WELCOME!

Alameda County Behavioral Health Care Services

Quality Assurance Office

Medi-Cal Documentation Training

(updated 12/22/10)

Content Disclaimer

- General Overview: Non-exhaustive list of rules & regulations.
- Primary authority: Provider contract with ACBHCS.
- References: Title 9 and MHP contract with DMH.
- General rules & regulations do not permit any person or agency to provide a service for which they are not authorized to provide by licensure or contract.
- Attendees must ensure the application of these rules within their organization's practices.

Types of services NOT discussed in this training:

- Medicare (separate training)
- Residential
- TBS
- Crisis Stabilization/Emergency Room
- Hospitalization/Intermediate Care
- Medi-Cal Administrative Activities (MAA)
- MHSA/FSP Service Codes

Training Agenda

1. Medi-Cal Documentation Basics
   - Informing Materials, Medical Necessity & Service Necessity
   - Definitions of Specialty Mental Health Services & Non-Billable Activities
   - Entering Services for Reimbursement

Break

2. Documentation Rules & Clinical Documents
   - General Documentation Standards
   - Assessment, Client Plan, ACFE, & Discharge: Timing & Requirements
   - Progress Notes: Requirements, Co-Staffed, Samples per Services

Q&A, if there's time

3. Optional & if we have time... Goals, Objectives, and Interventions: A Way to Use Them

FYI: Please review last section about CQRT on your own!

Alameda County Behavioral Health Care Services

1. Medi-Cal Documentation Basics

Good things to keep in mind:

- You are employed by the County or its contracting agency to provide mental health services billable to Medi-Cal.
- Medi-Cal is a Fed/State funded, County-op insurance program
- Insurance programs must inform its beneficiaries of their rights.
- Insurance programs have rules about:
  - what services they'll pay for & how to document those services.
  - how to prove that those services were appropriate for the beneficiary.
  - how to prove the services were actually provided.

This training addresses how you prove that your services meet these rules.

Informing Materials Packet: Notifying Clients of their Rights

In 2010: "Informing Materials Packet" was sent to all providers, with memo to explain how providers are now required to use this packet in place of previous BHCS forms (see QA tab at Providers website).

- Contains up-to-date BHCS documents regarding client rights (e.g., Consent to Treat, Freedom of Choice, HIPAA, etc.), per State/Federal requirements.
- Simplifies review with clients at admission & required offering to all clients for annual review.
- Single signature page requires only 1 signature by client & clinician for all materials; Multiple spaces for 'client initial/date' to prove annual review offer to clients.
- Before distributing to staff for use, PASSWORD PROTECT the document!

Informing Materials Packet, Cont'd.

Not Included in the Informing Materials Packet:

- BHCS items *required* to be posted or available in lobby for client review
  - "Complaint poster"
  - "Guide to M-C MHS"
  - Current Provider List (updated quarterly www.acbhcs.org/providers)
  - Grievance/appeal forms & envelopes
  - "Member Handbook" pamphlets in 8 languages

  (Tip: Put the "Guide" and Provider List in a binder indicating those items are available upon request.)
- Provider's *required* written policy about confidentiality of records at their site

4 Reasons to Document What You Do & Use Correct Service Codes

- Supports quality care
- Supports continuity/coordination of care
- Basis of billing (simply required for payment!)
- Protection against audits & malpractice

Medical Necessity Criteria
Proof of "Appropriate level of care"

Providers MUST document the following:

1. "Included" DSM diagnosis (see MN handout) that is supported by chart documentation – description of client's mental health presentation must all 'hang together'
   - An "excluded" diagnosis may be addressed, but may not be Primary (Primary = "included")
   - Specify symptoms & behaviors meeting DSM criteria of each diagnosis that is a focus of treatment

Medical Necessity Criteria

2. Impairment in life functioning exists & is a result of an included DSM diagnosis:
   - Describe the impairments to life functioning (aka client's mental health barriers to reaching their life goals)
   - Indicate how the impairment/barriers are related to included diagnosis
   - Don't assume that a valid diagnosis = impairments!
     - And don't assume that you can't address client strengths just because you also address mental health barriers!!!

Service Necessity Criteria
Proof of "Appropriate level of service"

3. To meet Service Necessity:
   - Services (therapy, rehab, etc.) must address the functional impairment resulting from the primary included diagnosis.
   - Services are expected to diminish or prevent impairment OR allow appropriate development.
   - The condition would not be responsive to physical health care treatment.

   Also:
   - The condition could not be treated by a lower level of care clinician and/or provider agency.
   - If more than 1 staff provides the same service at the same time, must identify the unique contribution for each staff (suggest within pertinent Progress Note).

Medical & Service Necessity Criteria -- EPSDT ONLY (under age 21)

If a youth does not meet the functional impairment criteria for medical necessity, the services provided must correct or ameliorate either:

- a documented mental illness or condition

Or

- the documented risk of developing a mental illness or condition, or of not progressing developmentally as expected.

(EPSDT clients must still have an “included” diagnosis.)

How to Document Medical & Service Necessity

- Initial Assessment establishes medical necessity for services
- Initial Client Plan builds on the Assessment:
  - Establishes client's goals & mental health barriers to achieve them
  - Identifies mental health objectives, per barriers
  - Identifies MHS & clinician interventions to address barriers
  - Licensed signature attests that MN/SN are met
- Ongoing Client Plans serve as progress reports & support ongoing MN/SN.
- Progress Notes - EVERY ENTERED SERVICE MUST MEET MN/SN in the corresponding progress note. You attest that this requirement is met by entering the service for reimbursement.

Documenting Medical Necessity – Special Considerations

- If Mental Health Services, other than Assessment, are provided before the Initial Assessment is completed, MN rationale for each service must be in 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.

What Medi-Cal will Pay For: Types of Specialty Mental Health Services

(including, but not limited to...)

Planned Services:

A. Mental Health Services
- Assessment
- Collateral
- Plan Development
- Rehabilitation (Ind./Group)
- Psychotherapy (Ind./Group/Family)
- Evaluation

B. Case Management/Brokerage

C. Medication Support

D. Psychologist Services*

E. EPSDT Services*

F. Day Treatment*

*Documentation of these services is the same as for A-C.

Unplanned Services:

Crisis Intervention

Specialty Mental Health Services
A. Mental Health Services Definition

Mental Health Services are a subset of Specialty MHS & are interventions designed to provide the maximum reduction of mental health disability, and the restoration, improvement or maintenance of functioning.

