licensed clinical staff (MD, PhD, MFT, LCSW) and staff who are registered with the California Board of Behavioral Sciences, usually registered MFT/ASW interns; psychologists who are waivered by the State to provide services; and Master's level clinical nurse specialists who have national or state licensed to practice independently. See the BHCS QA Manual, Sections 4 & 17 for more information.

MAA: Medi-Cal Administrative Activities which are recorded on the MAA form and do not include mental health services provided directly to program clients.

Medical Necessity: Chart documentation that establishes the necessity for mental health services provision given certain included diagnoses and supporting information. See the reverse side of the CQRT Review Form, as well as the "Medical Necessity for Specialty

Mental Health Services" found in Title 9, Chapter 11, Sect. 1830.205(b)(1)(A-R) available at the DMH website.

MHP: Mental Health Plan; the Medi-Cal insurance plan for mental health services.

MHSA: Mental Health Services Act.

Program Representative: Clinical Supervisor or designee of a provider program who brings client charts to the CQRT for review & acts as CQRT Reviewers at the meeting.

Program: An ACHBCS contracted provider of Specialty Mental Health Services.

QA Office: Quality Assurance Office of the ACBHCS.

Quality Review: Comprehensive review of client chart documentation; follows Regulatory Compliance checklist on reverse side of CQRT Request Form. See pg. 19 of this manual.

Review Cycles: Cycle of months in which a client's chart must be reviewed by the CQRT; based upon the month of the client's episode opening date; always stays the same regardless of approval timeframes. See Section 1 of this manual.

RU/Reporting Unit: County-assigned number for a provider's program(s); used for billing & charting purposes.

Service Necessity: Chart documentation that establishes the necessity for the level and quantity of mental health services being provided. See the reverse side of CQRT Request Form, as well as the "Medical Necessity for Specialty Mental Health Services" found in Title 9, Chapter 11, Sect. 1830.205(b)(1)(A-R) available at the DMH website.

Staff Number: County-assigned identification number for staff that provide services and chart documentation. Providers use a form to request staff numbers; it is posted on the BHCS provider website.

TBS: Therapeutic Behavioral Services; County-contracted individuals who provide supportive services to eligible mental health clients.

Client/Treatment Plan Cycle: Cycle of months in which a client's Client Plans must be completed; based upon the month of the client's episode opening date. See Section 1 of this manual.

Source Citations

(Materials are available on the Department of Mental Health website: www.dmh.ca.gov)

[1] California Code of Regulations (CCR), Title 9, Chapter 11 and Title 22, Section 51184.

[2] CCR, Title 9, Chapter 11, Section 1830.215 and Section J(4e) Non-Hospital Chart Review-EPSDT Reviews FY06-07.

[3] CCR, Title 9, Chapter 11, Section 1810.204; Section J Non-Hospital Chart Review-EPSDT.

[4] CCR, Title 9, Chapter 11, Section 1830.205(b), Section 1830.210(a); Section J Non-hospital Chart Review-EPSDT; DMH Letter No. 99-03, pages 6-7.

[5] DMH Letter 02-01.

[6] DMH Review Protocol, FY06-05, page 50, item 1c(5).

[7] DMH Letter 02-01.

[8] CCR, Title 9, Chapter 3, Section 532.4.

[9] DMH Review Protocol, FY 06-05, page 55, item 3e.

[10] Section I Non-Hospital Chart Review-EPSDT Reviews in FY06-07.

[11]CCR, Title 22, Chapter 7.2, Section 75343.

Steps to Completing ACBHCS Clinical/Quality Review Form

The purpose of the **Clinical Review** is to ensure that medical necessity is being met in an ongoing fashion. If there is no medical necessity, the client's episode is closed. The essential documents that must be in place are the Informing Materials Signature Page, an assessment, and a treatment plan. The purpose of the **Quality Review** is to assess a chart's compliance with Documentation Standards. This is accomplished via the Regulatory Compliance Tool. Use the tool to identify the items in the chart indicating whether the information is present (Yes), not present (No), or not applicable (NA). Compliance for adult charts is 90% and for children and youth charts 95%.

Clinical Review Items:

1) Fill in today's date
2) Fill in client's full name
3) Fill in client's PSP #
4) Fill in the Provider Name in which the client's episode is opened
5) Fill in the clinician completing the Clinical/Quality Review Form
6) Fill in the Admission Date. The admission date is identical to the date the client's episode was opened in INSYST
7) Fill in the Review Period (Consult with CQRT Manual)
8) Check the Mental Health Services that are being authorize
9) Check the Treatment Services that are being authorized
10) Check the Service Necessity
11) Write a sentence indicating anticipated discharge date and aftercare plan
12) List the 5-Axis Diagnosis from current DSM. Primary diagnosis must be an "included" diagnosis
13) Describe the outcomes as a result of treatment in measurable terms
14) Describe the proposed interventions that will be provided, the frequency , and length of treatment
15) The clinician is the person responsible for the client's treatment.
16) The clinical supervisor is the person responsible for the clinical oversight of the clinician.
17) The CQRT Reviewer is the LPHA completing the form[1]

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[1] **Criteria for CQRT Agency Representatives:**

- Must be program supervisors/or their designees, trained in the CQRT process, authorized to represent/provide feedback to their program.
- Must be licensed, waivered, or registered LPHA's (Licensed Practitioner of the Healing Arts) staff (see the Glossary of Terms in this Manual).
- **Must know their County staff identification number**.
- Must be prepared to stay until ALL charts have been reviewed.
- Must provide 1 qualified representative for every 10 charts brought (i.e., 11-20 charts = 2 reps.; 21-30 charts = 3 reps.). Any exception to this ratio requires advance approval from the CQRT Chairperson.

ALAMEDA COUNTY
Behavioral Health Care Services

ADULT MENTAL HEALTH SERVICES
CLINICAL/QUALITY REVIEW

Date: ____

Client Name:
Client PSP#:
Provider Name:
Reporting Unit:
Clinician:
Admission Date:
Review Period: *from* *to*

Request for (check all that apply):

Mental Health Services:
- ☐ Individual/Family Treatment/MHS
- ☐ Group Treatment/MHS
- ☐ Rehabilitation Services/MHS
- ☐ Case Management/Brokerage Services/MHS
- ☐ Medication Services/MHS

Day Treatment Services (check all that apply):

INTENSIVE: ☐ 5 Days/Week or Less ☐ Exceeds 5 Days/Week ☐ Initial ☐ 90 Days (3 months)

REHABILITATIVE: ☐ 5 Days/Week or less ☐ Exceeds 5 Days/Week ☐ Initial ☐ 180 Days (6 months) ☐ OTHER: ____

Service Necessity (current or within past six months):
- ☐ Psychiatric hospitalizations
- ☐ Suicidal/homicidal ideation or acts
- ☐ Psychotic symptoms
- ☐ Other: ____

Tentative Discharge Date and Aftercare Plan:

____

Medical Necessity- including 5-Axis covered diagnosis; support for primary diagnosis, impairments to functioning:

____

Outcomes Desired/Expected with Continued Services:

____

Interventions & timeframes:

____

Clinician _____ **Recommended Approval:** ☐ Yes ☐ No ☐ Needs Discussion
Signature/License

Clinical Supervisor: _____ **Recommended Approval:** ☐ Yes ☐ No ☐ Needs Discussion
Signature/License

CQRT Reviewer: _____ **Recommended Approval:** ☐ Yes ☐ No ☐ Needs Discussion
Signature/License

Rationale for Continuation of Services:
- ☐ At risk for psychiatric hospitalizations: ____
- ☐ Suicidal/homicidal ideation or acts: ____
- ☐ Severe or psychotic symptoms: ____
- ☐ Other: ____

Provisional Authorization (6 months): ☐ Yes ☐ No
Provisional Authorization (30-days): ☐ Yes ☐ No
☐ Attach the previous CQRT form on return.

