ALCOHOL, DRUG & MENTAL HEALTH SERVICES
MANUEL J. JIMÉNEZ JR ., MA, MFT, DIRECTOR

Quality Assurance Office
2000 Embarcadero Cove, Suite 400
Oakland, California 94606
(510) 567-8105 / TTY (510) 533-5018

Date: March 14, 2016

To: ACBHCS Mental Health County Clinics & Master Contract Providers

From: Quality Assurance Office

Re: Update to 3/1/16 Provider Memo.

Background:

Our Quality Management Director has been in communication with DHCS and we are now able to hold off on any Clinical Documentation Standards changes until DHCS issues their Provider Information Notice in regard to their own Documentation Standards update. **Please note that below we have indicated both the existing ACBHCS documentation standards which remain in effect, as well as the changes indicated in the 3/1/16 Provider Memo which are now on hold.**

We apologize for any confusion that the 3/1/16 Provider Memo may have caused. We anticipate that a memo will go out in April with updates on ACBHCS Clinical Documentation Standards which will coincide with the issuance of the DHCS Information Notice regarding proposed changes to their documentation and claiming guidelines for Medi-Cal Specialty Mental Health Services. As well, we will keep Providers up-to-date in each of our regular scheduled trainings and monthly "Brown Bag Luncheon" Q&A sessions.

Claiming for Planned Mental Health (MH) Services – 3/14/16 Update:

Per the ACBHCS Clinical Documentation Manual 'planned mental health services' may NOT be provided to a client before completion of *both* the Mental Health (MH) Assessment and the Client Plan. This includes all planned services and only allows Assessment, Plan Development and Crisis Intervention services to be claimed before completion of both the MH Assessment and Client Plan. Planned services include, but are not limited to, Case Management, Medication Services, Rehabilitation Services, Psychotherapy Services, Crisis Residential, Adult Residential, Day Treatment Intensive Day Rehabilitation, etc.

ACBHCS has consistently trained to this, however there are two exceptions to this rule in the Clinical Documentation Manual (12/3/14, pg. 6) which will now remain in effect **(changes indicated in the 3/1/16 Provider Memo are now on hold):**

1.) *If services other than for the purpose of assessment are provided prior to completion of the initial assessment document, the Medical Necessity rationale for those services must be provided in the corresponding progress notes.*
    a.) *Note that it must be within the scope of practice/experience of the writer of the note to establish medical necessity.*
2.) *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*

3.) *clinical issue arises that is not identified in the Initial Assessment, each Progress Note addressing that issue must evidence medical necessity.*

What does this mean for our staff who claim for a "planned service" before completion of the MH Assessment and/or Client Plan?

1.) If the requirements for exception #2 are met, any M/C staff may provide the planned service before completion of the Client Plan.
2.) If exception #1 applies, the staff providing the 'planned services" must also provide "*the Medical Necessity rationale for those services … in the corresponding progress notes."* Note, documentation of Medical Necessity in the progress note requires a MH Diagnosis which may not be provided by a Graduate Student/Trainee, MHRS, or Adjunct Staff. A waivered or registered LPHA may provide the diagnosis in the note—but it must also be co-signed by a licensed LPHA.

MH Assessment & Client Plan Timeframes for Brief Programs (Residential & Day) – 3/11/16 Update:

All changes are on hold. Please reference the Clinical Documentation Manual for any exceptions to the established outpatient 30 day deadline for the MH Assessment (pgs. 9 – 10) and the 60 day deadline for the Client Plan (pgs. 13 -14).

Reminders Regarding the Client Plan Update:

1. In order for planned services to be claimed planned service modalities must be listed in the Client Plan. Exceptions are the following unplanned services: MH Assessment (Psychiatric Diag Eval and Behavioral Eval), Plan Development, and Crisis Intervention (coded as Crisis Psychotherapy).
2. In addition, each service modality in the Client Plan must list detailed interventions. Detailed interventions for Collateral would include contact with individuals in the client's life who support the client plan. Best practice would be to list any known contacts and "to include others as needed".
3. **The change indicated in the 3/1/16 Provider Memo is now on hold.** This change required that a Collateral service to be considered a "planned service". Therefore, Collateral does not currently have to be listed in the Client Plan as a Service Modality in order to claim it. *However, in order to prepare for this likely change in the future—Providers may wish to start including the Collateral service modality in newly written Client Plans (when collateral services are clinically indicated).*

Case Management Services Update – **No change** (this was just provided as a resource as requested by providers): See 3/1/16 Provider Memo.

Providing Case Management to a client's significant other:

As well, we have received clarification from DHCS that Case Management Services may be provided to the client OR significant support person—**No Change**. *[It may be worth noting that many counties' QA departments have found that Auditors prefer that whenever possible, Collateral (i.e. Psychoeducation to support the Client Plan) be provided instead of Case Management to a client's significant support person.]*

For questions regarding this memo, please contact QA Technical Assistance staff.