These services are directed toward achieving the *individual's* goals and desired milestones.

Types of Mental Health Services

1. Assessment
2. Collateral
3. Plan Development
4. Psychotherapy (Individual/Group/Family)
5. Rehabilitation (Individual/Group)
6. Evaluation (used only for Annual Community Functioning Evaluation, Youth Performance Outcome & FSP data)

Note: Day Treatment Intensive/Rehab are "bundled" services including all of the above, unless provided outside of the day treatment timeframe.

1. Assessment Services

Assessment is a service activity to gather & document a collection of information about the history, current status & factors impacting a client's mental health (think about co-occurring conditions!), in order to determine medical necessity & facilitate treatment planning while beginning to develop a staff-client partnership toward health.

- No "cap" on Assessment services in order to determine MN.
- Once MN is established & the Initial Assessment completed, Assessment services may be provided later to clarify diagnoses or if a client's clinical presentation needs to be re-evaluated.

2. Collateral Services

Collateral is a service activity with a client's significant support person(s) in order to improve or maintain the mental health status of the client.

- Who is a Significant Support Person? Any person identified by client or clinician who has or could have a significant role in improving the client's mental health condition.
- Client doesn't need to be present for Collateral services.

Also Collateral: Consultation with someone outside a program's treatment team to discuss a client's treatment (gathering information for treatment planning purposes).

3. Plan Development Services

Plan Development services are any activities related to development & approval of Client Plans, and/or monitoring a client's progress toward Client Plan goals & objectives.

Consultations/discussions about a client's treatment among team members are billable as Plan Development ONLY when:

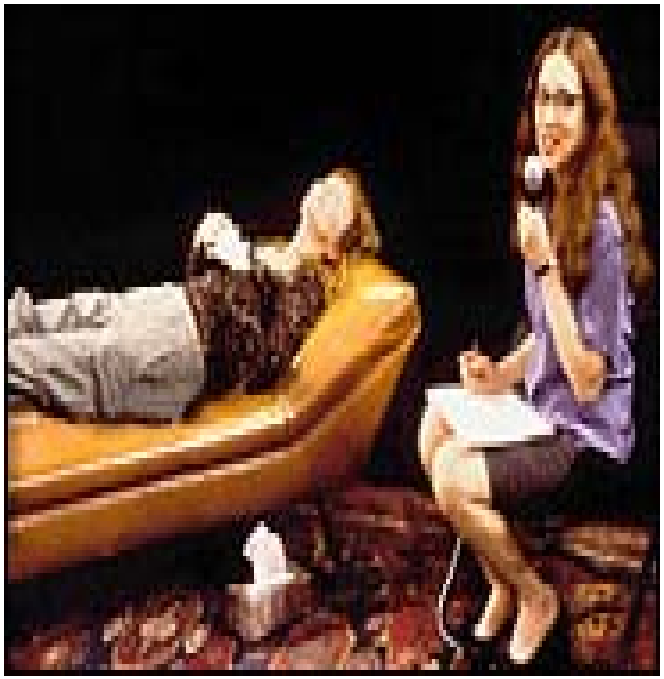
- driven by the client's mental health needs, or
- driven by staff need to review progress toward MH goals/objectives

Therefore, team consults are non-billable if provided in order to meet:

- Agency's needs (peer review, incident debriefing)
- Staff clinical supervision requirements
- Staff development needs

4. Psychotherapy Services

Psychotherapy is a service activity with interventions that focus primarily on *symptom reduction* as a means to improve functioning, via exploration of intra- & interpersonal processes.



Types: Individual / Group / Family

5. Rehabilitation Services

Rehabilitation services help improve, maintain or restore clients' support resources & functional skills (e.g., social, daily living, hygiene).

May include counseling, psycho-social education, informational support, medication education, etc.

Scope of practice & Rehab:

- "Counseling" is psychosocial education. *It is not Therapy.*
- Medication education supports compliance. *It is not prescribing, dispensing or distributing medications.*

Types: Individual / Group

Specialty Mental Health Services

B. Medication Prescribing Services

Medication Prescribing Services are to prescribe, administer, dispense and monitor medications that are necessary to alleviate symptoms of mental illness.

Includes evaluation of the need for medication, side effects & effectiveness; obtaining informed consent; medication education and plan development *related to the delivery of the service and/or assessment of the client.*

Services are provided by staff who are practicing within their scope of practice.

- Documentation guidelines for Medication Prescribing are on the BHCS website under Office of the Medical Director.

Specialty Mental Health Services

C. Case Management/Brokerage

Case Management services help clients to access medical, educational, social, vocational, rehabilitative or other community services that are identified as needed in the Client Plan or Assessment.

Service activities may include, but are not limited to:

- Communication with client & significant support persons
- Coordination of care
- Referrals
- Monitoring service delivery to ensure client's access to services
- Monitoring client's progress toward making use of services

When a CM service includes plan development or collaterals, may document as part of that service, or split into separate services/PN's.

Specialty Mental Health Services – Unplanned

Crisis Intervention

Crisis Intervention is a service lasting no more than 8 hours in a 24-hour period: Immediate response to client's acute psychiatric symptoms in order to alleviate problems which, *if untreated, would present an imminent threat* to the client, others or property. Purpose is to stabilize the client.

Service activities may include, but are not limited to: Assessment, Collateral, and Therapy.

(Crisis Intervention is not the same as Crisis Stabilization which requires different eligibility/certification.)

DO COORDINATE CARE!!!

Document what others are providing to increase clinical efficiency, increase clinical effectiveness and decrease claiming risks.

Collateral calls to coordinate treatment with another provider is “best practice” and a reimbursable service!

Avoid Duplication of Services

If different providers are doing the same service:

- They may not duplicate the focus of the services;
- There must be a clearly documented rationale for why the same service is being provided in each provider's Client Plan; and
- The Plan delineates clinician responsibilities.
- Best Practice: Client Plan Objective for coordination of care (for TBS client, this is required).

Examples:

- Social Services CM and Mental Health CM.
- School-based individual therapist and outside mental health agency individual therapist.

What Medi-Cal won't pay for!
Non-Billable Activities (including but not limited to...)

Lockouts:

- Client incarcerated.

  Exceptions:

  a) *Adjudicated* youth in Juvenile Hall (awaiting placement only – get proof of placement order!); or

  b) On day of admission.