COMMITTEE COMMENTS:

Start Date: | **End Date:**

Committee Chair: Signature | Staff #

Approval Date:

Quality Review: ☐ Approved ☐ Return to Supervisor

(See back page)

Reviewer: Signature

Review Date:

Regulatory Compliance

Chart ID: **Provider Name:**

Medical Necessity	Yes	No	N/A
1. 5-axis diagnosis from current DSM & primary diagnosis is "included."	☐	☐	☐
2. Documentation supports primary diagnosis(es) for tx.	☐	☐	☐
Impairment Criteria: ***Must have one of the following as a result of dx***			
3. Signif. impairment in important area of life functioning, or	☐	☐	☐
4. Probable significant deterioration in an important area of life functioning, or	☐	☐	☐
5. Probable the child won't progress developmentally, as appropriate, or	☐	☐	☐
6. If EPSDT: MH condition can be corrected or ameliorated.	☐	☐	☐

Intervention Criteria: Must have: 7 and 8, or 9, or 10			
7. Focus of proposed intervention: Address condition above, and	☐	☐	☐
8. Proposed intervention will diminish impairment/prevent signif. deterioration in important area of life functioning, and/or	☐	☐	☐
9. Allow child to progress developmentally as appropriate, or	☐	☐	☐
10. If EPSDT, condition can be corrected or ameliorated.	☐	☐	☐

Service Necessity: Must have both 11 and 12			
11. The mental health condition could not be treated by a lower level of care? (true = yes)	☐	☐	☐
12. The mental health condition would not be responsive to physical health care treatment? (true = yes)	☐	☐	☐

Informing Materials:			
13. Informing Materials sig. pg. signed annually (Tx Consent, Free.Choice, Conf/Priv., BenefProblemRes., HIPAA/HiTech, AdvDir.)	☐	☐	☐
14. Releases of information, when applicable.	☐	☐	☐
15. Informed Consent for Medication(s), when applicable.	☐	☐	☐

Special Needs:			
16. Client's cultural/comm. needs noted & addressed.	☐	☐	☐
17. Client's physical limitations are noted & addressed.	☐	☐	☐

Chart Maintenance			
18. Writing and signatures are legible.	☐	☐	☐
19. Admission date is noted.	☐	☐	☐
20. Clinical record kept in individual folder/chart with name.	☐	☐	☐
21. Client identification on each page in clinical record.	☐	☐	☐
22. Discharge/termination date noted, when applicable.	☐	☐	☐
23. Face Sheet info, esp. emergency contact info prominent.	☐	☐	☐

Med Order Sheet ("pink sheet")			
24. Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gardens, MD)	☐	☐	☐
25. Date	☐	☐	☐
26. Drug name	☐	☐	☐
27. Drug Strength/Size	☐	☐	☐
28. Instructions/ Frequency	☐	☐	☐
29. Signatures/Initials	☐	☐	☐

Assessment:	Yes	No	N/A
30. Initial Assessment done by 30 days of episode opening date. (FSP/Brief Service by 60 days; Level 3 by 4th visit.)	☐	☐	☐
31. Psychosocial history.	☐	☐	☐
32. Presenting problems & relevant conditions.	☐	☐	☐
33. Risk(s) to client and/or others assessed.	☐	☐	☐
34. Client strengths/supports.	☐	☐	☐
35. MHP MD Rx's: Doses, initial Rx dates.	☐	☐	☐
36. Allergies/adverse reactions/sensitivities or lack thereof a) noted in chart	☐	☐	☐
b) noted prominently on chart's cover.	☐	☐	☐
38. Relevant medical conditions/hx noted & updated.	☐	☐	☐
39. Mental health history.	☐	☐	☐
40. Relevant mental status exam (MSE).	☐	☐	☐
41. Past/present use: Tobacco, alcohol, caffeine, illicit/Rx/OTC drugs.	☐	☐	☐
42. Youth: Pre/perinatal events & complete dev. hx.	☐	☐	☐
43. Annual Community Functioning Evaluation (ACFE) (N/A for FSP/Brief Service Programs & Level 3)	☐	☐	☐

Client Plan:			
44. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit)	☐	☐	☐
45. Plan reviewed every 6 months from opening episode date. (N/A=FSP/Brief Svcs.) (Level 3 from first f-to-f)	☐	☐	☐
46. Client Plan revised/rewritten annually.	☐	☐	☐
47. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	☐	☐	☐
48. Client Plan is consistent with diagnosis.	☐	☐	☐
49. Goals/Objectives are observable or measureable with timeframes.	☐	☐	☐
50. Plan identifies proposed interventions & their frequency to address identified impairments.	☐	☐	☐
51. Updates client strengths, Dx & special needs, if applicable.	☐	☐	☐
52. Risk(s) to client/others have plan for containment.	☐	☐	☐
53. Plan signed/dated by LPHA (if licensed, use desig.).	☐	☐	☐
54. Plan signed/dated by MD, if provider prescribes MH Rx.	☐	☐	☐
55. Coordination of care is evident, when applicable.	☐	☐	☐
56. Plan signed/dated by client, or documentation of client refusal or unavailability.	☐	☐	☐
57. Plan signed/dated by legal rep., when appropriate.	☐	☐	☐
58. Plan indicates client was offered copy of Plan or client may obtain copy on request (may be in informing materials).	☐	☐	☐
59. Plan contains Tentative Discharge Plan	☐	☐	☐

Progress Notes:			
60. There is a progress note for every service contact.	☐	☐	☐
61. Correct service/code,	☐	☐	☐
62. Date of service	☐	☐	☐
63. Location	☐	☐	☐
64. Amount of time. *(Level 3 n/a - Location & Time)*	☐	☐	☐
65. Notes for client encounters include clinical decisions, interventions & client response.	☐	☐	☐
66. Group service notes include # clients served/on behalf.	☐	☐	☐
67. Services are related to Client Plan's goals/objectives.	☐	☐	☐
68. Notes provide follow-up date or plan to service.	☐	☐	☐
69. Unresolved issues from prior services addressed, if app.	☐	☐	☐
70. Signed/dated + title/degree/lic. (if lic., use designation).	☐	☐	☐
71. Completion line at signature (n/a for elec. notes).	☐	☐	☐

Reviewer:	Date:

CHILDREN'S MENTAL HEALTH SERVICES
CLINICAL/QUALITY REVIEW

Date:

☐ **Returned after 30-day provisional authorization. ***
* Please attach the previous CQRT form to this one.

