alameda county behavioral health
SERVICES FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS

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To: CBO & County Providers of Specialty Mental Health Services

Executive Directors and Quality Assurance Leads

From: ACBH Quality Assurance Office

RE: Updates to Clinical Documentation Changes Memo of February 23, 2018

This BHCS memo supplements the 12/29/17 and 2/23/18 memos, with clarifications highlighted.

For each Clinical Documentation & Protocol change please find below: the category of Clinical Documentation, and the new BHCS process. As well, this memo replaces the Power Point distributed at the ACBHCS Clinical Documentation Updates trainings. The detailed changes are also being incorporated into the revised ACBHCS Clinical Documentation Manual dated November 30, 2018- release to follow.

Clinical Area	**New Process**
Diagnosis (Dx)	• Allow Second Year (full-time equivalent), or later, Graduate Students in Mental Health Programs to conduct a Mental Status Exam (MSE) and diagnose with appropriate training and experience with: ○ *This requires 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 the Licensed Supervisor's on-going full record review, supervision and co-signature.*
Assess	• 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 entered directly into a Progress Note--not the MH Assessment form.*
Assess	• The due date for the completed MH Assessment will be 60 days from episode opening date unless required sooner based on program type.

	○ Programs that have an earlier due dates for the <u>completed full</u> MH Assessment include: ▪ Day Rehab & Day Treatment Intensive (by day 7), ▪ Crisis Residential & Adult Residential (by days 7), ▪ and Inpatient services (within 72 hours of EOD). ○ Before TBS behavioral interventions can be billed, both a TBS assessment and TBS plan must be completed. • If the full MH Assessment is unable to be completed in the required timeframe due to clinical issues—the provider should document that in the record and may continue to claim for <u>Unplanned</u> services (see below). If the Client Plan is already completed, the full MH Assessment must also be completed for Planned Services to be claimed beyond the MH Assessment due date. Exceptions to this extension are based on program type with specific firm Assessment Due dates as indicated above.
Assess	• DHCS has elaborated with twelve (12) specific examples of categories of risk: ○ History of Danger to Self (DTS) or Danger to Others (DTO) ○ Previous inpatient hospitalizations for DTS or DTO ○ Prior suicide attempts ○ Lack of family or other support systems ○ Arrest history ○ Probation status ○ History of alcohol/drug abuse ○ History of trauma or victimization ○ History of self-harm behaviors (e.g., cutting) ○ History of assaultive behavior ○ Physical impairments (e.g. limited vision, deaf, wheelchair bound) which makes the beneficiary vulnerable to others ○ Psychological or intellectual vulnerabilities [e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality]. • When these categories exist for the client, they should be addressed in the MH Assessment. • As well, if in the past 90 days there has been suicidal or homicidal ideation (plan and/or means not required) or any other significant risk (including above examples) BOTH a written Comprehensive Risk Assessment AND a Formal Written Safety Plan must be created and documented in the medical record. See Provider website/QA/Training Material & Resources for sample templates.
Dx	• Per DHCS guidance, a historical diagnosis (including an Inpatient Dx) may **<u>not</u>** be simply referenced as the current Dx in an outpatient setting without re-diagnosis.
Dx	• Each contracted agency must have its own process for resolving discrepant diagnoses between staff and this must be done (align the primary diagnoses) as best practice.

	• As well, it is best practice for providers to collaborate across agencies regarding conflicting diagnoses.