- Client inpatient psychiatric (hospital, IMD, psych SNF).

  Exceptions:

  a) On day of admission;

  b) Case Management only for discharge planning.

Doing FOR client:

- Personal care activities (e.g., child care, cleaning, meal prep, shopping).

What Medi-Cal won't pay for! Cont'd.

Reports/Forms: Some are billable, some are not.

- Non-billable: Reports/forms completed for purposes *other than* to determine medical necessity or for treatment (e.g., CPS/APS report, Court-ordered report, SSI application).

- Billable: Reports/forms completed that are:
  - a) noted as utilized *for treatment purposes* (e.g., Social Services/Court-ordered "Treatment Updates"); or
  - b) noted as a *mental health intervention* (e.g., CPS report made with client; help reduce client's anxiety re. SSI app as they complete their portion; para-transit app done as a CM).

What Medi-Cal won't pay for! Cont'd.

Non-mental health activities:

- Solely work, educational, recreational & social activities
- Solely clerical activity documented (fax, voicemail, email)
- Solely payee, transportation or interpreter services

  (FYI: Providers may not give illegal reason for payee requests! e.g., for purchase of illicit drugs)
- Prep time for services (e.g., set up room, copy handouts, research activities, etc.)
- Staff processing/debriefing time in preparation for or after a service (e.g., co-staffers decide roles/activities for the day, process group dynamics afterwards, etc.)
- Utilization Review/CQRT activities

Less than InSyst minimum of 5 minutes

Entering Services for Reimbursement: Per Minute or Per Day Service Units

The following services are documented & entered for reimbursement on a "per minute" basis -- the exact number of minutes used by persons providing a reimbursable service:

- All Mental Health Services (Assess/Collat/Therapy/Rehab/ProgDev)
- Case management
- Medication Support
- Crisis Intervention

The following services are documented/entered as half- or full-days:

- Day Treatment Intensive
- Day Treatment Rehab

- Billing is related to the service provided, not staff qualifications.

For Per Minute Service Units ONLY: Documentation & Travel Time

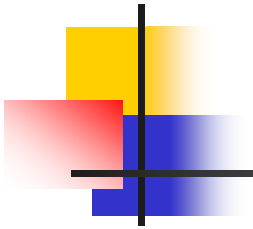
Time for documentation of a service and travel to/from providing a service are billable **when part of a reimbursable *per minute* service**.

- If travel to meet client, but client wasn't there, documentation & travel time are not billable.
- If the activity itself is not billable, then documentation & travel time are not billable.
- Non-billable: Travel time to/from home; Travel time between provider sites (site w/ provider number, including affiliated satellite & school site operations).

Entering service time

Total Time: Add up service time + documentation time + travel time.

If travel time is significantly longer than the actual service time, please indicate the Face-to-Face time vs. Total Time on the Progress Note (e.g., Face-to-face 30 min./Total 180 min.).



Do we need a break?!?

General Documentation Standards

- MUST BE LEGIBLE (illegible signatures may not pass audit; suggest typed name/licensure under sig. line or “signature page”)
- Use only ink (black is still the standard, but not required)
- Every page must have some form of client ID
- Don’t leave blank areas on forms (indicate “n/a” or “none”)
- No post-it’s or loose papers (can staple)
- Only County-designated acronyms (www.acbhcs.org/providers)
- No names of other clients in charts. Consider confidentiality when using family names.
- Don’t “rubber stamp” your writing! Tailor it to changing needs of individuals.

General Documentation Standards, cont'd.

- All staff entries require a "complete signature".
  - Includes date. (Exception: When progress note date of service is same as date written.)
  - Includes licensure, degree or job title. *If licensed, must use licensure with signature.*
  - End entries with a drawn line to indicate nothing was added post-signature. (n/a for electronically signed entries)
- Addendums/notations: Include dated initials or signature when adding information.
- Errors: No correction tape/fluid. No scribbling over errors! **Do** draw one line through error & initial (don't write "error").
  - Only original authors make edits. Reviewers or supervisors DO NOT edit original authors but may add addendum.

“What types of clinical documents do I need to create for each client?”

1. Initial Assessment
2. Client Plan
3. Annual Community Functioning Evaluation (ACFE) (n/a for some programs)
4. Discharge Note/Summary
5. Progress Notes

1. Initial Assessment: Timeliness & Frequency

- Initial Assessment is due within 30 days of episode opening date ("loose" count of 30 days is okay).
  - Example of "loose": EO date 3/14/09; Assessment done by 4/14/09. ("Strict" 30 day deadline = 4/12/09, also okay but requires counting!)
  - Exception for FSP & Identified Brief Service Programs: Complete within 60 days of EO date – always "strict" count of 60 days.
  - For all, 30/60 day timeline is per EO date, not per 1st client face-to-face!

- Completed by LPHA or board-registered interns (co-signature not required, but see next slide re. establishing diagnosis).
  - Other staff may gather assessment information

- Alameda County does not require an annual assessment – instead, Client Plan includes key assessment items related to client risk and/or that may require updates.

Initial Assessment: DSM Diagnosis

Diagnoses must be established by licensed clinicians.

- In diagnosis area, provide name/licensure of person who established the current diagnosis (not signature).
- All 5-axes must be documented (must "crosswalk" to DSM).
- Axis I or II: First-listed diagnosis must be the primary focus of treatment ("included" diagnosis only).
  - Insyst accepts Deferred Dx to open episode; must update to "included" diagnosis at 30 days, if will provide treatment.
  - Insyst accepts No Diagnosis to close episode, if no MN found.
- Axis III: May be documented by non-medical staff. Indicate source (e.g., Per client, referral document or clinician observation; See progress note on x/xx/xx of PCP collateral; etc.).
- UPDATE THE DIAGNOSIS IN INSYST whenever it changes!!! Deferred/Provisional = 6 month limit unless explain.

Initial Assessment: Required Contents

CBO's must ensure that their templates contain at least this information. Will be notified when BHCS template is updated.

