CQRT/Documentation Training
Q & A May,
June and July 2004

These responses do not supersede any and all contracts and agreements between an agency and ACBHCS Children's Services Operations. In addition, these responses are for informational purposes and do not supersede the content of State Medi-cal regulations. It is a best practice that agency administrators reference their contract and Medi-cal regulations in implementing policy within their agency.

If progress notes must be signed within a day or two, it would seem that they need to be printed out one per page. This makes a chart quite large. It would be better to wait until there are enough progress notes. In the computer to fill out a full printed page, then print the page and have all the notes signed at the same time.
So what should we do, print one note per page or wait till we have a full page of notes, to print & sign?
The process should be adherent to the laws and regulations regulating the practice of the agency and independent practitioner. The best practice is to print each PN, sign, date and place in medical record.

Do you have limitations on time for writing program notes? We wrote procedures for our therapists to write their progress notes in 72 hours and submit that to their supervisors and supervisors have 72 hours to review and sign it.
Medi-cal documentation guidelines indicated that progress note charting must be completed at the end of the shift (program specific).

What is the specific difference between Day Treatment Intensive and Day Treatment Rehab?
The primary difference between Therapy and Rehabilitation Option pertains to Day treatment services. Rehabilitation is primarily focused to improve functioning by providing *skill development*, resources and information. Although, Intensive may include skill development, resources and information, the primary focus is to improve functioning by utilizing *therapeutic interventions* to reduce symptoms. Therefore, the symptom severity and functional impairment of the beneficiary and staffing requirements may differ between Rehabilitation and Intensive Day Treatment. Intensive Day Treatment is intended to enroll beneficiaries who require an alternative to a more restrictive placement (i.e. Hospital). CCR Title 9 1810.212-13

Which providers are considered Day Treatment Rehab?
Provider sites have contracts with BHCS that specify the type of services provided.

What should we do if we cannot get signatures on Treatment Plans on Treatment Plans from the DSS workers?
In general, programs are required to obtain signatures from the entity responsible for the child. When exceptions occur, note any and all attempts to obtain a signature.

At what age does Alameda County expect clients to sign?
Obtaining consent should be in compliance with State law for consent to treat a minor. Obtaining a signature on the treatment plan is not the same as obtaining consent. The signature on the treatment plan is not a legal issue, but rather an issue of assuring the "client" is involved in the treatment plan. The clinician will need to define "client" and obtain that signature for this purpose.

For other counties, we are using child welfare worker signatures for 300 clients whose parents are not in reunification – is that acceptable? For purposes of legal consent, programs should adhere to State laws governing consent. See above note.

What if you are working w/a teen who does <u>not</u> want their parent to read and sign their client care plan (if the teen is honestly going to put true goals which may revolve around issues they are not willing to share w/parents): for example: drug & alcohol abuse, risky sexual behavior, sexual identity issues, etc. Can you just have teen sign the TX plan and <u>document why</u> you are <u>not</u> having parent sign? /or do you need to make a less explicit TX plan & have parent sign?). See above note.

Do M/Cal regulations or ACMHP Policy require that the client or parent/guardian sign the treatment plan or is it optional? If they refuse to sign or disagree with the treatment plan, should that be noted on the treatment plan? See above note.

Signature can be legal guardian or child welfare worker if client is a child?
See above. Consent for treatment signatures is a legal issue. Signatures on the treatment plan are regulatory and required to assure the participation of the client.

Can the client agreement [to the treatment plan] be verbal and documented in progress note?
Yes. Note the verbal agreement and obtain the signature when the client is available.

Can signatures be co-signed by a witness if the treatment plan is reviewed w/person over the phone? (I.e. placing worker)
The provider may document the verbal approval without a witness and obtain the written signature when the client is available. (Treatment plan signature is not a legal issue. Consent for treatment is a legal issue.).

