WELCOME!

Alameda County Behavioral Health Care Services

Quality Assurance Office

Medi-Cal Documentation Training

(updated 7/14/10)

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:

- 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 (slide #6)
   - Medical Necessity & Service Necessity (#10)
   - Definitions of Specialty Mental Health Services (#15)
   - Non-Billable Services (#27)
   - General Documentation Standards (#29) Break?
2. Clinical Documents: Content, Timeliness & Frequency (#32)
   - Sample Progress Notes (#48) Break
3. Goals, Objectives, Interventions: How they fit together (#67)
4. Entering Services for Reimbursement: General Rules (#81)
   - Co-Staffed Services (#85) Break?
5. CQRT/Authorization Guidelines (#90)

Q & A, if possible

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

New from BHCS: "Informing Materials Packet"

In 2010, the Informing Materials Packet will be sent via email to all providers, with a memo explaining how <u>providers will be required</u> to use it in place of previous BHCS forms.

- Contains <u>updated</u> BHCS Informing Materials documents regarding client rights per State/Federal changes.
- Simplifies review with clients at admission & required offering to 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.

"Informing Materials" Content

Contents of Informing Materials Packet

- BHCS Consent for Services
- BHCS Freedom of Choice
- Discussion of 3 BHCS items providers are required to offer clients:
  - "Guide to Medi-Cal MHS" (stapled packet 8.5" x 11")
  - "Member Handbook..." (maroon pamphlets in multiple languages)
  - Provider List (updated quarterly at www.acbhcs.org/providers)
- BHCS Confidentiality & Privacy
- Advance Directive Info (for ages 18+)
- BHCS Beneficiary Problem Resolution Info
- "Maintaining a Welcoming & Safe Place"
- Notice of Privacy Practices/HIPAA
  - CBO's must at least include their name on the NPP; may amend per legal advice

Informing Materials Content, 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
  - 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 successful life functioning exists & is a result of an included DSM diagnosis:
   - Describe the impairments to successful life functioning (aka mental health barriers to reaching client's life goals)
   - Indicate how the impairment/barriers are related to included diagnosis *(Or per insurance. Questions? Contact BHCS Finance)*
   - 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. *(Exception: Medi-Cal/Medicare insurance. Questions? Contact BHCS Finance.)*
   - If more than 1 staff provides the same service at the same time, must identify the unique contribution for each staff (either when listing MHS in Client Plan or in 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.
  - If MHS other than Assessment are provided before Initial Assessment done, MN rationale for each service must be in Notes.

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 (ACFE, YPO's & FSP data ONLY)

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 the 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:

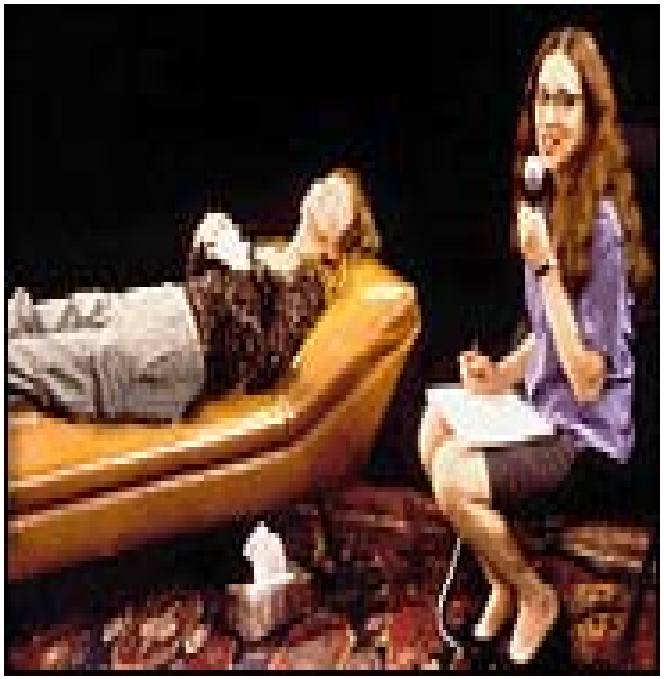
- driven by the client's mental health needs, or
- driven by staff need to review progress toward MH goals/objectives

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 Support Services

Medication Support Services are services to prescribe, administer, dispense and monitor psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness.