- Identifying Information
- Client Strengths & Supports
- Risk Situations
  - Address risks in Client Plan
- Presenting Problems
- Self-Identified Culture & Gender Needs
- Language/Communication Needs
- Co-Occurring Conditions, such as Substance Use – History/Last use
  - Include nicotine, caffeine, Rx, over-the-counter
- Medical/Health, Medication, Mental Health and Social Histories
  - Allergies (any kind) or lack thereof. Note prominently on outside of chart.
- Relevant Mental Status Exam
- Medical Necessity Items
  - 5-Axis DSM Diagnosis (see next slide)
  - Identify functional impairment
  - Identify basic service needs, including mental health

<u>For Child/Adolescent</u>

- Developmental History, including pre/perinatal history (document attempts to obtain info.).

<u>Best Practice</u> (not required at this time): Clinical analysis/formulation clearly indicating MN with description of mental health barriers to achieving client's goals. (May be in Client Plan instead. Good place to note "Stages of change.")

2. Client Plan

Strength-based treatment planning, including creating Client Plans in partnership with clients, is considered best practice by BHCS. However… the provision of Medi-Cal mental health services must still be based on the ongoing assessment of a client's functional impairments that result from the primary diagnosis for treatment.

Client Plans: Timeliness & Frequency

- Initial Client Plan: As of 11/1/10, must be completed within 60 days of episode opening date.
  - Example: EO is 5/9/10; Initial CP done by 7/14/10. (Initial Client Plan may be completed *before* deadline.)
  - Use the MHS 485 report's 60-day prompt to avoid late Initial Client Plans!
  - 60 days = per the EO date, not per 1st face-to-face with client.

Use the MHS 485 report to avoid late Client Plans!

Client Plans: Timeliness & Frequency, cont.

- Annual Client Plans: Completed during the month prior to the episode opening month.

  Example: EO Month April = Annual Client Plans are always completed in March.

- 6-Month Update: Complete in 6th month from EO month.

  Example: EO Month April = 6-Month Updates are always completed in September.

  The MHS 485 Report gives 6-month prompts for these documents… use it!

  - FSP exception: 6-Month Update not required.

Initial/Annual Client Plans: Required Contents

CBO's must ensure that their templates contain at least this information. Will be notified when BHCS template is updated.

- Describe client's life goals, strengths & supports.
- Identify objectives to address functioning issues & mental health barriers that interfere with client reaching their life goals.
  - Objectives are measurable or observable
  - Provide current baseline as "best practice"
  - Estimated timeframes to reach objectives (revise when objectives are reached or risk disallowed services/progress notes!).
- Identify service interventions & frequency to help reach MH objectives (e.g. Group Rehab 1x/week, Medication Support 1x/month).
- "Best practice" to identify clinician's interventions to reach objectives, utilizing client strengths & supports whenever possible.

  May also identify client/significant supports tasks to help reach objectives.

Initial/Annual Client Plans: Required Contents, cont.

- Key Assessment Items (updated with each review):
  - Diagnosis
  - Risk situations
  - Client strengths & resources
  - Special needs
- "Best practice" - Coordination of Care: When applicable, include MH Objective for coordination of client's care with other identified providers.
  - *For minors with TBS, Client Plan must indicate coordination of services with TBS provider.*
- Tentative Discharge Plan.
- A way to prove that client was offered a copy of the Plan.
- Signatures (see next slides).

Client Plans: Required Signatures

All Client Plans must be signed by:

- The clinician providing & documenting the services.
- A licensed LPHA must finalize the Plan (same clinician ok)

  No longer have to sign in last 15 days of month, just within the month it's due! (tho InSyst still can't accept entry until next month.)
- If provider agency's MD prescribes psychotropic medication, MD must sign.
- The client on the Plan (more in next slide).
- The client's legal representative, when appropriate, as determined by the provider.

  Client Plan is not a legal document (unlike a consent), so does not REQUIRE client's legal rep. unless client is unable to represent self. Follow your program's rule about this.

Client Plan: Client's Signature

Client's dated signature **on** the Client Plan indicates their participation in treatment planning. Client signature is **required**, minors included if understand concept of ownership.

DMH sanctioned test to know if minor has concept of ownership: If minor knows that their "x" on a ball means it's theirs.

- If unable to obtain client signature, note why near their signature line (with dated initials). Examples:
  - "Client unavailable to sign due to current incarceration."
  - "Client signature not obtained due to her current high level of paranoia."
- If client disagrees with Plan or refuses to sign, note that.
- Note follow-up efforts (with dated initials) to obtain the signature, either on Plan or reference dated progress note that describe efforts.
- If client lacks capacity to represent self, legal representative must sign.

ANY change in planned services after client's signature invalidates the signature, so requires client & clinician re-signature!

3. Annual Community Functioning Evaluation (ACFE)

- The ACFE is completed when the Client Plan is done and annually thereafter.
- All providers are required to complete this quantified assessment of functioning.

  Exception: FSP & Brief Service programs

- Please use the Evaluation service code for this activity.

4. Discharge Note (usually non-billable) vs. Discharge Summary (may be billable)

Discharge Note: A Progress Note that includes brief documentation of the following:

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

This is usually considered an administrative activity, therefore non-billable, *unless part of a final billable service with the client present* (e.g., discussed in last session).

Note: No services are billable after a client dies, even if episode still open!

Discharge Note
vs.
Discharge Summary, con't.

Discharge Summary: A substantive document that meets the requirements of a Discharge Note *plus a summary of the following:*

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

BHCS considers this billable as Plan Development when documented to be **clinically necessary for continuity of care**.

5. Progress Notes: Documenting Interventions

Clinician interventions are your billable activities! But your agency only gets paid for those activities when they are documented appropriately in the Progress Notes.

Progress Notes are the record of all services, whether entered for reimbursement or not. A service must be documented before it can be entered into Insyst.

Does EVERY SERVICE entered for Medi-Cal have to meet medical necessity & service necessity?

Yes!

Progress Notes: Timeliness & Frequency

Services must be documented during the shift or within one (1) working day.

- Outpatient Mental Health Programs:
  - Every service contact, per minute
- Day Treatment Rehabilitation:
  - Weekly summary
- Day Treatment Intensive:
  - Daily Notes & Weekly Summary (Weekly requires LPHA sig.)

<u>Tips</u>

- Write enough to account for service delivery time. Use common sense: Brief service=brief note. Long service=longer note.
- Avoid *process* notes (purely observational, narrative content).

Late Progress Notes

- Progress Notes written after 1 working day must be labeled “late entry”.
  - Date of service delivery is noted at the beginning (e.g., Late entry for 3/3/09).
  - Signature date is the date the note is written.