<u>Medical Necessity</u> is very important for documentation. Please give guidance regarding ongoing charting of Medical <u>Necessity</u>.
Programs adhering to the progress note documentation requirements outlined in the Medi-cal regulations may be more likely to establish ongoing medical necessity. A best practice is to relate each progress not to the treatment plan.

How do you determine medical necessity, esp. as related to Mental Health Services? The technical definition(s) are very broad, but the county's view appears narrow.

ACBHCS adheres to Medical and Service Necessity requirements as defined under CCR Title 9 1830.205, 1830.210, Title 22 51340. If a provider has an experience during a CQRT meeting where services are limited due to medical or service necessity, it will be referred to Quality Assurance Office for final disposition prior to an official denial of services.

Assessment. Can be Multiple Sessions (ex. Play therapy, family meeting, and school observation)?
Yes. Assessment can be clinical assessment, psychological or psychiatric assessment or crisis. Assessment is a broad code definition that does cover these clinical assessment areas. As for coding, assessment is billed as a portion of the crisis intervention and not separately as assessment.

Regulations do not require a date of signature but a date of service. Date of signature brings up audit issues)
In theory, the date of service and date of signature should be the same on a progress note. The regulations do not speak to this issue.

Can MHRS participate in CQRT?
No. CQRT members must be, at a minimum, licensed/waivered/registered LPHA's AND completed training on the CQRT process from their agency.

-

For level III services, is there a CQRT process?
The decision to be involved in the CQRT process is contractual and not necessarily based on the level of the provider. Provider organizations should consult with their BHCS contract manager for specifics.

Does one [Can you] bill the file review/documentation time for assessment as assessment or as plan development?
Documentation time is considered a portion of the service provided connected to the documentation. If the file review has a purpose of accomplishing tasks as defined in the definition for plan development, then it may be billed as plan development.

Could I please have access to the spreadsheet you mentioned describing Client Care Plan Signature requirements?
According to Title 9, Client plans will be signed by:
1. The person providing the services, or
2. A person representing a team or program providing the service

When the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category (Licensed, registered and waivered LPHA).

What is an LPHA?

Licensed psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, marriage and family therapist and RN with MSN and experience.

If our contract is approved (e.g.) July 1, 2004 and we start to bill August 1, will we need to bring to August 1 CQRT any clients that have been seen for 6 months or more prior to contract the order to bill for them. Can we choose not to bill?
Any program may choose not to bill for a date of service or period of time. Those services are not required to meet Medi-cal standards, but are required to meet any and all laws and regulations regulating the practice of the agency and/or independent practitioner.

Could you please explain whether we can bill for TCM activities under these contracts? If so, what do we do to qualify? If not, why not?
The codes utilized by the program are defined in the contract between the agency and BHCS. Use the contract as the guide to define the services that may be billed by the agency. For programs with contracts that include TCM, they would bill most of these services under brokerage.

Is time required for Travel reimbursable for the Mental Health Services (individual, Family & Group Therapy)?
Travel and documentation time is considered a portion of the service being provided. Therefore, if a provider travels to the client location and the client is not present, then no service is provided and no time is billable. No Show's are not billable to Medi-cal or Medi-cal recipients.

Please give an example of Mental Health Services that would constitute telephone services with significant support persons – how is this different than collateral?
It is collateral and collateral is defined under MHS.

Can I bill when I'm discussing my client's progress on their treatment plan with my supervisor or peer consultant?
Plan development may be billed when the service provided has the primary purpose of meeting the beneficiary's needs. It may not be billed for staff development, clinical supervision hours or casual conversations with no clear objective (casual conversation).

In billing for "Assessment," does there have to be client contact, or can this include paperwork/formulating diagnosis, etc.?
A best clinical practice is that a portion of the assessment must be face-to-face contact with the client. "Paperwork in itself is not a billable service, but documentation time and diagnostic formulations may be billed as a portion of the assessment service being provided.

If contacting a "collateral" person for purposes of assessment, do you bill for "collateral" or "assessment?"