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

B. Medication Support Services, cont'd.

The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development *related to the delivery of the service and/or assessment of the client.*

- Documentation guidelines for Medication Support Services 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 accessing services
- Can include plan development activities

Specialty Mental Health Services – Unplanned

Crisis Intervention

Crisis Intervention is a service lasting 8 hours or less in a 24-hour period. It is an immediate response to a client's acute psychiatric symptoms in order to alleviate problems which, if untreated, would present an imminent threat to the client, others or property.

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.)

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 STATUS); 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)

Reports/Forms: (e.g., CPS/APS reports, Court-ordered reports, SSI apps.)

- Non-billable: Reports/forms completed for purposes **other than** determining medical necessity or treatment planning.
- Billable: Reports/forms completed that are a) **also noted** as utilized for treatment planning (e.g., Social Services/Court-ordered "Treatment Updates"); or b) Completed **with client** as a Mental Health or Rehab intervention (e.g., CPS report or para-transit application).

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: Payee request reasons may not be illegal! 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.)

Less than InSyst minimum:

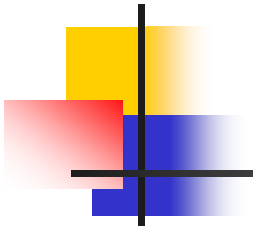
- Services lasting less than 5 minutes

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 or scribbling over errors. Do draw one line through error & initial (don't write "error").
  - Only original authors make alterations; reviewers or supervisors DO NOT edit original authors.



Do we need a break?

“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

- Due within 30 days of episode opening date.
  - Example: EO date 2/14/09; Assessment done by 3/14/09
  - Exception for FSP & Brief Service Programs: Due within 60 days of EO
  - 30/60 day timeline is per EO date, not per 1st face-to-face with client

- Completed by LPHA (incl. board-registered interns); does not require co-signature.
  - MHRS staff may gather assessment information, but may not create the document.

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

BHCS Initial Assessment templates at www.acbhcs.org/providers.

- CBO's must ensure their templates contain at least the same information.

Initial Assessment: Contents
(minimum requirements)

- Identifying Information
- Client Strengths & Supports
- Risk Situations
  - Address risks in Client Plan
- Presenting Problems
- Self-Identified Culture & Gender Needs
- Communication Needs
- Co-Occurring Conditions, such as Substance Use – History/Last use
  - Include nicotine, caffeine, Rx, OTC
- Medical/Health, Medication, Mental Health and Social Histories
  - Allergies 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. (Notes: May be in Client Plan instead; Good place to note "Stages of change.")

Initial Assessment: DSM Diagnosis

Diagnoses must be established by licensed clinicians.

- In diagnosis area, provide name/licensure of person who established 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 if MN exists).
  - Insyst accepts Deferred Dx to open episode; must update to "included" diagnosis at 30 days, if will treat.
  - 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.

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 Plan: Timeliness & Frequency

- Initial Client Plan: Complete within 30 days of episode opening day
  - Example: EO Date 4/14/09; Initial Client Plan done by 5/14/09
  - Exception for FSP & Brief Service Programs: Due within 60 days
  - 30/60 day timeline is per EO date, not per first client face-to-face
- Annual Client Plan: Complete during the month prior to the episode opening month
  - Example: EO Month April; Annual Plans completed in March
- 6-Month Updates: Complete in 6th month from EO month
  - Example: EO Month April; Update completed during September
  - Exception for FSP & Brief Service Programs: Not required

MHS 485 Report = 6-month prompts for these documents... use it!

Client Plan: Main Points

- 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 objectives (e.g. Group Rehab 1x/week, Medication Support 1x/month).
- Identify clinician's interventions to reach objectives, using client strengths & supports when possible. (May also identify what client and/or significant support people will do to reach objectives.)
- Way to prove that client was offered a copy of the Plan.

This is not a complete list of required Client Plan elements. See the BHCS Client Plan templates at www.acbhcs.org/providers.

- CBO's must ensure that their templates contain at least the same elements.

Client Plan: Required Signatures

Client Plans must be signed by:

- The clinician providing & documenting the services
- A licensed LPHA to finalize the Plan (may be same clinician)
  - No longer must sign in last 15 days of month, just within the month it's due! (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.

Client Plan: Client's Signature

Client's dated signature **on** the Client Plan indicates their participation & agreement with Plan. Client signature is **required**, minors included if understand concept of ownership.

Good 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 rep. must sign.

ANY change in Plan after client's signature = 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/Transition Documentation: Discharge Note (non-billable) vs. Discharge Summary (billable)

Discharge Note: A progress note that briefly documents termination/transition of services - NOT billable. Include:

- Discharge diagnosis,
- Progress made during treatment,
- Reason for termination, and
- Referrals made for client.