- If No Note = Service may not be entered!

- If written after 3 working days into the next month:
  - Data entry supervisor must authorize entry of the service.
  - Agency may not be reimbursed until year-end.
  - Agency’s data reports may not be accurate.

Progress Notes: Basic Elements

All entries in the client record must include:

- Date of service delivery, including year
- Service code number (helpful to include service type)
- Location of service (per InSyst codes)
- Length of service (plus documentation & travel time, if applicable)
- Description of the service provided (see sample slides)
- Signature of the service provider and co-signature, if applicable (or if per agency's rules)
- Service provider's licensure (if licensed, must use this), professional degree, or job title

One Staff Serving Multiple Clients

Single-staffed service to multiple clients, or on behalf of multiple clients, at the same time (usually a group).

Progress Notes must indicate....

- Total service time (add up service time + the time it takes to write notes on all group members)
- Number of all group members (whether M-C or not)

.....so that InSyst can calculate time claimed per client.

Multiple Staff Serving One or More Clients

If multiple staff provide same service at same time to/for 1 or more clients (e.g., group service, clinical consult, etc.), Progress Notes may be done either by:

- Each staff writing their own note **OR**
- One staff writing a co-staffed note for up to 2 staff.
  - (Insyst limits 2 staff per note, so if more than 2 staff provided service, the "leftover" staff have the same two options above).

Co-Staffed Progress Notes: Decide which staff writes notes

- Writer is "Primary" Staff
- Non-writer is "Co-Staff"

(see next slides)

Progress Notes Content: Group Services (Therapy or Rehab)

Must write a Progress Note for each Medi-Cal client!

Required for Insyst's calculation of billable time:

- Total number of all clients (including non M-C clients)
- Total service minutes (group time + time to write all clients' notes)
- If applicable, co-staff name & staff #, their total service minutes (and their unique role/contribution, if not in Client Plan)

Progress Notes Content:
Group Services (Therapy or Rehab) con't.

Progress Note Content:

- Brief statement of group's mental health goal
- Relate the service to Client Plan Objectives
- Report on client's group interaction & involvement
- Describe staff interventions & client's responses
- Identify follow-up plan

Sample Progress Note: Group Therapy

- 7/7/10
- Primary Staff: 116 min. (FYI: 60 min. group + 56 min. @ 8 x 7 min. each)
- Co-staff: J. Tzudiker, MFT #007, 60 min. To maintain optimal client/staff ratio for clinical interventions.
- 8 members
- Location code xx
- (351) Group Psychotherapy
- Objective #3: "Improve ability to tolerate & increase social contact."
- Group Focus: Practice social interaction via role play
- Client participated in social situation role-plays with peers though initially anxious, distractible & unable to sit calmly. Said she enjoyed the activity & that it helped to reduce some anxiety at even the thought of socializing more. Also participated in group exploration of feelings during role plays & able to identify increased anxiety when talking with males. Co-staff & peers normalized that (given her history of interacting with males) & provided support.
- MB will attend next week's group.
- B.B. Wolf, MFT

This note describes behaviors/interventions related to process.

Sample Progress Note: Group Rehab

- 6/25/10
- 123 minutes (FYI: 60 min. group + 63 min. @ 7 x 9 min. each)
- 7 members--1 staff
- Location code xx
- (391) Group Rehabilitation: Improving Social Skills
- Objective #2: "Improve ability to tolerate & increase social contact."
- Group Focus: Practice social interaction via role play
- Client participated in social situation role-plays with peers though she was initially anxious, distractible & unable to sit calmly. She said she enjoyed the activity & that it actually helped to reduce some of her anxiety at even the thought of socializing more. Was able to identify increased anxiety when talking with the opposite sex which other members validated. I offered stress-reduction techniques to use in these situations & client said she'd think about trying to use them, but did not commit to practice.
- Plan: Client will attend group next week.
- Hans C. Anderson, Rehab Counselor

This note describes behaviors and interventions that focus on skill building.

Progress Notes: Collateral Service

If the collateral is with another professional, specify the contact person's name & relationship to client.

- Relate service/intervention to Client Plan Objectives
- Describe staff actions
- Describe collateral person's responses, if applicable
- Provide any relevant clinical decisions
- Identify follow-up plan

Sample Progress Note: Collateral

- 6/21/10
- 12 min.
- Location code xx
- (311) Collateral
- Objective #2: “Stay in current residence for next 6 months.”
- TL’s mother called to say she’ll move to Nevada next month. As his major support, she’s worried about his ability to “keep it together” when she leaves. Suggested she meet with TL & his care team to see how we can each support him in this transition. She’ll call the CM to set up the meeting & I agreed to be present.
- Freudian Slippers, PhD.

Progress Notes: Plan Development

Document how the service either:

- Meets the client's mental health needs,

  OR

- Meets the need for treatment planning (if worked on a Client Plan, provide the Plan's start date).

- May no longer "roll" Plan Development into another Mental Health Service when provided on the same day to the same client. Instead, write a separate Plan Development progress note for that amount of time. *(New rule from Provider Relations due to SDII transition.)*

Sample Progress Note: Plan Development

- 7/1/10
- 60 minutes
- Location code xx
- (581) Plan Development
- Objective #N/A: Client Plan revised
- Met with client to review his Client Plan & create Annual Plan. He identified his goals for the coming year. See Client Plan dated 7/1/10.
- Jack N. Jill, BA, Peer MHS

Progress Notes: Plan Development Team Consultations

Team consultation progress notes :

- Only the minutes spent discussing a particular client are billable.
- Provide consultant's name
- Summarize discussion
- Describe the unique contribution of each staff involved.

- May write co-staffed note.

  Exception: If staff provided different Specialty MHS, they must write their own notes because reimbursement is different (e.g., MD provides Med Support expertise in consult with CM).

Progress Note Content: Individual Services (Therapy or Rehab)

- Indicate reason for the contact/intervention as related to Client Plan Objectives
- Assess client's clinical presentation, esp. related to primary diagnosis (add relevant history, if applicable)
- Describe staff interventions/actions
- Describe client's responses to interventions
- Provide any relevant clinical decisions
- Identify follow-up plan

Sample Progress Note: Individual Therapy

- 6/18/10
- 64 minutes
- Location code xx
- (341) Individual Therapy
- Objective #1: “Reduce depression/anxiety”
- Client was less disheveled today, had flat affect but maintained eye contact. Voiced concerns about her social skills but says she’s less depressed/anxious overall & wants to take a dance class but client appears ambivalent about this. Just had dream that triggered abuse memories – we explored this with support & empathy but she became flooded with anxiety. Engaged her cognitively to manage this – she thinks it’s connected to her anxiety about the possible dance class & using her body to express herself.
- Plan: F/u next week re. dreams & how coped with anxiety.
- Freudian Slippers, PhD.