The provider may bill either assessment or collateral in this situation as long as the documentation justifies the service. Both assessment and collateral are MHS and reimbursed at the same rate.

What is the code number for "Targeted Case Management?"
BHCS defines TCM as brokerage (CODE=361)

If two staff members (clinicians) are working w/client during same hour/for ex. w/family TX, or med support, etc, can both clinicians bill for one same client for that full hour? This is not considered "double billing?"
If the service provided by multiple clinicians is clinically justified and primarily meets the needs of the beneficiary (not intended as staff/intern development), both providers may bill it. The clinicians must both be eligible to provide the service.

> Example of Group Notes: (provided by training participant):
> On the note, they just need to put staff names (or staff numbers) of people leading the group – not just staff present in the room. They (co-staff) must be qualified to lead group on their own.
>
On the note They enter:	John Smith	90 min
	Tina smith	60 min
	# In group	6

> The INSYST system will do the math.
> John's minutes are longer because he did the documentation for all 6 kids.

If a clinician does a crisis intervention, for example, a suicide assessment w/a student, and the student is then 5150'd, can the clinician still bill for services ("crisis intervention") done that day? (I understand once in hospital, clinician can not bill.)
The lockout for hospitalization does not include the crisis intervention services provided on the day of admission. In this case, it appears the documentation would reflect the disposition of inpatient referral. Once the client is admitted, these services are no longer billable.

Must the HIPPA form be signed by a witness if it is mailed to parent/client's home and not signed in presence of program staff?
Refer to the specific agencies policy on HIPPA implementation.

Day Treatment regulations (DFMH 03) require weekly summaries of the client's progress, goals met, etc. Where should the weekly summary be located? At the end of week's Daily Notes or included in the Mental Health Progress notes?
The regulations do not address the structure of the clinical record. The program is required to have the documentation, but the location in the record is at the discretion of the program.

Destiny, PALS, and Safe Passages charts-which CQRT meeting do they go to?

Project Destiny clients in most cases are receiving additional services by other providers (i.e. Med monitoring, Day Treatment, family or individual work, residential, TBS or other services). Should Treatment Plan/progress notes always include evidence of collaboration with collateral providers? YES.

Do all TP have to be signed by the clinician's clinical supervisor? If the clinical supervisor is the treating clinician, who signs as the supervisor?
Medi-cal regulation requires the treatment plan to be signed by a LPHA. For authorization purposes, BHCS requires the licensed supervisor to sign the treatment plan. The clinical supervisor and LPHA may be the same person, if allowed by the provider organization.

Do supervisors always co-sign for waivered or unwaivered staff?
This is an issue that is governed by the licensing laws for licensed registered/intern and waivered staff. BHCS doesn't regulate the issue, but does require programs to be adherent to all laws and regulations. These providers should be full informed of the requirements for their practice.

What if a chart is due, but doesn't make it to CQRT on time?
The period of time without the required authorization will not be retro-actively authorized and therefore will not be billable.

Does the time frame of "due date but no more tan 14 days prior to the due date" apply to the initial documentation (TX Plan, Assessment) or only to the updates and anniversary dates?
It applies to the **re**-authorization date. The initial authorization allows 30 days from opening episode to complete and sign the treatment plan.

Does the HIPAA form/consent need to be signed and dated on the same day as the episode opening or is there a timeframe to work with (i.e. w/in lst 2 weeks of opening case)?
HIPAA practices are determined by the specific agency. The best practice is that HIPAA notices be provided at the onset of service delivery.

Can day TX provider bill separately for crisis intervention service which falls outside of day TX hours – similar to family TX provision?
The contract between the program and ACBHCS determines which services are being purchased from the program. Refer to the agency contract for guidelines.

What counts as observable/quantifiable goal?
Can the clinician observe and define the goal? Make the goals as specific and measurable as possible. It is the responsibility of the program and director of services (licensed) to assure the treatment plan is consistent with Medi-cal requirements.

How specific do interventions need to be?