Client Name:

Client PSP# :

Provider Name: **Program:**

Reporting Unit:

Clinician:

Admission Date:

Next Cycle:

From: **To:**

Class:

☐ Regular Education ☐ Independent Study
☐ Resource Specialist Program ☐ Special Day Class
☐ Counseling Enriched Special Day Class
☐ NPS Day Treatment
☐ School-Based Day Treatment

Handicapping Condition(s):

☐ Emotionally Disturbed
☐ Specific Learning Disability
☐ Learning Handicapped
☐ Other Handicapping condition: _____

AB3632: ☐ **Yes** ☐ **No**

Request for:

OUTPATIENT MENTAL HEALTH SERVICES (check all that apply)

☐ Individual/Family Treatment/Collateral
☐ Group Treatment
☐ Rehabilitation Services
☐ Case Management/Brokerage Services
☐ Medication Services

DAY TREATMENT SERVICES (check one)

☐ **INTENSIVE: 90 Days (3 months)**
☐ **REHABILITATIVE: 180 Days (6 months)**

Service Necessity (current or within past six months):

☐ Psychiatric hospitalizations.
☐ Suicidal/homicidal ideation or acts.
☐ Psychotic symptoms.
☐ At risk for out of home placement or change in placement.
☐ Severe school and social impairment due to mental disorder.
☐ OTHER:_____

Current Covered Diagnosis:

_____

Symptoms and Behaviors Supporting Current Diagnosis and Service Level:

_____

Current Level of Functioning and Response to Treatment Interventions:

_____

Tentative Discharge Date and Aftercare Plan:

_____

Clinician:	
Signature and Date	
Clinical Supervisor:	Recommended Approval: ☐ Yes ☐ Needs Discussion
Signature and Date	
CQRT Reviewer:	Recommended Approval: ☐ Yes ☐ Needs Discussion
Signature and Date	

Rationale for Continuation of Services:

☐ At risk for psychiatric hospitalizations.
☐ Suicidal/homicidal ideation or acts.
☐ Severe or psychotic symptoms.
☐ At risk for out of home placement or change in placement.
☐ Severe school and social impairment due to a mental disorder.
☐ Other (specify): _____

Committee Comments:

Provisional Authorization: ☐ Yes ☐ No	Quality Review: ☐ Approved ☐ Return to Supervisor *(See Back Page)*
Start Date: End Date:	
Committee Chair:	Reviewer:
Signature and Staff Number	Signature and Staff Number
Approval Date:	Review Date:

Childrens CQRT Form v.10-11.1

Regulatory Compliance

Chart ID: Provider Name:

Medical Necessity	Yes	No	N/A
1. 5-axis diagnosis from current DSM & primary diagnosis is "included."	☐	☐	☐
2. Documentation supports primary diagnosis(es) for tx.	☐	☐	☐
Impairment Criteria: *Must have one of the following as a result of dx*			
3. Signif. impairment in important area of life functioning, or	☐	☐	☐
4. Probable significant deterioration in an important area of life functioning, or	☐	☐	☐
5. Probable the child won't progress developmentally, as appropriate, or	☐	☐	☐
6. If EPSDT: MH condition can be corrected or ameliorated.	☐	☐	☐

Intervention Criteria: Must have: 7 and 8, or 9, or 10			
7. Focus of proposed intervention: Address condition above, and	☐	☐	☐
8. Proposed intervention will diminish impairment/prevent signif. deterioration in important area of life functioning, and/or	☐	☐	☐
9. Allow child to progress developmentally as appropriate, or	☐	☐	☐
10. If EPSDT, condition can be corrected or ameliorated.	☐	☐	☐

Service Necessity: Must have both 11 and 12			
11. The mental health condition could not be treated by a lower level of care? (true = yes)	☐	☐	☐
12. The mental health condition would not be responsive to physical health care treatment? (true = yes)	☐	☐	☐

Informing Materials:			
13. Informing Materials sig. pg. signed annually (Tx Consent, Free.Choice, Conf/Priv., BenefProblemRes., HIPAA/HiTech, AdvDir.)	☐	☐	☐
14. Releases of information, when applicable.	☐	☐	☐
15. Informed Consent for Medication(s), when applicable.	☐	☐	☐

Special Needs:			
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17. Client's physical limitations are noted & addressed.	☐	☐	☐

Chart Maintenance			
18. Writing and signatures are legible.	☐	☐	☐
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23. Face Sheet info, esp. emergency contact info prominent.	☐	☐	☐

Med Order Sheet ("pink sheet")			
24. Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gardens, MD)	☐	☐	☐
25. Date	☐	☐	☐
26. Drug name	☐	☐	☐
27. Drug Strength/Size	☐	☐	☐
28. Instructions/ Frequency	☐	☐	☐
29. Signatures/Initials	☐	☐	☐

Assessment:	Yes	No	N/A
30. Initial Assessment done by 30 days of episode opening date. (FSP/Brief Service by 60 days; Level 3 by 4th visit.)	☐	☐	☐
31. Psychosocial history.	☐	☐	☐
32. Presenting problems & relevant conditions.	☐	☐	☐
33. Risk(s) to client and/or others assessed.	☐	☐	☐
34. Client strengths/supports.	☐	☐	☐
35. MHP MD Rx's: Doses, initial Rx dates.	☐	☐	☐
36. Allergies/adverse reactions/sensitivities or lack thereof a) noted in chart	☐	☐	☐
b) noted prominently on chart's cover.	☐	☐	☐
38. Relevant medical conditions/hx noted & updated.	☐	☐	☐
39. Mental health history.	☐	☐	☐
40. Relevant mental status exam (MSE).	☐	☐	☐
41. Past/present use: Tobacco, alcohol, caffeine, illicit/Rx/OTC drugs.	☐	☐	☐
42. Youth: Pre/perinatal events & complete dev. hx.	☐	☐	☐
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47. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	☐	☐	☐
48. Client Plan is consistent with diagnosis.	☐	☐	☐
49. Goals/Objectives are observable or measureable with timeframes.	☐	☐	☐
50. Plan identifies proposed interventions & their frequency to address identified impairments.	☐	☐	☐
51. Updates client strengths, Dx & special needs, if applicable.	☐	☐	☐
52. Risk(s) to client/others have plan for containment.	☐	☐	☐
53. Plan signed/dated by LPHA (if licensed, use desig.).	☐	☐	☐
54. Plan signed/dated by MD, if provider prescribes MH Rx.	☐	☐	☐
55. Coordination of care is evident, when applicable.	☐	☐	☐
56. Plan signed/dated by client, or documentation of client refusal or unavailability.	☐	☐	☐
57. Plan signed/dated by legal rep., when appropriate.	☐	☐	☐
58. Plan indicates client was offered copy of Plan or client may obtain copy on request (may be in informing materials).	☐	☐	☐
59. Plan contains Tentative Discharge Plan	☐	☐	☐

Progress Notes:			
60. There is a progress note for every service contact.	☐	☐	☐
61. Correct service/code,	☐	☐	☐
62. Date of service	☐	☐	☐
63. Location	☐	☐	☐
64. Amount of time. *(Level 3 n/a - Location & Time)*	☐	☐	☐
65. Notes for client encounters include clinical decisions, interventions & client response.	☐	☐	☐
66. Group service notes include # clients served/on behalf.	☐	☐	☐
67. Services are related to Client Plan's goals/objectives.	☐	☐	☐
68. Notes provide follow-up date or plan to service.	☐	☐	☐
69. Unresolved issues from prior services addressed, if app.	☐	☐	☐
70. Signed/dated + title/degree/lic. (if lic., use designation).	☐	☐	☐
71. Completion line at signature (n/a for elec. notes).	☐	☐	☐

Reviewer:	Date:

CLINICAL RECORD DOCUMENTATION STANDARDS

This policy section defines the procedures and minimum standards for documentation of Medi-Cal/Medicare Specialty Mental Health Services at any site providing those services within Alameda County Behavioral Health Care Services and its Behavioral Health Plan's Provider Network.

CONTENTS

Mental Health Policy & Documentation Standards

POLICY STATEMENT: MENTAL HEALTH

All service providers within the Alameda County Mental Health Services system shall follow the Clinical Record Documentation Standards Policy. This includes providers employed by BHCS and all contracted providers. Service providers may develop additional policies in order to adapt these standards to their specific needs. If variance from this policy is needed, approval must be obtained from the Quality Assurance Administrator.

