Alameda County Behavioral Health Care

MHP Provider Network Documentation Manual

This Section of the Quality Assurance Manual contains information about basic required chart management, and the minimum requirements for clinical documentation. This section applies to the Mental Health Plan Provider Network of Individual and Group Providers.

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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.

***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:

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

A Word About Terminology: ACBHCS providers and administrative offices have the intention to be inclusive in the language used to refer to beneficiaries of the Mental Health Plan (MHP) (e.g., consumers, clients, families, children, youth, transition-age youth, etc.). Depending on the language used, it is possible that some beneficiaries could feel excluded or secondary in importance. While it is the goal of ACBHCS to honor each individual's desire to be identified as they wish, this 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.

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General Management of Clinical Records

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

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

General Record Maintenance:

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

- Records should be organized and divided into sections according to a consistent standard allowing for ease of location and referencing. (*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, than enter correct material. (*BHCSQA09*)
- 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. (CBO's)
- 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. (*DMH02*)
- 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*)
- 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)

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 (RES) establishes Medical Necessity (MN) A Client Plan is now included in the new RES and RCR. 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.

Medical Necessity is determined by the following factors:

1. The client has an "included" DSM diagnosis that is substantiated by chart documentation.) (CCR17)
    a. A client's excluded diagnosis may be noted, but there must be an "included" diagnosis noted that is the primary focus of treatment. (An "excluded" diagnosis may not be noted as primary.)

b. Identify and note the DSM diagnostic criteria for each diagnosis that is a focus of treatment.

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

3. Identify how the proposed service intervention(s) meets both of the following criteria: *(CCR19)*
    a. The focus of the proposed intervention(s) is to address the condition identified in No. 2. (a-c) above; or for full-scope M-C beneficiaries under age 21, a condition identified in No. 2 (d) above.
    b. 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.

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

Clinical Documentation Standards for Specialty Mental Health Services

[Citations noted under each subject.]

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

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

providers may also have an administrative "signature page" containing staff signatures with their typed names and credentials. (CCR30) *(DMHcontract3)*

- ***Credentials:*** 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. (CBO's that supervise interns/students) 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 Notes' 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*)
- ***E-***signatures: There are extensive rules and regulations governing the use and security involved in e-signatures. DMH and the MHP accept only those e-signatures that meet the guidelines set out in DMH Letter 08-10. (DMH06)

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1. Initial Assessments *(DMHcontract2)*

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 (RES) or section of the clinical record, per MHP requirements. (*BHCSQA09*)

❖ *Timeliness & Frequency of Initial Assessments*(BHCSQA09)

All Providers: Per the MHP requirements, a completed and filed Initial Assessment (RES) is required between the 3rd and 4th session.

- 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 the 3 sessions, with notations of when addendums with missing information are expected.
- If the case is closed before the 4th session, best practice is to complete the Initial Assessment (RES) as much as possible.

❖ *Minimum Requirements for Initial Assessment Content*

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. It is the preference of BHCS that family members not be used as interpreters due to the potential for conflicting needs. Because of this, it is to be strongly discouraged. (*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. <u>If a risk situation is identified, the Client Plan must include how it is being managed</u>. (*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 <u>MD employed by the provider</u>, including dose/frequency of each, dates of initial prescriptions & refills. Documentation of informed consent for each medication prescribed is required and may be located in a different section of the record. A general medication consent is not sufficient. (*DMHcontract1*)
    - Medications prescribed by an <u>outside MD</u> 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, <u>or the lack thereof</u>, must be noted in the Initial Assessment(*DMHcontract1*) <u>and prominently noted on the front of the chart</u>.(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..(BHCSQA09)

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

The Client Plan is now included in the RES and the RCR. If filled out completely, it will meet these requirements.

Definition: Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.) are plans for the provision of mental health services to clients who meet the Medical Necessity criteria. Strength-based and recovery/resiliency oriented treatment planning is strongly encouraged.(BHCSQA09) 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(es) that is the focus of mental health treatment. (CCR05) (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)

❖ *Timeliness & Frequency of Client Plans, applies to all providers*

- The RES and RCR will meet the documentation requirements for treatment plans if completed appropriately.

❖ *Minimum Requirements for Client Plan and Updates*

The following elements must be fully addressed in the 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)*
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 service interventions. (e.g. CBT 1x/week for 6 months) *(DMHcontract1) (BHCSQA09)*
e. ***Key Assessment Items:*** The following four key assessment items (included in the RES/RCR) 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)*
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 the L3 CBO's Psychiatrist, that Psychiatrist must also sign the Client Plan. *(BHCSQA09)*

   If the above person providing the service(s) (at the CBO) 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 offered to the client and provided to the client (or legal representative) upon request and a statement to that effect must be also on the Plan. *(DMHcontract1) (BHCSQA09)*

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3. Progress Notes

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

Progress Notes must be entered into the clinical record within one (1) working day of each service provided. *(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)*

❖ *Minimum Requirements for Progress Note Contents*

Progress notes are documentation of services provided to or on behalf of clients. Services may or may not include direct contact with clients. *Not all providers are contracted to provide all of the services described in this section.* *(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*** (e.g. psychotherapy, collateral, medication support, etc.). (*DMHcontract1*)
  c. ***Location*** of the service provided. (*BHCSQA09*)
     MHP Network providers: Location is required only if location is other than office. (Service is expected to be office-based; approval from Authorization Services is required for other locations.)
  d. ***Time*** spent providing a *billable* service. Varies per provider type, as below:. (CCR26)
     - MHP Network providers: The time spent to provide a service determines which code is selected for claiming (e.g., Individual Psychotherapy for 30 minutes requires a different service code than for 60 minutes). This type of contract allows for the inclusion of the "community standard" of 10 minutes for documentation with a 50 minute session. This type of contract does not provide for reimbursement of travel time.

e. ***Documentation of specific services/interventions:*** Succinct description of clinically relevant information. (BHCSQA09) (*DMHcontract1*)
In general, the BIRP format (Behavior, Intervention, Response, Plan) meets this standard:
- When a service includes client contact, minimum requirements are description of the following, as applicable:
  - Reason for the contact.
  - Assessment of client's current clinical presentation.
  - Relevant history.
  - Specific mental health/clinical interventions by provider, per type of service and scope of practice.
  - Client's response to interventions.
  - Unresolved issues from previous contacts.
  - Plans, next steps, and/or clinical decisions. If little or no progress toward goals/objectives is being made, describe why. Include date of next planned contact and/or next clinician action. Indicate referrals made. Address any issues of risk.
- When a service does not include client contact, minimum requirements are description of:
  - 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. (*DMHcontract1*)

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

Group Services: A note must be written for each client participating or represented in a therapy or rehabilitation group. 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).

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.
- MHP Network 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.
  - 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)

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4. Discharge / Termination / Transition Documentation

Applies to All Providers *(DMHcontract2)*

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)*

MHP Network 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)*

❖ *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.

Approval Date: 5/11/12
Application: MHP Network, Fee for Service Providers

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

Citations

CCR22	CCR, Title 9, Chapter 11, Section 1840.312
CCR23	CCR, Title 9, Chapter 11, Section 1840.314
CCR24	CCR, Title 9, Chapter 11, Section 1840.314(b)
CCR25	CCR, Title 9, Chapter 11, Section 1840.314(c)
CCR26	CCR, Title 9, Chapter 11, Section 1840.316
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
DMH06	DMH Letter No. 08-10
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