ALCOHOL, DRUG & MENTAL HEALTH SERVICES
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December 29, 2017

To: CBO & County Providers of Specialty Mental Health Services
Executive Directors and Quality Assurance Leads

From: BHCS Quality Assurance Office

RE: 1.) Policy, procedure & protocol changes to be implemented no later than 3/1/18
2.) Highly Recommended January and February Trainings regarding ACHBCS policy, procedure, and protocol changes.

On August 24, 2017, the CA Dept of Health Care Services (DHCS) issued Information Notice No.: 17-040.

DHCS indicated that *"(t)he purpose of this Information Notice (was) to provide clarification regarding documentation and related requirements for Medi-Cal Specialty Mental Health Services (SMHS). This (Notice) provide(d) guidance and addresse(d) frequently asked questions regarding chart documentation."*

http://www.acbhcs.org/providers/QA/memos/2017/DHCS_17-00_MHSUDS_Chart_Doc_Info_Notice.pdf

Rudy Arrieta, BHCS Quality Management Director presented this Information Notice to the ACBHCS Quality Improvement Committee (QIC) which is made up of stakeholders throughout our system of care. At the October 23rd meeting, he inquired if the QIC committee was interested in forming a sub-committee to work collaboratively with BHCS Quality Assurance Office in an effort to shape any needed changes to ACBHCS policies, procedures and protocols as a result of the DHCS Info Notice. QIC took on this task.

The QIC Sub-Committee consisted of eight (8) contracted agency representatives and four (4) county representatives. The sub-committee met four times over two months and presented their recommendations to QIC on 12/4/17. QIC approved the recommendations for forwarding to BHCS for their consideration.

As a result, the following modifications in BHCS protocols are being implemented effective March 1, 2018.

On January 23rd and February 14, 2018 two-hour presentations will be offered which will explain the updates in detail and answer any questions that providers may have at that time. Please have QA Staff and/or Managers sign up for one of these trainings at the following link: http://alameda.netkeepers.com

For each Clinical Documentation & Protocol change, please find below: the category of Clinical Documentation, the DHCS Info Notice assigned number (see Info Notice link above), the current BHCS process, the new BHCS process (shaded in pink), the soonest implementation date, and if non-compliance of this item (for services 3/1/18 or later) during a chart audit could result in claims disallowances. For more detailed implementation guidance, attend one of the two-hour trainings described above. All changes must be implemented by March 1, 2018.

Clinical Area	DHCS Info Notice Item #	Current Process	New Process	Soonest Implementation Date	Possible Claims Disallowance
Diagnosis	A2 & 3	MH Graduate Student Practicum/Trainee may not diagnose or conduct the Mental Status Exam.	1.) Allow Second -Year (and beyond) Graduate Students in Mental Health Programs to diagnose with appropriate training and experience with: a.) Written attestation (placed in personnel file) by the current Licensed Clinical Supervisor of the Trainee that the student has sufficient education, training and experience to diagnose independently with only the Licensed Supervisor's on-going full record review, supervision and co-signature.	1/1/18	Yes—if any requirements indicated are not met.
MH Assessment	A4	MHRS & Adjunct Staff may currently collect demographic and self-report non-clinical data for Assessment purposes (must write it up in their progress note – not within the MH Assessment).	MHRS & Adjunct Staff may collect self-report information in the areas of: mental health and medical history; substance exposure and use; identifying strengths, risks and barriers to achieving goals; and demographic information **IF** the agency determines this is within their Scope of Ability, training & experience. *The specific assessment information gathered must be*	1/1/18	Yes—if they collect additional clinical informa-

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			entered directly into a Progress Note--not the MH Assessment form.		tion OR if they write within the MH Assess-ment document .
MH Assess-ment	B1	The current Initial Assessment deadline is within 30 days of the Episode Opening Date (EOD).	The due date for the completed MH Assessment will be 60 days from episode opening date. As well, if the MH Assessment is unable to be completed in that time due to clinical issues—the provider should document that in the record and may continue to claim for Unplanned services (see Section D1 below). If the Client Plan is completed, the MH Assessment must also be completed for Planned Services to be claimed beyond the MH Assessment due date.	1/1/18	Yes—for Planned Services if the Plan is Written and the MH Assess-ment is not completed within the timeline.
MH Assess-ment	A4	Risks for Assessment purposes have included DTS, DTO, self-harm and any other clinically significant risks	DHCS has elaborated with twelve (12) specific examples of categories of risk—see Info Notice.	1/1/18	Quality comment only.
Diag-nosis	A6	Currently, a client's diagnosis provided in an inpatient stay (or outpatient episode) may be simply referenced as the diagnosis of record for MH Assessment purposes.	Per DHCS guidance, a historical diagnosis (including an Inpatient Dx) may **not** be simply referenced as the current Dx in an outpatient setting without re-diagnosis.	By 3/1/18	Yes—if a current diagnosis is not establish-ed for each new episode of care