PROCEDURE

This Section of the Quality Assurance Manual contains information about basic required chart management, informing materials, and the minimum requirements for clinical documentation. Most requirements are for all types of providers, as indicated; differences and exceptions for certain types of providers are so noted.

TABLE OF CONTENTS *PAGE*

Definitions of Commonly Used Terms

***Specialty Mental Health Services*:** This is the broad umbrella of Medi-Cal services directed at the mental health needs of Medi-Cal beneficiaries. Speciality Mental Health Services include the smaller umbrella of Mental Health Services. (CCR09)

- ***Mental Health Services***: Assessment, Plan Development, Psychotherapy, Rehabilitation, and Collateral. (CCR08)
- Medication Support
- Case Management/Brokerage
- Psychiatrist & Psychologist Services
- EPSDT Supplemental Specialty Mental Health Services
- Day Treatment Intensive & Day Treatment Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment Services & Crisis Residential Treatment Services
- Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services (PHF), and Psychiatric Nursing Facility Services

(Mental Health Rehabilitation Centers [MHRC's] follow the documentation standards established in the California Code of Regulations, Title 9, Chapter 3.5, Section 786.15.) *(CCR02)*

This Policy addresses the documentation standards for all Specialty Mental Health Services except Psychiatric Inpatient, PHF and Nursing Facility Services.

***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-operated service providers of outpatient services (includes BHCS-identified Brief Service Programs, e.g., Crisis, Assessment Only)
- Organizational providers of outpatient services
- Full Service Partnerships (FSP's)

Level 3 Providers:

- Provider Network (office-based individual clinicians)
- Community Based Organizations with fee-for-service contracts

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 (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 Section of the 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" in this Section.

General Management of Clinical Records

(CFR2) *(CC1) (CC2) (HS1) (CalOHI1)* (*DMHcontract2*) (CCR23)

Applies to All Provider Contracts

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. (*BHCSQA09*)
- Records should be sequential and date ordered. (*BHCSQA09*)
- Records should be fastened together to avoid loss or being misplaced. No loose papers or sticky-sheets in the chart (may staple). (*BHCSQA09*)
- 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) *(DMHcontract3)*
- Use only ink (black or blue recommended). (*BHCSQA09*)
- Every page must have some form of client identification (name or identification number, etc.). (*BHCSQA09*)
- Do not use names of other clients in the record (may use initials or similar method of preserving other clients' identities). (*BHCSQA09*)
- Do not "rubber stamp" your record entries; tailor wording to the changing needs of each individual. (BHCSQA09)
- Correcting errors: Do not use correction tape/fluid, scribble over, etc. Instead, draw a single line through the error & initial, then enter correct material. (*BHCSQA09*)
  - Only original authors may make alterations.
  - Reviewers or supervisors may not edit original authors but may supply an addendum with dated signature.
- Acronyms & Abbreviations: Use only universal and County-designated acronyms and abbreviations. A list is available at www.acbhcs.org/providers under the QA tab. (*BHCSQA09*)

Record Storage:

Clinical records contain Protected Health Information (PHI) 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 in a "double locked" manner (e.g., in a locked filing cabinet located 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 not left in an unattended vehicle). Electronic Health Records (EHR) must be stored in a password-protected computer located within a locked room. (*BHCSQA09*)

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.)

Record Retention:

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 for at least one (1) year after such minor has reached age 18, and in any case, not less than seven (7) years.
- For psychologists: Clinical records must be kept for seven (7) years from the client's discharge/termination date; in the case of a minor, seven (7) years after the minor reaches age 18 (*DMH02*)
- Third party: If a provider uses a third party to perform work related to their BHCS contract, the provider must require the third party to follow these same standards. (*BHCSQA09*)
- Audit situations: Records shall be retained beyond the seven (7) year period 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 exists only if the MHP notifies Contractor of the commencement of an audit prior to the expiration of the seven (7) year period. (*BHCSQA09*)
- 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)*

Record Destruction:

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

Medical Necessity: Providing the Rationale for Services

(CCR16) (CCR20)

Applies to All Provider Contracts

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 providers use the following documents to document medical necessity for services: Initial Assessment, Initial/Annual Client Plan (or Consumer Plan, Life Plan, Treatment Plan, etc.), and 6-Month Review/Update to the Client Plan.

Relevance of Medical Necessity for Documentation

- Initial assessment documentation establishes Medical Necessity (MN).*
- Initial client plans are based on the Initial Assessment. A licensed signature on the 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.

**If services other than for the purpose of assessment are provided prior to completion of the initial assessment document, the Medical Necessity rationale for those services must be provided in the corresponding progress notes.*
*** In the gap of time that may exist between the Initial Assessment's completion and while the Initial Client Plan is being developed, mental health services may be provided as long as the medical necessity for services is clearly identified in the Initial Assessment. If a clinical issue arises that is not identified in the Initial Assessment, each Progress Note addressing that issue must evidence medical necessity.*

Medical Necessity is determined by the following factors:

- The client has an "included" DSM or ICD-9 (current editions) diagnosis that is substantiated by chart documentation.) (CCR17)
    - A client's excluded diagnosis may be noted, but there must be an "included" diagnosis that is a primary focus of treatment. (An "excluded" diagnosis may not be noted as primary.)
    - Identify the DSM diagnostic criteria for each diagnosis that is a focus of treatment.

- As a result of the included diagnosis, it must be documented that the client meets at least one of the following criteria: (CCR18)
    - A significant impairment in an important area(s) of life functioning.
    - A probability of significant deterioration in an important area of life functioning.
    - A probability that the child will not progress developmentally as individually appropriate.
    - 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.

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

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

- 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 diagnosis that is a focus of treatment.)

Clinical Documentation Standards for Specialty Mental Health Services

[Citations noted under each subject.]

Applies to All Providers, per Type of Contract/Service

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:

All providers:

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

Level 1 Providers (except FSP's):

5. ***Annual Community Functioning Evaluation***

TBS providers:

6. ***Therapeutic Behavioral Services (TBS): All Documentation***

Signature Requirements: All providers (*DMHcontract2*)

- ***Complete Signature:*** Every clinical document must be followed by a "complete signature," which includes the writer's signature, appropriate credential and date. (*BHCSQA09*)
- ***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. Providers may also have an administrative "signature page" containing staff signatures with their typed name and credential. (CCR30) *(DMHcontract3)*
- ***Credentials:*** If applicable, professional licensure (e.g., ASW, LCSW, MFT-Intern, MFT, PhD, MD, etc.) or student status (currently in a degree program) is required to accompany the signature. Job title or educational degree is sufficient if there is no professional licensure. It is best practice to select the credential which best qualifies the person for the majority of mental health services they provide. *(DMHcontract3)*
- ***Dates:*** All signatures require a date (00/00/00). Exception: If a Progress Note date of service and date the note was written are the same, the date of service is sufficient. (*BHCSQA09*)

- ***Late entries:*** Provide complete signature using the date the late entry was written, not the date of service. (See above and "Progress Notes" below for more information.) (*BHCSQA09*)
- ***Completion Line:*** Nothing may be added within a document after it is signed. To indicate the end of an entry, draw a line up to the signature (n/a for electronic signatures). If additional information must be added, write an addendum. (*BHCSQA09*)
- ***Addendums:*** Include complete signature (see above). (*BHCSQA09*)

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1. Initial Assessments (*DMHcontract2*)

Applies to All Providers
Exception: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Assessments are forthcoming.

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 either a specific document or section of the clinical record, per MHP requirements. (*BHCSQA09*)

County-Operated providers must use BHCS Initial Assessment templates.