Define the level and type of intervention. For example, individual psychotherapy (group therapy code) or group psycho-education groups (group rehabilitation code). The practice approach, theory or philosophy of the provider does not need to be addressed in the beneficiary record. There MUST be a link between the intervention in the progress note and the planned intervention in the treatment plan.

What's the best way to correct notes to TX plan?
The best practice for making a correction to a medical record is to mark through the words once, initial and date. Then, continue writing the note.

When researching new service providers ___ are being identified such as job program or karate classes, can we bill under Brokerage when it is directly attached to clients needs?
Staff and program development, including research, are not billable services.

When sexual or physical abuse is referred to in a treatment plan, is there any requirement in documenting that CPS was contacted, even when report is historical?
It is the responsibility of the provider and program to be adherent to all laws governing provider-reporting requirements. The best practice is to fully document any and all communications related to the CPS reporting. CQRT chairs and members are licensed, registered and waivered LPHA's and are governed by the same reporting requirements. Therefore, the best practice for reviewers and chairs is to assure the reporting of any and all knowledge they have regarding critical incidents (abuse/violence/threats).

On the progress note [presented in the training], it states we should put stability rating each month – where does it go? What would that look like?
This is a template document and the rating system is a condition of the author. The rating system is not a requirement of BHCS.

Lockouts of Targeted Case Management: When client is in a psychiatric hospital, can we bill Brokerage for discharge planning? (Ex. discuss with hospital staff, client and his family Re: discharge plan). I believe I used to bill.
According to the regulations, CM/brokerage for the sole purpose of placement coordination may be billed during the 30 days prior to the day of discharge.

How long is the HIPPA Consent for Services, Special Needs, and Consent for Meds – Forms when "partner/caregiver" consent signature valid? Required for re-auth? 1 year, 2 years? Put answer on web site.

The ct (15 y.o-MS) went to SF where he was arrested and kept at the Juvenile Hall more than 3 weeks. Can LSW bill for following the court hearing due to the ct's mother being monolingual and disabled. Case management? Crisis Intervention?
Based on current information, when the client is in criminal justice system facility, services may be provided, but may not be billed to Medi-cal.

Format for developmental history.
There is not a required standard for the developmental history, but it should be comprehensive and be consistent with community standards.

Is it a requirement to write notes in BIR format (behavior, intervention, and response?
No. It is only a requirement that programs meet the general documentation standards as outlined in the regulations.

Is conduct disorder approved as primary diagnosis?
Yes. CCR Title 9 1830.205

Is adjustment disorder approved as the primary focus for day treatment?
Yes. CCR Title 9 1830.205. It may be if the impaired functioning resulting from the disorder meets the service necessity requirements for day treatment.

Can it be primary for outpt/ If so, is there a time limit it can be primary?
Adjustment disorder is a clinical issue and is not governed by regulation. Clinical judgment will determine if the symptoms of Adjustment Disorder exist and therefore, billable under that diagnosis. Adjustment disorder is a specific diagnosis and all criteria must be met to diagnosis this disorder. Any utilization of the diagnosis without the criteria being met is not sound clinical practice.

Will there be a meeting to address specifically about the audit?
Once additional information is obtained from the State, Children's Operations will hold a meeting for agencies.

Can this [treatment plan] be on a separate page if the TX plan goals are re-written in layman's terms?
It is encouraged that the treatment plan be written in lay terms that the beneficiary may read and not the language of the providers. There should be no need to have a separate page.

Can you have a v-code as primary diagnosis for the first 6 months of TX?
Although, V-code may be the appropriate diagnosis, they are not on the list of acceptable diagnosis for Medi-cal billing. They are not billable and will not be accepted in the PSP system.

Please provide written definition of Crisis Intervention for a Residential, b) non-Residential.
The definition for crisis intervention is the same regardless of the setting. According to the regulations, "crisis intervention means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. A lock out for crisis intervention is admission to crisis residential treatment services. The utilization of crisis intervention in a residential setting is not

intended to be a substitute for crisis residential services. Therefore, the utilization of crisis intervention should be brief and not a regular pattern of billing by a residential site.