Discharge Summary: A substantive document, billable only when written prior to episode closing and includes:

- Same information as Discharge Note,
- Summary of treatment,
- Clinical recommendations, and
- Treatment planning information for possible future services.

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

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
- Type of MH service and/or Service code number
- Location of service
- 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

Progress Notes: Basic Elements, Cont'd.

Descriptions of services require slightly different content focus, per service type. Here is a general breakdown (specifics are in following slides):

- Client contact: Client's presentation, unresolved issues, your interventions, client's response, plan
- No client contact (collateral/team): Who contacted, purpose, actions, plan
- Paperwork: Purpose, document's date & basic content & where located in chart

Sample Progress Note: Assessment

- 7/1/07
- 45 minutes
- (331) Assessment
- Client Plan Objective: N/A. Initial Assessment work.
- Met with client to gather information about previous mental health treatments & what's worked well for him in the past. Updated the Initial Assessment with this information; need more information to complete the document.
- Jack N. Jill, BA, Peer MHS

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

- 6/21/07
- 10 minutes
- (311) Collateral
- Client Plan Objective: #2, “Maintain in current residence for the next 6 months.”
- TL’s mother called to say she’ll move to Nevada next month. As a major support for TL, she’s concerned about his ability to “keep it together” when she leaves. Advised her to meet with TL & his care team to discuss how we will all support him in this transition. His mom will call the case manager 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 annual or 6-month treatment planning (if worked on Client Plan, provide the Plan's start date).

- No longer required to "roll" Plan Development into another Mental Health Service, if provided on the same day to the same client. (May still do so, if desired!)

Sample Progress Note: Plan Development

- 7/1/07
- 60 minutes
- (581) Plan Development
- Client Plan Objective: N/A. Client Plan revised

- Met with client to review his Client Plan and revise his Annual Plan. He identified his goals for the coming year. The details are written in the Client Plan dated 7/1/07.
- 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 (even if not co-staffed note).
- 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 (e.g., MD provides Med Support expertise in consult with CM).

Progress Note Content: Individual Services Therapy & Rehab

- Describe client's clinical presentation, esp. related to primary diagnosis
- Relate the service/intervention to Client Plan Objectives
- Describe staff interventions/actions
- Describe client's responses to interventions
- Provide any relevant clinical decisions
- Identify follow-up plan

Sample Progress Note: Individual Therapy

- 6/18/07
- 64 minutes
- Office
- (341) Individual Therapy
- Client Plan Objective: #1 “Reduce depression/anxiety”
- Client was less disheveled today, had flat affect but maintained eye contact. She is still concerned about her social skills but says she’s less depressed/anxious overall & is thinking about starting a dance class after school. Explored feelings/thoughts related to memories of abuse triggered by a recent dream. Provided client with support & empathy and engaged her cognitively to manage emotional flooding – client thinks it’s connected to anxiety about using her body to express herself in dance & interacting with other students.
- Plan: Individual session next week.
- Freudian Slippers, PhD.

Sample Progress Note: Individual Rehab

- 6/12/07
- 50 face to face/95 total time
- Home visit
- (381) Individual Rehabilitation
- Care Plan Objective: #2 “Improve self-care impacted by depressive symptoms.”
- Worked with client on hygiene skills which are 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 client see how they impact each other. He was willing to do this activity & was talkative & maintained eye contact through session. 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 Content: Group Services Therapy & Rehab

Must write a Progress Note for each M-C client in group!

Required for Insyst's calculation of billable time:

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

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

- 7/7/07
- Primary Staff: 97 min.
- Co-staff: J.Tzudiker, MFT #007, 90 min. Required to maintain optimal client/staff ratio for clinical interventions.
- 8 group members
- (351) Group Psychotherapy
- Client Plan Objective #3 "Improve ability to tolerate & increase social contact."
- Focus: Practice social interaction via role play
- Client did participate in social situation role-plays with peers even 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. Participated in group exploration of feelings that arose during role plays & was able to identify increased anxiety when talking with males. Co-staff & peers normalized that experience & 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

- 6/25/07
- 66 minutes
- 7 members--1 staff
- (391) Group Rehabilitation: Improving Social Skills
- Client Plan Objective: #2 “Improve ability to tolerate & increase social contact.”
- Focus: Practice social interaction via role play
- Client did participate in social situation role-plays with peers even 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 also validated. This clinician 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: 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