Sample Progress Note: Individual Rehab

- 6/12/10
- 50 face-to-face/95 total mins.
- Location code xx (for client's home)
- (381) Individual Rehabilitation
- Objective #2: "Improve self-care impacted by depression."
- Worked with client on hygiene skills impacted by his depression & social isolation as he did not shower this week & did not leave home. Co-created a chart to keep track of ADL's & his feelings to help him see connection. He was willing to do this activity & was talkative, maintained eye contact. Responded well to praise & active support, seemed more hopeful at end of session.
- Plan: Monitor progress with chart in next sessions.
- Jane Doe, Case Manager

Progress Notes: Case Management/Brokerage

Describe:

- Clinician's activities
- Relate to Objectives
- Note client's response, if applicable
- Next step, if applicable

Sample Progress Note: Case Management/Brokerage

- 6/21/10
- 30 FTF/60 TT
- Location code xx (for field)
- (571) Case Management
- Objective #3: “Reduce angry outbursts from 2 to 1x/week.”
- Met TL to review the support group referral from his therapist. I shared info about the 2 groups & why I thought the one focusing on anger management would work best given his MH Objective. He said he liked the idea but chose the social skills one instead. He called about the group right then, but they need the referral. I later contacted his therapist to fax the referral today & we discussed the importance of supporting TL’s group choice, though we both think the anger group is more appropriate right now. I called the group counselor to make sure everything was set for TL to start next week & left a message for TL.
- Jane Doe, Case Manager

Progress Notes: Crisis Intervention

In addition to Individual Services progress note contents, Crisis Intervention notes must address:

- Relevant clinical details to support MN (events leading to crisis, how client is imminently at risk of DTS/O/GD due to mental health issues OR how client's condition is highly likely to become an immediate psychiatric emergency)
- Assessment of risk & measures taken to reduce risk
- Involvement of client in their own aftercare safety plan
- Collateral & community contacts to participate in follow-up

Sample Progress Note: Crisis Intervention

- 3/3/10
- 210 face to face/270 total time
- Location code xx (for field)
- (371) Crisis Intervention
- Objective #1: “I won’t be aggressive toward BART police” and #2: “I will follow B&C rules so I can stay there with my girlfriend for the next 6 months.”
- Got call from BART Officer Shields at Ashby Station that RB had raised his arms aggressively at BART passenger & refused to leave when asked by Officer. He’d been panhandling & increasingly threatening as people ignored him. Shields knows RB, so called me to help calm RB and return him to his B&C. I went to BART & found RB still arguing with Officer, refusing to leave. It took a while to de-escalate RB by reminding him of Goals above, especially #2, & the risk of eviction if he didn’t maintain control. I helped him call his girlfriend to make dinner plan as motivation to reduce aggressive & argumentative behavior. As he calmed, he let me to walk him to the parking lot but then got agitated & tearful which required more monitoring to avoid his re-escalation to aggression. Helped him do guided imagery re. dinner w/ gf; was then calm enough to transport to B&C – on the way, helped him restate Plan goals & dinner plan. Officer said won’t press charges “this time”; RB confirmed tomorrow’s appointment & agreed to call the program if begins to get agitated again.
- Jane Doe, Case Manager

Recent DMH State-wide Audit Findings: Reasons for Disallowances

- Insufficient documentation of MN (e.g., no substantiation of diagnosis or impairments related to diagnosis, progress note doesn't address mental health condition)
- Client Plans not completed within required timeframes
- No documented evidence of client participation in treatment planning (no client signature/explanation on Plan)
- Service provided while client in lockout situation
- Progress Note missing, not signed by service provider,
- Progress Note describes solely academic, vocational, recreational, socializing, clerical, transportation or payee-related activities
- Time entered was greater than time on Progress Note (overbill).

Red Flags!

Auditors notice:

- Notes & Client Plans that all seem the same
- Paperwork that is difficult to read
- Client Plans that are not explicit
- Client Plans that don’t comment on progress or lack thereof
- Too many check-off boxes without comments

Reviewing Medical Necessity: "Was that billable?"

When you wonder.... *"What was the mental health value of what I just did with this client? Is it billable?"*

- Think about why the client has difficulty accomplishing life tasks on their own & requires your help....

  If the difficulty is related to mental health problems that you've identified in the Client Plan and/or in that Progress Note, your service is probably billable.

Brief Q & A

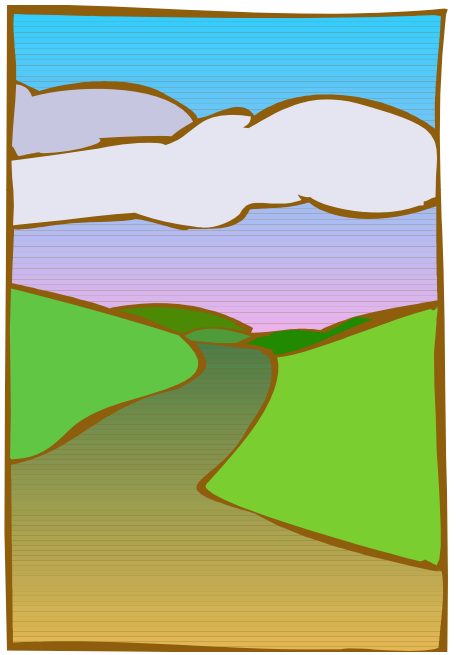
The next section is optional.

Otherwise, thank you for your time and attention!

And don’t forget to review the final section about CQRT on your own...

Client Plan: Relationship Between Goals, Objectives & Interventions

Many staff are confused about the differences between goals, objectives & interventions. The following is a suggested way to think about these important Client Plan elements.



Defining Goals:

- Client goals express their own hopes and dreams.
- Staff help identify the mental health barriers preventing attainment of those goals; barriers that can be addressed via the services provided.

Client Plan:
Client's goals are...