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Diag-nosis	A7	Current best practice requires providers within one program (and preferably across programs during the same time period) collaborate on an agreed upon diagnosis (rather than different diagnoses).	BHCS policy is: now that each contracted agency has its own process for resolving discrepant diagnoses between staff and that this must be done (align the diagnoses) as best practice. As well, it is best practice for providers to collaborate across agencies regarding conflicting diagnoses.	1/1/18	Quality comment only.
MH Assess-ment	A8	Currently, each program RU has a unique episode of care for the client and must conduct a MH Assessment and write a Client Plan.	1.) Change that within one agency--multiple RU's be allowed to share one MH Assessment (and diagnosis) for concurrent services, 2.) Change that across multiple outpatient agencies the completed MH Assessment from one agency be allowed to be shared (for Initial Assessment only) if the first MH Assessment was conducted within the past 6 months AND it is incorporated into the Medical Record with a MH Assessment Addendum which indicates: the interim history, any changes in the MH Assessment previously collected data, and which documents that the diagnosis is consistent with the client's current status of their mental, emotional or behavioral health (signs and symptoms must be indicated). 3.) Note: Multiple RU's within one agency may also decide to share a Client Plan OR create a Client Plan for each RU.	1/1/18	Yes—if any stated require-ments are not met.
Client Plan	C2	Currently in addition to the staff signing the Client Plan, and beneficiary or their representative signing, the Medical Provider prescribing (within the same agency) must also sign the Client Plan.	It remains Best Practice that any current prescriber (for the client) within the same agency signs the Plan. However, this is no longer a reason for disallowance.	As soon as desired.	Quality Comment only if the Medical Provider (same agency) does not

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					co-sign the Plan.
Client Plan	C3	A Client Plan is now effective no earlier than the date of the latest signor (client/representative, staff writing the Plan, same agency prescriber).	Change that the date the staff person writing the Plan (with any required co-signature) signs the Plan is the effective date rather than the date of the last required signature (such as the beneficiary or their representative, Medical Provider, etc.).	1/1/18	Yes—if require-ments such as co-signor for certain Plan writers are not met.
Client Plan	C4	Currently, the client (or representative) signature is required on the Client Plan.	Change that the client (or representative) signature is required on the Client Plan when: 1. the client is expected to be in treatment longer than 60 days, **OR** 2. is receiving MORE than one SMHS service modality other than Plan Development, MH Assessment, Crisis Services or TCM/ICC linkage and referral to community supports. a. Collateral is a second service modality and would require the Client's signature on the Plan. Note, it remains best practice for the Client Signature to be obtained (or reason why not is documented) whenever a Plan is written.	311/18	Yes—if require-ments are not met.
Client Plan	C5	Client (or representative) signature required on Client Plan (unless refused).	Change that if the client has not signed the Plan per the requirements in C4 above, the following must be documented in the dated Progress Note for the service: 1. Client's participation in the development of the Plan, and agreement with the Client Plan, and that client was offered a copy of the Plan.	1/1/18	Yes—if require-ments not met.

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			2. Alternatively, the Provider could attest on the Client Plan that all three requirements were met (most Plans are not set up for this and it would have to be written in on the Plan or in the PN).		
Client Plan	C7	The Client (or representative) signature must be dated.	Change that that the client's signature is not required to be dated on the Client Plan (no claims disallowances). However, it is best practice to do so.	1/1/18	Quality Comment if not dated—and PN indicates date Client participa-ted in the develop-ment of the Plan, agreed with the Plan and was offered a Copy.
Client Plan	C8	Currently if a client refuses to sign the Plan, it must be indicated why and when the next attempt will be made (and documented). If next attempt not documented—reason for claims disallowance.	Change to:: 1. If Client (or representative) noted as not available (or refuses) to sign the Plan--the Plan shall include a written explanation. 2. It is best practice to make additional attempts to obtain the client's signature and to document the attempts in the client record. 3. As well, the progress note must indicate the date the client participated in the creation of the plan, their	1/1/18	Quality Comment only with no resultant claims disallow-ances if such follow-up

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			agreement with, and that they were offered a copy of the plan. i. Alternatively, the Provider could attest on the Client Plan that all three requirements were met (most Plans are not set up for this and it would have to be written in on the Plan or in the PN).		attempts are not documented--if the reason for no signature is indicated on the Plan and/or PN and the additional requirements are documentted in the PN or in the Plan..
Client Plan	C9	Planned services may be provided after completion of the MH Assessment if the medical necessity for the provided service is evident in the Assessment.	Change to: 1. No planned services may be provided until the completion of a Client Plan. 2. Non-planned services that may be provided until the Client Plan is completed are outlined below (see Section D1).	By 3/1/18	Yes—no Planned services may be claimed until completion of the Client Plan (and medical necessity).