- 6/21/07
- 30 FTF/60 TT
- Field
- (571) Case Management
- Client Plan Objective: #3, “Reduce anger outbursts from 2 to 1x/week.”
- Met TL at Mel’s Diner 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 Plan objective. He said he liked the idea but chose the social skills one instead. He called about the group, but they need the referral. I later contacted his therapist to fax the referral today & we discussed the importance of just supporting TL’s group choice. 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, clearly document how client is imminently a current DTS/O/GD due to mental health & needs inpatient services 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

- 3/3/07
- 210 face to face/270 total time
- Field
- (371) Crisis Intervention
- Care Plan Objective: #1 “I will have no incidents of aggression toward BART police” and #2 “I will remain in the same B&C as my girlfriend for at least the next 6 months.”
- Received call from BART Officer Shields at Ashby Station that RB had raised his arms aggressively at BART patron & refused to leave when asked by Officer. RB had been panhandling & increasingly threatening as patrons ignored him. Due to history with RB, Officer contacted 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 MC to make dinner plan as motivation to reduce his aggressive & argumentative behavior. As he calmed, he allowed me to walk him to the parking lot but then got agitated & tearful which required ongoing monitoring of his re-escalation. Helped him do guided imagery re. dinner w/ MC & was then calm enough to transport to B&C – on the way, helped him restate Plan goals & dinner plan. Officer won’t press charges this time; RB confirmed seeing me at tomorrow’s regular appointment & will call the program if begins to get agitated again.
- Jane Doe, Case Manager

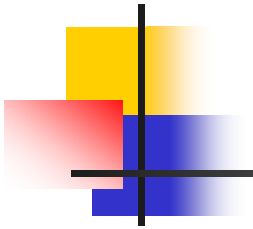
Recent DMH State-wide Audit Findings: Reasons for Disallowances

- Insufficient documentation of MN (e.g., no substantiation of diagnosis or impairments related to diagnosis, documentation 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, content doesn't address mental health condition
- 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:

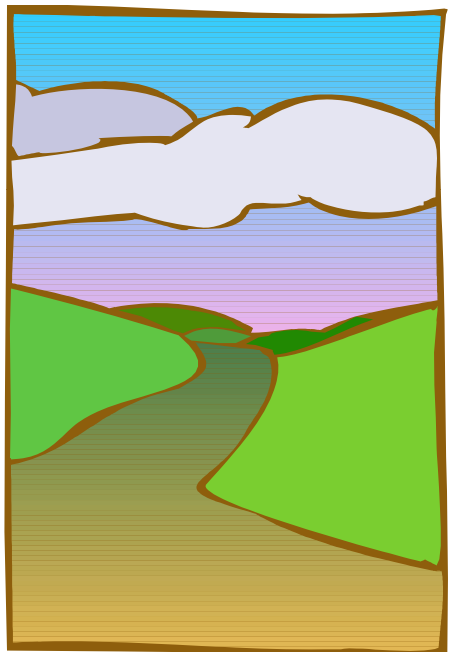
- Notes & Client Plans that all seem the same
- Paperwork that is difficult to read
- Client Plans that are not explicit
- Client Plans that don’t comment on progress or lack thereof
- Too many check-off boxes without comments



Do we need another break?

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

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

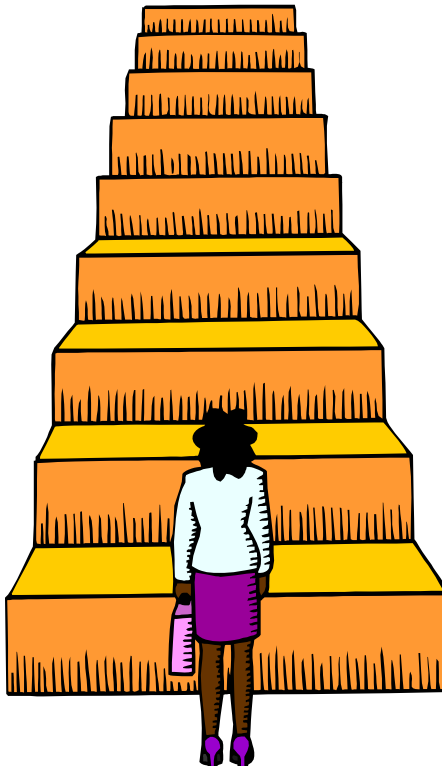
Partner with clients to understand underlying benefits of an "inappropriate" goal (e.g. to be a drug dealer – benefits may be money, power, prestige).