- BIG (life goals that stay true over time)
- Inspiring to the client
- Written in client's own words (help state them in positive language!)
- Linked to discharge & transition criteria

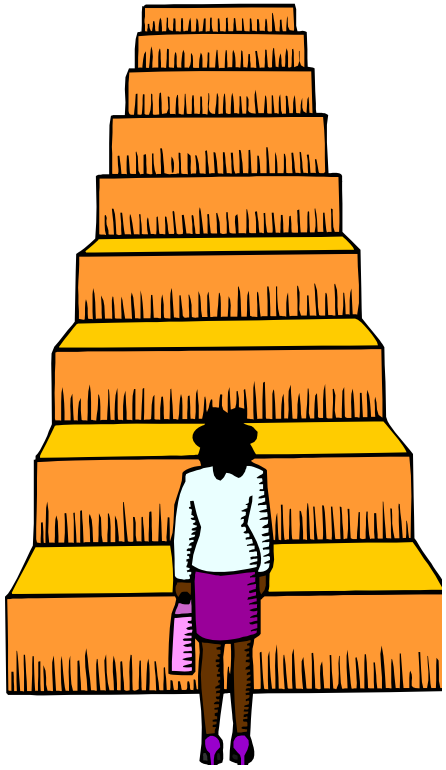
Partner with clients to understand underlying benefits of an "inappropriate" goal (e.g. to be a drug dealer – benefits may be money, power, prestige).

Identify together client's strengths, supports & resources that can help them achieve their goals.

Client Plan: Defining Objectives

"What Do Objectives Do?"

- Objectives divide big life goals into manageable units of completion.
- They take into account the client's culture & strengths.
- They provide time frames for assessing progress & celebrating achievements.



Client Plan: Objectives & Medical Necessity

- Objectives describe positive changes in key behaviors, functions or status that the client agrees to accomplish, in partnership with you, in order to reach their goals.
- Objectives address a client's functional impairments & goal barriers DUE TO an "included" diagnosis.
- Think of Goldilocks: Objectives = "Just the right size!" Should be smaller than client's goals, but big enough to allow your Services/Progress Notes to relate to them over time.
- Revise objectives if they seem too difficult to achieve within a timeframe that feels hopeful to the client.
- When objectives are met, revise them!
  - Keeps clinician interventions relevant to the current Client Plan
  - Gives client & staff a well-deserved sense of progress & achievement!

Client Plan: How to Write an Objective

	Example
Subject ----------	Client
Verb/Action Word ----------	Will demonstrate
What ----------	Improved ability to ... x/y times, currently z/y times.
When will it be done/timeframe? -----	Within x months
How will it be measured? ----------	As measured by ...
Why is it important? ----------	Link back to client's goals!

Client Plan: Defining Interventions

Objectives & Interventions are different!

- Objectives are the WHAT –
  - What are the next significant milestones toward reaching client's Goal?
- Interventions are the HOW –
  - How will mental health services help reach Objectives?
  - How will client's strengths be utilized to get there?
  - How will be the clinician's service focus help achieve Objectives, and ultimately client's Goal?

(Note: Current BHCS Client Plan template does not provide designated areas for clinician interventions; please add them under relevant Objectives.)

Client Plan: The 5 W's of Interventions per Service & Clinician

- Who: Which clinician will provide the services? Who else on team will help?
- What/When: What mental health services will be provided? Frequency of those services? Clinician's intervention focus during services?
- Where: Identify the location of Interventions, if relevant.
- Why: Identify the purpose of the Interventions by linking them back to Objectives.

Client Plan Objectives: Case Example

- Sue is a warm & creative person who used to knit and paint & work as a secretary. She comes to the mental health clinic for meds to help relieve depression & social anxiety. She can get overwhelmed by sadness & self-critical thoughts at times & used to drink alcohol to “numb-out”. Sue is proud to have 30 days of sobriety & feeling much better, she wants to get back into the workforce. She occasionally experiences cravings, but finds that she gets back on her feet more quickly now.

Client Plan: Example of Goal/Barrier Statements.

- Sue's Goal: I want a full-time job.
- MH barriers to Sue's goal:
  - Sue gets depressed and self-critical. She sometimes has cravings to use alcohol to relieve her symptoms, which are hard to manage, especially in a work setting. She is anxious around people. She misses appointments and often isolates herself due to depressed moods & social fears.

Client Plan: Sample of Objective #1

- Sue will develop 3 positive coping skills for her symptoms of depression & anxiety within the next 6 months as measured by self-report & clinician observation, to help reach her goal of getting a job. Currently, says has no positive coping skills.
- Who: Sue
- Verb: Will develop
- What: 3 positive coping skills, currently none per Sue
- Timeline: In the next 6 months
- Measurement: As measured by (amb) self-report & clinician observation
- Why: To help reach job goal

Client Plan: Sample of Objective #2

- Sue will stay clean/sober for 3 months as measured by self-report & clinician observation, to help reach her goal of getting a job. Currently has cravings every other day.

- Who: Sue
- Verb: Will be
- What: Clean & sober, current cravings
- Timeline: Three months (Note: This will require update to keep progress notes relevant!)
- Measurement: amb self-report & clinician observation
- Why: To help reach job goal

Client Plan: Sample Objective + Interventions

Objective: Increase coping skills

- Intervention #1: Indiv. Rehab 1x/week.
  - Clinician will help client identify negative self-talk & practice positive self-talk in each session to improve self-awareness.
  - Clinician will actively support client to get out of the house each day (e.g., to a café knitting circle) to reduce isolation & re-experience creativity.

- Intervention #2: Group Rehab 1x/week.
  - Utilize group to improve client's ability to manage anxiety while interacting with others.

- Intervention #3: Brokerage 2x/month.
  - Clinician will connect client to Voc Rehab program & support her regular attendance; focus on building current computer skills to enhance secretarial skills.

Connecting Mental Health Barriers & Objectives to Clinician Interventions

The next slide shows a sample list of common mental health barriers to task/goal accomplishment.

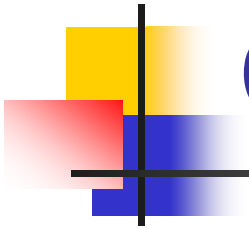
Each barrier is matched with basic examples of mental health interventions -- billable when the progress note clearly links the intervention to symptoms & signs of an included diagnosis.

Combine basic interventions with client strengths to build on what's worked well in the past!