Level 1 Organizational providers: Per the MHP requirements, Level 1 organizational providers may develop their own Initial Assessment templates, as long as the BHCS minimum required content areas are addressed in the document. Note: The QA Office is unable to review and/or approve templates created by providers. (*BHCSQA09*)

Note to Level 3 providers: The Request for Extended Service Review (RES) form meets the full requirements of the Initial Assessment. (Please see the L3 Documentation Manual available at www.acbhcs.org/providers under the Forms tab).

❖ *Timeliness & Frequency of Initial Assessments, per Type of Provider* (BHCSQA09)

All Providers: Per the MHP requirements, a completed and filed Initial Assessment is required within 30 days of the opening episode date. BHCS does not require an annual re-assessment; instead, four (4) assessment elements are included in the Client Plan requirements and so shall be reviewed/updated every time the Client Plan is reviewed or renewed: Diagnosis, Risk situations, Client strengths & resources, and Special needs.

- If it is not possible to address all required elements due to issues of client participation or inability to obtain a full history, but medical necessity has been established, the Assessment should be completed within 30 days, with notations of when addendums with missing information are expected.
- If it is not possible to determine medical necessity within 30 days, the need for more time must be documented in a progress note and the deadline may be extended to 60 days.

- If the case is closed before 30 days, 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.

Exceptions:
Full Service Partnership Programs: Per the MHP requirements, a completed and filed Initial Assessment is due within 60 days of the opening episode date.

- If it is not possible to address all required elements due to issues of client participation or inability to obtain a full history, but medical necessity has been established, the Assessment should be completed within 60 days, with notations of when addendums with missing information are expected.
- If the case is closed before 60 days, best practice is to complete the Initial Assessment as much as possible.
- Progress Notes for every billed service must be in the clinical record.

Time-Limited Programs: The due dates for a completed and filed Initial Assessment varies based upon program length. Consult with your agency's MHP contracts for these timeframes.

All Providers: Initial Assessments shall be updated, as necessary, via addendums to the document. [The following four assessment items are included in the BHCS Client Plan requirements and so shall be reviewed/updated every time the Client Plan is reviewed or renewed: Diagnosis, Risk situations, Client strengths & resources, and Special needs.]

Re. Returning Clients: If a beneficiary's episode is closed but he/she returns to the provider for additional services within 12 months of an Initial Assessment's completion, that Assessment may be updated with new information and signatures and re-used for the new episode opening. If the beneficiary returns for services after 12 months of an Initial Assessment's completion, the Initial Assessment must be re-done.

❖ ***Minimum Requirements for Initial Assessment Content***

Applies to All Providers
Exceptions: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Assessments are forthcoming.

The following areas must be included in the Initial Assessment, as appropriate, as part of a comprehensive clinical record. (*DMHcontract1*)

a. ***Identifying information****:* Unless included in another document in the record (e.g., a face sheet or admission note), the Assessment must include: (*BHCSQA09*)
   - 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, and marital status
   - Information about significant others in the client's life including 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. (*BHCSQA09*)

c. ***Relevant physical health conditions*** reported by the client or by other report must be prominently identified and updated, as appropriate. (*DMHcontract1*)

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. (*DMHcontract1*)

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, the Client Plan must include how it is being managed. (*DMHcontract1*)

f. ***Client's strengths*** in achieving anticipated treatment goals (e.g., client's skills and interests, family involvement and resources, community and social supports, etc.). (*DMHcontract1*)

g. ***Medications:***

- List medications prescribed by an MD employed by the provider, including dose/frequency of each, date of initial prescriptions & refills. Documentation of informed consent for medications is required and may be located in a different section of the record. (*DMHcontract1*)
- Medications prescribed by an outside MD must be listed as above, per client or MD's report; provide the MD's name and telephone number. (*BHCSQA09*)

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(*DMHcontract1*) and prominently noted on the front of the chart.(BHCSQA09)

i. ***Substance use***, past & last use/current: Alcohol, caffeine, nicotine, illicit substances, and prescribed & over-the-counter drugs. (*DMHcontract1*)

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). (*DMHcontract1*)

k. ***Other history:*** As relevant**,** include developmental history; social history; histories of employment/work, living situation, etc. (*BHCSQA09*)

l. ***For clients under age 18:*** Include (or document efforts to obtain) pre-natal/ perinatal events, and complete developmental history (physical, intellectual, psychological, social & academic). (*DMHcontract1*)

m. ***Relevant Mental Status Examination:*** Includes signs and symptoms relevant to determine diagnosis and plan of treatment. (*DMHcontract1*)

n. ***Five-axis diagnosis*** from the most current DSM (or ICD), consistent with presenting problem, history, mental status examination, and/or other assessment data. (*DMHcontract1*)

- At least one diagnosis must be the 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. The name and license credential of the person who made the diagnosis must be noted within this item, even if from a referral source; the signature is not required within this item. (*BHCSQA09*)

o. ***Complete signature*** of the person completing the Initial Assessment and the signature of a licensed or registered/waivered LPHA. (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. This may be part of the Assessment document or the Initial Client Plan. (BHCSQA09)

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2. *Client Plans* (DMHcontract2) (CCR12)

Applies to All Providers
Exceptions: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Client Plans are forthcoming.

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. Services must address identified mental health barriers to goals/objectives. Client Plans are developed from the Initial Assessment must substantiate ongoing Medical Necessity and be consistent with the diagnosis/diagnoses that is the focus of mental health treatment. Client Plans must be maintained in a specific section of clinical records and must be clearly evident and identifiable, per the MHP. (CCR05) (BHCSQA09)

Strength-based and recovery/resiliency oriented treatment planning is strongly encouraged. (BHCSQA09)
The minimum required content areas of any Client Plan may not be left blank; instead, indicate the plan to complete those elements or indicate when they are not applicable. (BHCSQA09)

County-Operated providers must use BHCS Client Plan templates.

Level 1 Organizational providers: Per the MHP requirements, Level 1 organizational providers may develop their own Client Plan templates as long as the BHCS minimum required content areas are addressed in the document. Note: The QA Office is unable to review and/or approve templates created by providers. (BHCSQA09)

Note to Level 3 providers: The Request for Extended Service Review (RES) and Request for Concurrent Review (RCR) forms meet the full requirements of the Initial Client Plan, Annual Client Plan or 6-Month Update. Please see the L3 Documentation Manual available at www.acbhcs.org/providers under the Forms tab).

❖ *Timeliness & Frequency of Client Plans, applies to all providers except FSP & Time-Limited Programs*

- Initial Client Plan: A completed and filed Initial Client Plan is required within 60 days of the opening episode date. If the case is closed before 60 days, a completed Plan

is not required. The Initial Client Plan may be completed before the deadline. (*BHCSQA09*)

- Until 11/1/10, the BHCS requirement was a 30-day deadline (higher than the DHCS standard of 60 days) and there was no need to count actual calendar days. However, providers must now adhere to the BHCS and DHCS 60-day deadline; therefore it is prudent to utilize the InSyst system prompt of the 60 day deadline that is sent automatically to providers. The following is an example of the 60 day count: An open episode date of 9/13/10 requires the Initial Client Plan to be completed by 11/11/10.
- In the gap of time that may exist between the Initial Assessment's completion and while the Initial Client Plan is being developed, mental health services may be provided as long as the medical necessity for services is clearly identified in the Initial Assessment. If a clinical issue arises that is not identified in the Initial Assessment, each Progress Note addressing that issue must evidence medical necessity.
- **Time-Limited Programs**: The due dates for a completed Initial Client Plan vary for Time-limited programs. They are based upon program length. Consult with your agency's MHP contract for these timeframes.