What exceptions are there to "deficiency" in re: Quality Review (i.e. Special Needs?)
This question is not fully understood. As for the CQRT, all requirements on the re-authorization form are required. If there are deficiencies, then the CQRT chair may return the chart for correction.

It is true that if the primary diagnosis changes, a new treatment plan must be written?
If there is a significant change to the plan, service, diagnosis, problem or focus of treatment, then the plan should be revised. Depending on the situation and clinical judgment of the beneficiaries needs, the treatment plan would contain an addendum or a new plan will be initiated.

If we see a child during the year – school year ends, we know we are going to see in next year should be close the episode and open again for the new schOr just leave open?
In general, it is a best practice to close it when the last service provided, but in special situation when you expect the client to return in less than 1 year, the episode may remain open.

Will there be changes in the database to make it more compatible for the 0-5 population? Or will we need to continue to crosswalk? At this time, the existing database does not have the capacity to address this issue.

In an audit of a chart of a ct that has been in the system for several years (i.e. 1998-2004 current) will the entire chart be evaluated according to current regulations or only from the time new regs came into effect. Could sessions in past (before regs in place) be disallowed?
In general, audits are pre-planned and a specific period of time will be reviewed. Included in that period of time is any and all documentation that supports that period of time (i.e. Treatment plan and forms). In special situations, the reviewers may elect to expand the scope of the audit. The regulatory agency has the discretion to set these limits.

If milieu staff is documenting in <u>daily</u> notes the clients' participation in skill building, adjunctive and process groups, is it necessary for the <u>weekly</u> summary to also include progress in these groups/areas as well?
Although it would be a sound practice, it is not required.

Can TBS services be documented through a separate section in chart? (I.e. separate TP?) Or does Day Txt TP have to be changed/updated when TBS is added?

We have cases where we are providing therapy at school and there is another outpatient therapist providing services elsewhere. We collaborate with them and

clarify the different focus of therapeutic work in each case. Is this OK and adequate for clarification?
Yes, if the service meets the medical and service necessity criteria as outlined in the regulations. The continued collaboration and documentation of the collaboration is strongly encouraged.

What if parents are mono-lingual, therapist is bi-lingual, and forms are not all translated into parent's language?
It would be expected that the therapist or other staff would read the documentation to the beneficiary and document the special circumstances.

Can a client in the In-Home services Program that is currently receiving individual therapy in our Core Program, continue receiving individual therapy? Also, if so, my understanding is that he would be included within the primary program which in this case would be In-Home Services. My understanding was that the individual therapy would be billed through In-home services. Is that correct?
In order to self refer between programs within an organization, prior approval must be obtained by BHCS The service would be billed under the program under which services are provided. As always, documentation of collaboration to reduce duplication of services is needed.

Are there specific procedures for authorization of additional session for those in crisis? This would not be crisis intervention, but rather after, when it is medically indicated, such as in cases of recent hospitalizations, suicide threat or self-destructive behavior, severe depression or psychotic symptomatology. I am assuming we provide the necessary sessions, document the medical necessity in the Treatment Plan and bill accordingly. Any questioning would go through the Quality Assurance/Peer Review process.
There is no additional authorization process through BHCS. Qualified staff must exercise judgment under Medi-cal regulations in determining medical and service necessity for crisis intervention. As with all cases, documentation is required. If it isn't documented, then it didn't happen (or medical necessity wasn't determined).

We have still not received clarification regarding how to bill family therapy? Under individual?
At this time, there is not code for family therapy. Therefore, bill it under "collateral".

Is the signature of licensed psychologist to be followed simply by Phd/PsyD or does it need to include type of license and number?
The best practice is to include the license of the provider. It is not the degree, but license that qualifies this type of provider t practice. If there is no, then they may qualify under the MHRS category of staff.