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

Entering Services for Reimbursement

When you wonder.... *"What was the mental health value of what I just did for 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 you've identified in the Client Plan, your service is probably billable to Medi-Cal.

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 in half- or full-days:

- Day Treatment Intensive
- Day Treatment Rehab

- Billing is related to the service provided, not staff qualifications. (Medicare exception – ask Finance!)

For Per Minute Service Units ONLY: Documentation & Travel Time

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

- If travel but client not seen, documentation & travel time are not billable.
- If the activity itself is not billable, 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: Sum of 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.).

Services Provided by One Staff to Multiple Clients

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

Progress Note must indicate....

- Total service time (service time plus documentation time)
- Number of all group members (whether M-C or not)

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

Documenting & Entering Services Provided by Multiple Staff: Co-Staffed Services

Multiple staff providing the same service, at the same time, to 1 or more clients, or on behalf of 1 or more clients (e.g., group service or team consultation):

- Each staff may write their own note **OR**
- One staff may write a co-staffed note for 2 staff.
  - (Insyst limits 2 staff per note; if more than 2 provided service, individual or more co-staffed notes must be done).

Co-Staffed Progress Notes: Decide which staff writes notes

- Documenter is Primary Staff
- Non-documenters are Co-Staff

Co-Staffed Progress Notes: Content

In addition to regular content requirements, co-staffed progress notes must indicate....

- Total service time of Primary staff (service time plus documentation time)
- Total service time of Co-Staff (service time only since Primary does the documentation)
- Number of all clients served (whether M-C or not)

.....so that Insyst can calculate time claimed per client AND so both staff can get credit for their time!

Example:

- Primary Staff name/ID# and his/her total service time. Jane T. #xxxx, 90 min. (60 min. group + 5 min. to write note)
- Co-Staff name/ID# and his/her total service time.
  Cathy K. #xxxx, 60 min. (group time only)

Duplication of Services

The same type of service may not be provided by multiple providers, unless:

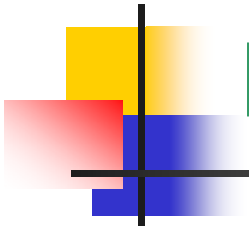
- There is a clearly documented rationale in each program's Client Plan,
- The Plan delineates responsibilities, and
- There is an Objective for coordination of care.

Example: Social Services CM and Mental Health CM should not be duplicating services.

COORDINATE CARE

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

Collateral calls to assess client's condition and care needs are reimbursable services!



Do we need another break?

Clinical Quality Review Team (CQRT)

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

CQRT Purpose

Providers are expected to either attend a CQRT sponsored by the County, or develop an internal process of chart review. The BHCS CQRT committees meet a minimum of one time per month.

- The purpose of the CQRT is to *review medical necessity, service necessity & quality of documentation of services, and to provide authorization*.

- Senate Bill 785 provides for standardized clinical templates & authorization request forms for California clients receiving out-of-county mental health services. For more info: www.dmh.ca.gov and search for SB785.

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 Client Plan, “included” diagnosis and corresponding Progress Notes?
- 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 (BHCS audit tool)
- Check for continuity between the Treatment Plan and the treatment documented in the progress notes

Schedule for Treatment Chart Review

- Charts are reviewed based on the date of the case episode opening. The review cycle begins on the first of the month in which the episode was opened.
- Outpatient and Rehabilitative Day Treatment charts are reviewed every six months. 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, charts with deficiencies are given a month's authorization and must be corrected prior to return to the following month's CQRT, if the chart is missing:

- CQRT Form completed (See CQRT Form online)
- Page 1 (Clinical Review)
- Medical Necessity
- Service Necessity

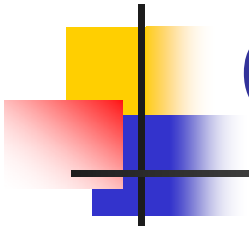
- Page 2 (Quality Review)
- Impairment Criteria (all items)
- Intervention Criteria (all items)
- Treatment Plan (all items)
- Progress Notes: if missing more than 30 consecutive days of notes

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 manual (online). It covers all aspects of the CQRT process.
- Train and familiarize your staff with the CQRT process.
- Develop a written agency QA Policy & Procedure Manual.
- Supervisors reviewing charts and returning to staff for correction prior to reviews will reduce deficiencies and the need for time consuming “30 day returns”.



Questions & Answers

Questions????

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!

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Laura Wells, QA Assistant (p/t)
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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.)