- Annual Client Plan: The Client Plan must be re-written at least once annually, just prior to the anniversary of the episode opening month (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. (*DMHcontract1*) (*BHCSQA09*)

- 6-Month Client Plan Update: The 6-Month Update must be done annually, in the sixth month from the episode opening month (e.g., opened in March, so due every August); in other words, it must be completed in the month prior to the next authorization/utilization review period. If the case is closed before the end of the sixth month, no Update is required. (*BHCSQA09*)
  - Exception for Full-Service Partnership Programs: The 6-Month Client Plan Update is not required for FSP programs. (*BHCSQA09*)

- Other Updates to the Client Plan: The Client Plan must be updated whenever there are significant changes in the client's presentation and/or situation that affect planned treatment. (*BHCSQA09*)

- 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. (*BHCSQA09*)

- Note for Day Treatment Intensive Programs: Though these programs are authorized for services every 3 months, Client Plans follow the above schedule.

❖ ***Minimum Requirements for the Initial/Annual Client Plan and Updates***

Applies to All Providers
Exceptions: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Client Plans are forthcoming.

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.

a. ***Client's goals*** (stated in own words, when possible) *(DMHcontract1) (BHCSQA09)*
b. ***Mental health goals/objectives*** that are specific and observable or measureable, 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. *(DMHcontract1) (BHCSQA09)*

   Note for Day Treatment (Intensive or Rehabilitation) and Minors in Group Home Programs: These Client Plans must identify the goal(s) that Day Treatment will assist the client to achieve, as well as the proposed duration of the Day Treatment Program. (DMH04)
c. ***Interventions and their focus*** must be consistent with the mental health goals/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). *(DMHcontract1) (BHCSQA09)*
   Indicate:
   - Service Interventions, which are the planned mental health services (e.g., Family Psychotherapy).
   - "Best practice" to also indicate Clinician Interventions, which are the provider's actions during services to support the client's progress toward goals/objectives (e.g., "Offer stress reduction techniques to reduce anxiety" or "Support client to express unresolved grief to reduce depression").
d. ***Duration and Frequency*** of the service interventions. *(DMHcontract1) (BHCSQA09)*
e. ***Key Assessment Items:*** The following four key assessment items (included in the BHCS Client Plan template) shall be reviewed and updated every time the Client Plan is reviewed or renewed: 1) Diagnosis, 2) Risk situations, 3) Client strengths & resources, and 4) Special needs. *(BHCSQA09)*
f. ***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. *(BHCSQA09)* For minors receiving Therapeutic Behavioral Services, the Client Plan must indicate coordination of services with the TBS provider. *(DMH03)*
g. ***Tentative Discharge Plan*** (termination/transition plan). *(BHCSQA09)*
h. **"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).
   - If psychiatric medication is prescribed by an organizational provider's Psychiatrist, that Psychiatrist must also sign the Client Plan. *(BHCSQA09)*

   If the above person providing the service(s) is not licensed or registered/waivered, a complete co-signature is required by at least one of the following:
   - Physician
   - Licensed/registered/waivered psychologist
   - Licensed/registered social worker
   - Licensed/registered marriage and family therapist, or
   - Registered nurse
i. ***Evidence of the client's degree of participation and agreement*** with the Client Plan must be addressed in the following ways: (CCR14) *(BHCSQA09)*
   - 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.

j. ***A copy of the Client Plan*** must be provided to the client (or legal representative) upon request and a statement to that effect must be either on the Plan or within informing materials signed by the client. *(DMHcontract1) (BHCSQA09)*

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3. *Progress Notes*

Applies to All Providers, per Type of Service (*DMHcontract2*)

For providers billing Medicare, see "Special Situations: Progress Note Documentation Requirements" following this section.

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. (*BHCSQA09*)

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)
- Each Progress Note must "stand on its own" regarding Medical Necessity; identifying a clear link to the Client Plan helps meet this rule. (*BHCSQA09*)

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

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.

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.

Psychotherapy Notes are defined by 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 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 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 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, per Type of Provider & Service***

Timeliness
Applies to All Providers
Progress Notes must be entered into the clinical record within one (1) working day of each service provided. Approval by the supervisor and clinician finalization must be completed within five (5) business days. Exception Inpatient Units: Notes must be entered every third day, nursing notes are required for each shift. *(DMHcontract1) (BHCSQA09)*

Late Entries: In the infrequent situation when an emergency prevents timely recording of services, the service must be entered in the clinical record as soon as possible. The beginning of the note must clearly identify itself as a late entry for the date of service (e.g. "Late entry for *date of service*."). Signatures for late entries must include the date the note is written. The note must be filed chronologically in the clinical record per the date it was written, not per the date of service. *(BHCSQA09)*

Frequency: Applies per Type of Service

Every service contact for:	Mental Health Services (see page 4)
	Medication Support Service
	Crisis Intervention
	Case Management/Brokerage
	Therapeutic Behavioral Services (TBS)
Daily for:	Crisis Residential
	Crisis Stabilization (one per 23-hr. period)

Day Treatment Intensive

Weekly for: Day Rehabilitation
Adult Residential
Day Treatment Intensive Weekly Summary (Must be co-signed by one of the following: Licensed/Registered Social Worker or Marriage & Family Therapist, Licensed/Waivered Psychologist, Physician, or Registered Nurse.)

❖ *Minimum Requirements for Progress Note Contents*

Applies to All Providers
Exception: TBS Providers (See #6)
For providers billing Medicare, see "Special Situations: Progress Note Documentation Requirements" following this section.

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.* *(BHCSQA09)*

➢ *Minimum requirements for Progress Notes:*

a. ***Date of service*** (00/00/00). If the date of service and the date on which the note is written are the same, the date of service is sufficient. (See "Timeliness" section above, "Late Entries" paragraph.) (*DMHcontract1*)

b. ***Service intervention*** or service code (e.g. psychotherapy, collateral, rehabilitation, medication support, etc.). (*DMHcontract1*)

c. ***Location*** of the service provided. (*BHCSQA09*)
   Level 3 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)
   - Level 1 providers: Enter claims only by the minute. Add the length of service time to documentation time. Include time spent travelling to/from a location (other than home) to provide service. If travel time exceeds service time, indicate face-to-face time with the client, per Federal guidelines. (CCR26)
     Exception: Providers of full-day, half-day or hourly services only claim for those portions of time (e.g., day treatment and crisis stabilization). These contracts do not provide for reimbursement of documentation or travel time.
   - Level 3 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. (BHCSQA09) (*DMHcontract1*)
   In general:

- 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:
  - Specific interventions by provider, per type of service and scope of practice.
  - 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 co-signature, if required (see ***Staff Qualifications for Service Delivery and Documentation*** in this Policy). (See also "Clinical Documentation Standards" section, "Signature Requirements.") (*DMHcontract1*)

❖ ***Special Situations: Progress Note Documentation Requirements*** (BHCSQA09) *[Other citations noted at specific lines]*

Applies to All Providers

Medicare Billable Services: Progress notes must contain the minimum requirements above, *as well as the following* in order to be potentially billable to Medicare:

- Medicare CPT code of the service provided.
- Face-to-Face Time and Total time to provide the service.
- ICD-9 Diagnosis.
- Physical exam findings & Prior test results, if applicable.
- Patient's progress: Response to treatment and changes in treatment, patient's level of compliance, revision of diagnosis.
- Plan of care: Treatments, medication, patient/family education, follow up instructions and discharge plan.