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Client Plan	C10	A significant change in a beneficiary's condition requires the provider to consider an update to the client's current Plan.	DHCS has provided additional specific examples of a "significant change". See Info Notice.	1/1/18	Yes—claimed services may be disallow-ed if a significant change did not trigger review (and as appropri-ate rewritten) of the Client Plan.
Client Plan	D1	Currently, before the Plan is completed only the unplanned services of Assess, Plan Development, & Crisis Services may be claimed.	1. Change: the following are added to unplanned services (and allowable before completion of the Client Plan): 1.) TCM and ICC for *linkage and referral* purposes (only) to community supports, and 2.) Medication services when documented as an "urgent need". 2. Client Plan not required for Crisis Stabilization Services (<24 hrs). 3. Modalities which require a firm Client Plan Due Date include as the service claimed is by the day: a) Inpatient MH Services: 72 hours-excluding Saturday and Sunday, signed by MD and client (or reason client refused). b) Crisis Residential and Adult Residential: 72 hours (NOT excluding Saturday and Sunday),	1/1/18	Yes—if planned services are claimed before comple-tion of the Client Plan.

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			signed by LPHA and Client (or reason Client refused). c) Day Rehabilitation & Day Treatment Intensive: First billed day, signed by LPHA and Client (or reason Client refused). d) *Client Plan must include (or be documented elsewhere) that client meets Medical Necessity: i. a current Included Dx, ii. Signs and symptoms of the Dx that meet DSM criteria, iii. functional impairments as a result of that Dx, and iv. level of impairment i. Client's ability to benefit from treatment.		
Client Plan	D2	Currently, an exception to completion of the Client Plan allowed completion of the Initial MH Assessment if medical necessity for the planned service was present.	Change: An approved client plan must be in place prior to service delivery for the following SMHS: 1. Mental health services (except assessment, client plan development, crisis psychotherapy (PKA Crisis Intervention), crisis stabilization & urgent Medication Services, TCM/ICC Case Mgt Linkage & Referral), 2. Intensive Home Based Services (IHBS), 3. Specific component of Case Management (TCM) and Intensive Care Coordination (ICC): Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs, 4. Therapeutic Behavioral Services (TBS), 5. Day treatment intensive—see time requirement in D1 above. 6. Day rehabilitation—see time requirement in D1 above.	By 3/1/18	Yes—if planned services are claimed before comple-tion of the Client Plan

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			7. Adult residential treatment services—see time requirement in D1 above. 8. Crisis residential treatment services—see time requirement in D1 above. 9. Medication Support (non-emergency), 10. Psychiatric Health Facility Services and, 11. Psychiatric Inpatient Services.		
Client Plan	D3	Currently, when the Client Plan is past due no SMHS services may be claimed until it is completed and finalized.	Change to, when the Client Plan is past due the following SMHS may be claimed: unplanned services, including urgent medication & TCM/ICC services for linkage and referral (when documented per DHCS guidelines) all be allowed during "gaps" of the Client Plan due date. 1. A gap is any time period for which the Client Plan is past due and may be due for any reason.	1/1/18	Yes, If planned services are provided when a Client Plan is past due.
Client Plan	D4	Currently, a completed MH Assessment is required before finalization of the Client Plan.	Change: a full Initial MH assessment is not required in advance of providing planned services (but is due by 60 days of EOD) if an initial client plan is in place, and consistent with the documented Medical & Service Necessity. 1.) Per DHCS Medical & Service Necessity needed for an Initial Interim Client Plan includes: a. a current Included Dx, b. Signs and symptoms of the Dx that meet DSM criteria, c. M.S.E. d. functional impairments as a result of that Dx, and e. level of impairment f. Client's ability to benefit from treatment.	1/1/18	Yes, if MH Assess-ment (or documen-tation for an extension) is not completed by due date.