Does the name of the therapist need to be typed under every Progress Note or is it sufficient for it to be included in the upper right hand box where client information

is included? A related question is whether we can add information in that box such as name of licensed supervisor who is countersigning.
The legible signature/credentials of the provider and co-signer must accompany each progress note.

When we open up the new files under EPSDT and organizational provider status, can we bill the time taken to complete that transition activities including completion of Initial Assessment Summary and Ds and Treatment Plans forms? I'm assuming we can, and that it would be billed under Assessment, but I would like confirmation of my interpretation. The direct services billed must have occurred following the contract date with BHCS. Documentation time may be billed as a portion of the initial service provided. If you are completing the new paperwork in combination with developing the treatment plan under EPSDT, then utilize "plan development" code.

County BHCS criteria for participation in our EPSDT programs is that child be a Alameda County CFS client, or have been adopted through the County Social Welfare System in the case of the Post-Adoption Program, and be Full-scope Medi-Cal. Is that correct?
The contract criterion is that the client must be full scope Medi-Cal. You can verify Medi-Cal on either the automated eligibility voice system or the internet.

What exactly does the Opening Episode date refer to? Is it the date of the referral? Is it the date of the first visit? Or is it the date the registration information is entered into the computer?
The Open Episode date is the first service date. This can be a direct service or an indirect service. You will not be able to post a service prior to the Open Episode date. This date also triggers the timing date of the clinical review with CQRT.

In cases where Opening Episode has been entered, but case was closed without any service or it was determined that child is not eligible (e.g., is from out of county), can we just delete it, or do we have to close the episode, even if we have not seen the client or billed anything?
Close the episode in the system.

Does the thirty days for completing the Assessment date from the Opening Episode date or from the first date of service (date first saw client), if they are not one and the same?
I believe it would be 30 days for the first date of service

Is the PSP # the same as the client # on the document forms?
The PSP/InSyst number is the client account number

Is there a cut off date when billings can no longer be submitted for payment? The question arises because under our previous contract, we had to bill a service no later than two months after it was provided.

You are expected to input services for the month by the third working day of the new month. You no longer have a 60 day billing cycle.

What is the service code for family therapy? We already asked that question at the documentation training in May, but have not yet received an answer. Collateral is the currently used code for family therapy. However, as of July 1, 2004, in accordance with the Day Treatment Guidelines sent to Day Treatment Provider agencies, two new Family Therapy codes will be available for use. Initially the codes will only be available for use by Day Treatment providers as it is one of the services billable in addition to Day Treatment. The decision to use the codes in outpatient settings is being discussed in BHCS administration. The codes are Family Therapy 318 (non-AB3632) and Family Therapy 319 (AB3632).

Is there a service code for case consultations? Or how do we bill for them?
When the qualified provider consults with another qualified provider for the primary purpose of supporting the specific beneficiary, then plan development may be billed. Clinical supervision for the primary purpose to satisfy licensure and program requirements (i.e. staff development) is not billable. Do not bill for time spent in clinical supervision.

If the child is receiving two types of treatments simultaneously (e.g., individual and group or family, or is receiving in-home services as well as individual at the center, do treatment plans need to be developed for each modality, or do we prepare a unified treatment plan?
In general, programs are required to complete the full documentation, as required by Medi-cal) for the beneficiary under each RU/program. The treatment plan must be specific to the services provided under the billed RU/program. If the multiple services are provided under one RU/program, then the minimum requirement is to complete one set of documentation. The progress note entries for each type of service should be connected to goals and objectives on the treatment plan.

If a client's chart is open at a site to Day Treatment and Project Destiny with the same episode opening month or admit date and the chart is combined (both services are documented in one chart), how is this indicated on the CQRT form when the chart is due for review?
Because the
Complete one CQRT form for each service reauthorization requested (i.e. one for Day Treatment and one for outpatient services). This will minimize the CQRT peer reviewers' confusion about what services they are reviewing and keep the authorization cycles on their respective timelines, since outpatient is reviewed every 6 months and intensive day treatment every 3 months.