Group Services: A note must be written for each beneficiary client participating or represented in a therapy or rehabilitation group. 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 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 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. Providers must document the need for such services in the clinical record. These services may be Crisis Intervention or Crisis Stabilization services, or an increased number/duration of services, per type of provider, as described below:

- Only Level 1 providers may claim for Crisis Intervention services.
- Level 3 providers may provide services in excess of the current authorization when warranted. These providers must contact 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.
- Crisis Stabilization Programs are the only providers who may utilize Crisis Stabilization services.

➢ 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)*

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) (BHCSQA09)

Documenting Lockout Situations: If 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), 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 who is identified in the Note. "Best practice" is to make ongoing efforts to obtain paper evidence of adjudication. *(BHCSQA09)*

Documenting the Creation of Clinical Documents (for Level 1 providers only): 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.

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4. Discharge / Termination / Transition Documentation

Applies to All Providers *(DMHcontract2)*
Exception: TBS Providers (See #6)

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, per type of provider: *(BHCSQA09)*

Level 1 Providers:

- 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. *(BHCSQA09)*

Level 3 Providers:

- Discharge Note: A Progress Note for the last face-to-face service with the client, per the Minimum Requirements below. This is billable to Medi-Cal if included in a progress note for the final session with a client. *(DMHcontract1)*

❖ ***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. *(BHCSQA09)*

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". *(BHCSQA09)*

❖ ***Minimum Requirements***

Discharge Note: A Progress Note that includes brief documentation of the following: *(DMHcontract1) (BHCSQA09)*

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

(Reminder for Level 1 providers: 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**: *(BHCSQA09)*

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

(Reminder for Level 1 providers: The MHP considers this a billable Plan Development service when **clinically necessary for continuity of care**.)

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5. *Annual Community Functioning Evaluation or Equivalent*

Applies to Level 1 Providers Only *(BHCS1) (BHCSQA09)*
Exception: Full Service Partnership programs & TBS providers

Definition: The Annual Community Functioning Evaluation (ACFE) is a tool developed by BHCS to quantify levels of functioning in common domains in the community for child and adult clients. (Child & Adult versions are available at www.acbhcs.org/providers under the QA tab.)

❖ **Timeliness:** The ACFE is completed at the time of admission for services and annually thereafter.

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6. Therapeutic Behavioral Services (TBS) Documentation

Applies to TBS Providers Only *(DMHcontract2)* (CCR07) *(BHCS2) (TBS1)*

All providers of Therapeutic Behavioral Services (TBS) must comply with:

- The documentation standards noted as relevant to "All Providers" in this Policy document;
- The documentation standards noted in the "TBS Documentation Manual" published by the California Department of Mental Health (DMH); **and**
- The BHCS items noted below:

In addition to the "TBS Manual" documentation standards, BHCS requires the following:

Evidence of Adjudication for Clients in Juvenile Detention Facilities:

Prior to providing TBS services to a client residing at Juvenile Hall but who is only there awaiting placement in a group home or other non-institutional setting (client has been adjudicated), evidence of adjudication must be obtained and filed in the clinical record. 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 billable TBS services, the clinician may use a Progress Note to document a client's adjudicated status as reported by a reliable source who is identified in the Note. "Best practice" is to make ongoing efforts to obtain paper evidence of adjudication.

Initial Assessments:

- Initial Assessments for TBS are due within 30 days of the TBS episode opening date.
  - If it is not possible to complete the Assessment within 30 days, the need for more time must be documented in a progress note and the deadline may be extended to 60 days.
- Initial Assessments must address the following, in addition to TBS Documentation Manual description:
  - ***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. (*BHCSQA09*)
  - ***Allergies & adverse reactions/sensitivities***, per client or by report, to any substances or items (especially medications), or the lack thereof, must be noted in the Assessment(*DMHcontract1*) and prominently noted on the front of the chart.(BHCSQA09)

Client Plans:

- Initial Client Plans for TBS are due within 60 days of the episode opening date and must be completed and reviewed before services are authorized.
- Monthly Summaries of the Client Plan are required (function as Client Plan Updates).
- Interventions in the Client Plan and Monthly Summary must utilize the standard behavioral measurement known as Frequency, Intensity, and Duration (FID).

Progress Notes:

- Progress Notes must also utilize the standard behavioral measurement known as Frequency, Intensity, and Duration (FID).

Staff Qualifications for Service Delivery and Documentation

(EPSDT1)

Applies to All Providers, per Type of Contract

Staff qualifications for delivery of Medi-Cal Specialty Mental Health Services are dictated in general by the following standards and scope of practice as defined by California Code of Regulations Title 9, and BHCS.

Providers must ensure, on an ongoing basis, that all staff credentials are up-to-date and meet the criteria of the BHCS Credentialing Policy.

Providers must also maintain documentation of all staff persons' qualifications to support their level of service provision.

The following staff qualifications are described in this section:

Licensed Practitioner of the Healing Arts (LPHA)
Waivered/Registered LPHA
Graduate Student Intern/Trainee
Mental Health Rehabilitation Specialist (MHRS)
Adjunct Mental Health Staff & Other Staff Not Meeting Above Category Qualifications

Licensed Practitioner of the Healing Arts (LPHA)

A Licensed Practitioner of the Healing Arts (LPHA) possesses a valid California clinical licensure in one of the following professional categories:

a. Physician
b. Licensed Clinical Psychologist
c. Licensed Clinical Social Worker
d. Licensed Marriage and Family Therapist
e. Registered Nurse

Approved Activities

- Can function as a "Head of Service" on agency application;
- Can authorize services as directed by BHCS;
- Can conduct comprehensive assessments and provide a diagnosis without co-signature. (Note re. RN Staff: In order to provide a diagnosis without co-signature, RN staff must possess a Masters degree in Psychiatric or Public Health Nursing *and* two years of nursing experience in a mental health setting. Additional post-baccalaureate nursing experience in a mental health setting may be substituted on a year-for-year basis for the educational requirement.)
- Can co-sign the work of other staff members, within their scope of practice; and
- Can provide all service categories within their scope of practice.

Waivered/Registered LPHA

"Licensed waivered staff" members includes the following:

a. Registered Psychologists and Psychological Assistants:

Each psychologist candidate must obtain a waiver—even if he/she is registered with his/her licensing board.

In order to be eligible for such a waiver, the psychologist candidate must have successfully completed 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.

There is no statutory provision for extension of psychologist candidate waivers beyond the five-year limit.

Psychologist interns are individuals registered with the Board of Psychology as "Registered Psychologists" or "Registered Psychological Assistants" that possess an earned doctorate degree in psychology or educational psychology, or in education with specialization in counseling psychology or educational psychology. These interns must obtain supervised post-doctoral clinical hours towards licensure as a psychologist. The waiver for Registered Psychologists or Psychological Assistants is issued by DMH and is granted up to five years from the initial date of registration with the Department. The waiver allows these staff to function as an LPHA while acquiring experience towards clinical licensure. Please see the Waiver Policy and Procedures in the QA Manual for further instructions.

Note: Registered Psychologist/Psychological Assistants are granted waiver by DMH. Registered MFT Interns and ASWs are over sighted and monitored by the hiring provider.