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Medication Consents	E4	Currently, it is not acceptable for a medication consent to include an attestation by the physician that the required consent components were discussed with the client (must be documented in the med consent).	Recommended change per DHCS guidance (that the following be allowed, but it is best practice to have everything written out on the Med Consent): 1.) Yes, it is acceptable for the medication consent to include attestations, signed by the provider and the beneficiary, that the provider discussed each of the required components of the medication consent with the beneficiary. a. For example, a physician may indicate that he or she discussed the type, range of frequency, amount, method (i.e., oral or injection), and duration of the medication(s), rather than specifying, "Prozac, for depression, 10-20mg, p.o BID for 6 months." b. There is then the need for a new Med Consent every time the dosage is changed by the prescriber—where the original Med Consent could have indicated a dosage range. c. The provider and beneficiary must sign and acknowledge the statement of attestation (Med Consent Form). **It is HIGHLY RECOMMENDED that all providers use the Medication Consent Forms posted on the ACHBCS website.**	1/1/18	Quality Comment
Medication Consents	E5	Currently, the use of check boxes on the medication consent form indicating that the provider discussed the need for the medication and potential side effects with the beneficiary DOES NOT suffice without listing the specific reasons and side effects?	Recommended changes per DHCS guidance (that the following be allowed, but it is best practice to have everything written out on the Med Consent): 1.) The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable <u>as long as the information is included in accompanying written materials provided</u> to the beneficiary (and a copy is in the Medical Record with the Med Consent form).	1/1/18	Quality Comment

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			2.) The reasons a provider prescribed a medication for a beneficiary must be documented in the beneficiary's medical record, but is not required specifically on the medication consent form. **It is HIGHLY RECOMMENDED that all providers use the Medication Consent Forms posted on the ACHBCS website.**		
Family Thera-py	H1, 2, 3	Currently, Family Therapy—with and without client present may be claimed.	Change: per DHCS guidance, "Family Counseling" with client not present must meet the procedure code requirements for Collateral (or as appropriate: Crisis Services, Assessment or Plan Development), and claimed as such. Family Therapy is ONLY claimed when client is present.	By 3/1/18	Yes, Family Therapy without Client Present will be disallowed and must be claimed as appropri-ate as: Collateral, Assessment, Plan Development, Crisis, etc.
Travel Time	M1	Currently, travel time between a provider's residence and a field location for the client is not claimable.	Change: the time from the provider's home to/from the field location is allowed to be claimed as travel time once their commute time is subtracted. (I.e. Provider's normal commute time is 15" from home to worksite. Instead of going first to the work site and then to the	1/1/18	Yes, if normal commute time is not subtrac-

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			field to see the client they go directly to the client in the field. The time from home to the field is 30", the 15" commute time is subtracted, and only 15" minutes is claimed as travel time. This must be explicitly documented in the PN.)		ted from travel time.
Client Plan	C12, D2	Service Modalities (Proposed Interventions on the Client Plan): Katie A now needs to be broken down to ICC and/or IHBS. As well, each Service Modality listed must describe a "detailed intervention".	1.) Unique Service Modalities that must be listed in the Client Plan for Planned Services: • Collateral • Case Management (Follow-up services are Planned) • Individual Rehabilitation • Group Rehabilitation • Individual Psychotherapy • Group Psychotherapy • Family Psychotherapy WITH Client Present • Multi-Family Group Psychotherapy • Collateral Family Group • TBS (Therapeutic Behavioral Services) • ICC (Intensive Care Coordination) • IHBS (Intensive Home Based Services) • DR (Day Rehabilitation) • DTI (Day Treatment Intensive) • Crisis Residential • Adult Residential • Crisis Stabilization • Psychiatric Inpatient Services • Medication Support Services (non-emergency) 2.) It is best practice to include a Detailed Intervention for each Service Modality listed. At a minimum , it is best to describe the approach to the intervention modality (i.e. For Individual Psychotherapy: "Cognitive Behavioral Therapy", or for Individual Rehabilitation: "Social Skills Training").	3/1/18	1.) Yes, if Listed Planned Service Modality is not indicated on the Client Plan— ALL such services will be disallow-ed. 2.) No disallow-ances for lack of a Detailed Interven-tion,.

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Questions regarding this memo can be directed to your BHCS Quality Assurance Technical Assistance contact. Please note, QA strives to respond to all emails within three (3) business days. See Table on next page.

CBO's by Parent Agency Name, or County Clinic by Program Name	**QA Technical Support Staff Member**
All CBO's: A-I & All Children's County Clinics & Programs	Jennifer Fatzler, LMFT Jennifer.Fatzler@ACgov.org
All CBO's: J-Z All Adult County Clinics & Programs	Brion Phipps, LCSW Brion.Phipps@ACgov.org