- **Print out the entire barrier/intervention list as a reference tool - 2 slides at end of this Powerpoint**

Connecting MH Barrier/Objective to Clinician Interventions

Barriers:	Clinician assists client to:
■ Angry outbursts	■ Identify triggers ■ Name emotions that underlie anger ■ Identify healthy responses
■ Anxiety, excessive worry, fear of others' responses, mania, racing thoughts, feeling on edge, difficulty concentrating	■ Offer/practice stress reduction techniques ■ Co-create list of alternative activities to use when anxious



Questions & Answers

Questions????

Clinical Quality Review Team (CQRT)

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

CQRT Purpose

The purpose of the CQRT is to

- *Review medical & service necessity,*
- *Review quality of documentation of services,*
- *Give feedback, and*
- *Authorize ongoing services*.

Providers either attend a CQRT sponsored by the County, or have an internal QA process for monthly review of charts that are due for a new or updated Client Plan.

CQRT Process:

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

- Use the MHS 696 Report to ensure match between entered service and progress note elements.
- CQRT is not a substitute for a provider's internal Quality Assurance (QA) process.
- The DMH 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.

- Perform either a Clinical Review or a Quality Review to approve the continuation of services.

Clinical Review

The Clinical Review establishes ongoing Medical & Service Necessity:

- Is there a current Client Plan, “included” diagnosis and corresponding Progress Notes? (current = written in the month prior to next authorization period)
- Are there indications of progress being made toward the goals? If not, is there an explanation?
- Is there an appropriate discharge plan?
- Are required dated signatures & informing materials present?

Quality Review

Fifteen percent (15%) of charts reviewed each month are randomly chosen for Quality Review.

Quality Review

The Quality Review is more comprehensive:

- It includes the Clinical Review components
- Use the “Regulatory Compliance” checklist on reverse of online CQRT Review Request Form to review charts (current BHCS audit tool)
- Check for continuity between the Treatment Plan and the treatment documented in the progress notes

Schedule for Chart Review

- Charts are reviewed based on the episode opening date of the case. The *review cycle* begins on the 1st of the month in which the episode was opened, no matter which day of the month it was opened.

- Outpatient and Rehabilitative Day Treatment charts are reviewed every six months. The review cycle always stays the same.

- Day Treatment Intensive charts are reviewed every three months.
- 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 Opened	Authorization cycles: They never change!	Start date for Tx Plan created for CQRT:	New Plan may not be signed before:	Do CQRT in:
January	Jan 1 - June 30 July 1 - Dec 31	July 1 January 1	June 1 December 1	June December
February	Feb 1- July 31 Aug 1 - January 31	August 1 February 1	July 1 January 1	July January
March	March 1 - Aug 31 Sept 1 - Feb 28	September 1 March 1	August 1 February 1	August February

BHCS CQRT Reviewers are:

- Provider agency supervisors, or their designees, authorized to represent their agency in meeting AND provide their agency staff with feedback regarding QA requirements, issues/concerns or compliments given by the CQRT.
- Licensed, waivered, or registered interns, Licensed Practitioners of the Healing Arts (LPHA) who have attended CQRT training or orientation.

Chart Content for CQRT

Charts must contain all of the elements required by Medi-Cal Documentation Guidelines (see CQRT Manual, available online).

Deficient charts: "30-Day Return"

In the BHCS CQRT, if a chart is missing any of the items listed below, it is given one (1) month's authorization and deficiencies must be corrected prior to return to the following month's CQRT:

- A completed CQRT Form
- Page 1 (Clinical Review)
- Medical Necessity documented

- Page 2 (Quality Review)
- Impairment Criteria (all items)
- Intervention Criteria (all items)
- Treatment Plan (all items)
- Progress Notes: if missing more than 30 consecutive days of notes

Meeting Schedules

- BHCS CQRT meetings are organized by the type of provider or primary treatment mode
- Meeting assignment is determined by the BHCS
- Schedules & CQRT documents are on the BHCS website, under Quality Assurance: www.acbhcs.org/providers

Final CQRT Advice

- Read the CQRT Manual - it covers all aspects of the CQRT process.
- Train your staff in 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”.

Connecting MH Barrier/Objective to Interventions (1 of 2 slides)

Barriers:	Clinician assist client to:
▪ Angry Outbursts	▪ Identify triggers ▪ Name emotions that underlie anger ▪ Identify healthy responses
▪ Anxiety: excessive worry, fear of others responses, mania, racing thoughts, feeling on edge, difficulty concentrating	▪ Offer stress reduction techniques ▪ Create list of alternative activities to use when anxious
▪ Depression: little pleasure from enjoyable activities, sleep problems, decreased energy, hopelessness, low self- esteem, loss if interest in anything, difficulty concentrating	▪ Identify positive self-talk statements ▪ Develop plan for social activity/exercise ▪ Create list of current negative self-talk for increased awareness
▪ Grief and Loss: thoughts dominated by loss of people, situation or grief of dealing with having a mental illness	▪ Express unresolved emotions ▪ Create feelings journal ▪ Create meaningful goodbye rituals
▪ No hope or vision of a better future	▪ Create list of good events
▪ Lack of Motivation: poor follow through on tasks, poor hygiene, poor household maintenance	▪ List negative effects of poor follow through ▪ Identify cognitive barriers ▪ Identify what is positive about not having motivation

Connecting MH Barrier/Objective to Interventions (2 of 2 slides)

Barriers:

- Unable to advocate for self, undeveloped negotiation skills, unable to refuse requests
- Easily overwhelmed
- Poor Social skills
- Difficulty trusting people
- Impulsivity
- Little or no insight into consequences of personal behaviors & choices

Clinician assist client to:

- Develop & practice assertive expressions or responses
- Identify underlying beliefs/fears of situation and expectations
- Practice conversation skills (per cultural identity: maintain good eye contact, ask questions, reflective listening)
- Develop useful expectations of others
- Identify motivations for quick decisions
- Review positive & negative experiences with others to discover role in outcomes

QA Contact Info

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For questions, limit 1 contact person per provider for consistency of information at your agency!

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Tiffany Lynch, QA Secretary *tlynch@acbhcs.org*

Resources

EPSDT Chart Documentation Manual:

www.CIMH.org/downloads/epsdt

General QA Information for Providers:

www.acbhcs.org/providers (Document templates, Informing Materials, CQRT Manual/schedule of meetings, List of Abbreviations, etc.)