Approved Activities

Registered Psychologists, Psychological Assistants, Registered Marriage Family Therapist Interns, and Associate Social Workers may perform the following activities under the supervision of a licensed professional within their scope of practice:

- Can function as a LPHA staff for the time dictated by their respective Boards and DMH;
- Cannot function as the Head of Service unless they meet qualifications dictated by the California Code of Regulations;
- Can authorize services as directed by BHCS;
- Can conduct/create comprehensive assessments and sign them. Per BHCS, may not provide a diagnosis without co-signature while under waiver (see Assessment section);
- Can create Client Plans but require co-signature by licensed LPHA;
- Can co-sign the work of other staff members within their scope of practice, except for other staff in their same category and graduate students performing psychotherapy;
- Can claim for all Mental Health Services, Unplanned Services, and Case Management within their scope of practice; and
- Cannot hold themselves out as independent practitioners and claim as a Fee-for-Service provider. (May be employed by a Fee-for-Service organization/agency with appropriate supervision, but may not be employed by an individual/group private practice provider.)

Graduate Student Intern/Trainee

A "Graduate Student Intern/Trainee" is an individual participating in a field intern/trainee placement while enrolled in an accredited Masters in Social Work (MSW), Masters of Art (MA), Masters of Science (MS), or clinical/educational psychology doctorate degree program that will prepare the student for licensure within his/her professional field. There is no minimum experience required for graduate students.

Some graduate students may qualify as "Mental Health Rehabilitation Specialists," if employed by the provider and if their experience permits. (Individuals enrolled in other degree programs may qualify as "Adjunct Mental Health Staff," as described below.)

Approved Activities

Graduate students may perform the following activities under the supervision of a licensed or waived professional within their scope of practice:

- Can conduct/create comprehensive Assessments and Client Plans, but require a co-signature by a licensed LPHA;
- Can write Progress Notes but require a co-signature by a licensed LPHA;
- Can claim for individual and group psychotherapy but require oversight and co-signature of a licensed LPHA staff member; and
- Can claim for any service within the scope of practice of the discipline of his/her graduate program.

Note: Waivered/Registered Professional staff cannot co-sign for a graduate student's psychotherapy progress notes. Those notes must be co-signed by a licensed LPHA.

Mental Health Rehabilitation Specialists (MHRS)

A "Mental Health Rehabilitation Specialist" (MHRS) is an individual who meets one of the following requirements:

- MHRS staff must have a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.
- Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis.
- Up to two years of post-Associate Arts (AA degree) clinical experience may be substituted for the required educational experience, in addition to the requirement of four years' experience in a mental health setting.

Approved Activities

MHRS staff may perform the following activities:

- Can function as a "Head of Service" on agency/provider application with BHCS approval. (Note: Does not qualify as "Director of Local Mental Health Services" unless approved by DMH);
- Can provide and collect information for Assessments;
- Can create Client Plans (require co-signature by licensed LPHA) and Progress Notes; and
- Can claim for all Mental Health Services (except Psychotherapy), Unplanned Services, and Case Management within their scope of practice.

Adjunct Mental Health Staff & Other Staff Not Meeting Above Category Qualifications

Level 1 providers have the prerogative and program flexibility to integrate and define other staff who can provide direct or supportive specialty mental health services, as determined by their BHCS contract. Bachelor's level staff may qualify for this designation.

It should be noted that it is not a requirement that staff are paid for services provided and claimed to Medi-Cal (i.e., staff may include unpaid graduate students/trainees/interns, volunteers or advocates), as long these unpaid persons meet Medi-Cal rules and regulations regarding claiming and scope of practice.

Approved Activities

Adjunct mental health staff and other staff not meeting the above category qualifications may provide services (except Psychotherapy) and follow the same clinical documentation rules as for MHRS staff (above), with evidence of on-going supervision, within the scope of the staff member's ability. *BHCS strongly advises that all adjunct mental health staff documentation be co-signed by a licensed LPHA.*

Note: Mental Health Services, Day Rehabilitation Services, Day Treatment Intensive Services, Crisis Intervention Services, Case Management, and Adult Residential Treatment Services may be provided by any person determined by the hiring provider to be qualified to provide the service, consistent with state law and their scope of practice. The hiring provider must retain personnel materials that justify their determination.

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
BHCS2	BHCS Office of the Medical Director, Guidelines for Psychotropic Medication Practices can be found at, http://www.acbhcs.org, under tab "Office of the Medical Director"
BHCSQA	**Behavioral Health Care Services, Quality Assurance** can be found at http://www.acbhcs.org, in tab "Quality Assurance"
BHCSQA09	BHCS/QA Requirement, 2009 or earlier
BHCSQA10	BHCS/QA Requirement, 2010
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)
CalOHI	**California Office of HIPAA Implementation** can be found at http://www.ohi.ca.gov under California Implementation
CalOHI1	CalOHI Chapter 4
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
CCR02	CCR, Title 9, Chapter 3.5, Section 786.15
CCR03	CCR, Title 9, Chapter 4.0, Sections 851 & 852
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
CCR07	CCR, Title 9, Chapter 11, Section 1810.225
CCR08	CCR, Title 9, Chapter 11, Section 1810.227
CCR09	CCR, Title 9, Chapter 11, Section 1810.247
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

Citations

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
CCR27	CCR, Title 9, Chapter 11, Section 1840.346
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
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. 06-07
DMH03	DMH Information Notice No. 02-08
DMH04	DMH Letter No. 02-01
DMH05	DMH Letter No. 02-07
DMHcontract	**Department of Mental Health Contract** with the Mental Health Plan; the boilerplate contract with DMH can be found at http://www.dmh.ca.gov
DMHcontract1	DMH Contract with MHP
DMHcontract2	DMH Contract with MHP, Exhibit A, Attachment 1, Appendix C
DMHcontract3	DMH Contract with MHP, Exhibit A, Attachment 1, Appendix C, page 39
EPSDT	**Early and Periodic Screening Diagnosis and Treatment (EPSDT)** Chart Documentation Manual, 2007 can be found at http://www.cimh.org
EPSDT1	EPSDT Chart Documentation Manual, 2007
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
RMS	**Risk Management Services**
RMS1	Risk Management Services 2010
TBS	**Therapeutic Behavioral Services Documentation Manual**, first published online in October 2009; can be found, along with future updates, at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp.
TBS1	TBS Documentation Manual

STATE DEPARTMENT OF MENTAL HEALTH MEDI-CAL MANAGED CARE

Medical Necessity for Specialty Mental Health Services that are the Responsibility of the Mental Health Plan

Must have all, A, B, and C:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included.)
- Tic Disorders
- Delirium, Dementia and Amnestic and other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions, including V-codes, that may be a focus of Clinical Attention. (Except medication induced movement disorders which are included.)

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have one of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria:
Must have one, 1, 2, or 3:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have all, 1, 2, and 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

B.I.R.P. Progress Note Checklist

B Behavior **Counselor observation, client statements**	**Check if addressed**
1. Subjective data about the client—what are the clients observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
I Intervention **Counselor's methods used to address goals and objectives, observations, client statements**	
1. What goals and objectives were addressed this session?	
2. Was homework reviewed?	
R Response **Client's response to the intervention, progress made toward Tx Plan goals and objectives**	
1. What is the client's current response to the clinician's intervention in the session?	
2. Client's progress attending to goals and objectives outside of the session?	
P Plan **Document what is going to happen next**	
1. What in the Tx Plan needs revision?	
2. What is the clinician going to do next?	
3. What is the next session date?	

General Checklist	**Check if addressed**
1. Does the note connect to the client's individualized treatment plan?	
2. Are client strengths/limitations in achieving goals noted and considered?	
3. Is the note dated, signed and legible?	
4. Is the client name and/or identifier included on each page?	
5. Has referral and collateral information been documented?	
6. Does the note reflect changes in client status (eg. GAF, measures of functioning)?	
7. Are all abbreviations standardized and consistent?	
8. Did counselor/supervisor sign note?	
9. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
10. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	