Assess	• Within one agency--multiple RU's (who share a medical record) are allowed to share one MH Assessment (and diagnosis) for concurrent services.
	  ○ This includes both Initial MH Assessments and Annual MH Re-Assessments.
	  ○ This may only be done when two episodes are concurrently open.
	  ○ Initially, this is accomplished by back dating the second RU opening date to the first RU opening date.
	  ▪ When indicated, any documentation that is in need of updating must be addressed. This will almost always include a new Client Plan. As well, this may require additional consents (to a new modality of treatment), additional Release of Information Consents, etc.
	  ○ Note: In these circumstances multiple RU's within one agency may also decide to share a Client Plan OR create a Client Plan for each RU. The Annual Re-Assessments may also be shared if the chart documentation is complete as indicated below.
	  ○ If multiple RUs (in one agency) do not share a chart, all shared documentation must be copied into each chart. This includes documents from the initial EOD, such as:
	  ▪ Screening Form (with associated PN's),
	  ▪ Informing Materials (with associated PN's),
	  ▪ Mental Health Assessments (with associated PN's),
	  ▪ CANS/ANSA (with associated PN's),
	  ▪ Client Treatment Plan (with associated PN's),
	  ▪ ROIs (with associated PN's), etc.
	  ○ For BHCS County owned and operated programs, "one agency" is considered one program which has a unique folder in the Laserfiche database. (I.e. Eden Child Services or Oakland Community Support Center,)
	• Across multiple outpatient agencies the completed BHCS MH Assessment (Medi-Cal equivalent) from one agency be allowed to be shared (for Initial Assessment only) if the first MH Assessment was conducted within the past 6 months.
	  ○ The Assessment utilized from an outside provider must be a completed full BHCS MH Assessment (Medi-Cal equivalent) done by that Provider (that is, it may not be a MH Assessment that the outside Provider utilized from a different Provider and then updated with their MH Assessment Addendum).
	  ▪ The full BHCS MH Assessment (Medi-Cal equivalent) from the outside Provider must be incorporated into the Medical Record with a MH Assessment Addendum which includes:
	  ➢ the interim history,

	➢ any changes in all of the areas of the MH Assessment previously collected, ➢ A current included (aka "Covered") diagnosis, ➢ Signs and symptoms of the Diagnosis that meet DSM criteria, ➢ Functional impairments as a result of that Diagnosis, ➢ Level of impairment, and ➢ Client's ability to benefit from treatment. ➢ Date of attached Complete MH Assessment ○ For BHCS County owned and operated programs, utilizing MH Assessments across multiple outpatient agencies includes not only from non-BHCS programs, but across all BHCS programs as well. • The existing ability for one agency to utilize a MH Assessment completed within the past 12 months for a client returning to services (prior episode closed) remains. ○ The Assessment utilized must be a completed full BHCS MH Assessment (M/C equivalent) done by the same Agency (it may not be a MH Assessment utilized from a prior episode or from and outside Provider which was updated with a MH Assessment Addendum). ▪ The completed full BHCS MH Assessment (M/C equivalent) from the same Agency must be incorporated into the Medical Record with a MH Assessment Addendum which includes: ➢ the interim history, ➢ any changes in all of the areas of the MH Assessment previously collected, ➢ A current included (aka "Covered") diagnosis, ➢ Signs and symptoms of the Diagnosis that meet DSM criteria, ➢ Functional impairments as a result of that Diagnosis, ➢ Level of impairment, and ➢ Client's ability to benefit from treatment. ➢ Date of attached Complete MH Assessment ○ For BHCS county owned and operated programs, "one agency" is considered one program which has a unique folder in the Laserfiche database. (I.e. Eden Child Services, Oakland Community Support Center, etc.)
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.
Client Plan	• The date the staff person writing the Plan (or of any required co-signature, whichever is later) 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.) and must be within 60 days of EOD, or sooner as outlined in specific program types (DR, DTI, etc.). o Note, this does not change the timeframe for the required client/representative Plan signature (or reason why not is documented) AND always includes documentation of the following: ▪ Client/representative's participation in the creation of the Plan ▪ Client/representative's agreement to the Plan ▪ Client/representative was offered a copy of the Plan
Client Plan	• The client (or representative) signature is required on the Client Plan when: o the client is expected to be in treatment longer than 60 days, **OR** o 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. o The only circumstance in which only one Service Modality is expected is for either TBS only episodes or Medication Services only episodes. ▪ A TBS only episode or Medication Services only episode which backdates their EOD to coincide with another RU in the agency is not exempt from the required Client/Representative Plan signature (or reason why not). This applies whether they are sharing a Client Plan or not. (They have essentially merged both types of services into one episode by backdating the second RU EOD to that of the first. o Collateral is a second service modality and would require the Client's signature on the Plan. **Note, it remains best practice for the Client/Representative Signature to be obtained (or reason why not is documented) whenever a Plan is written (even when it is a short term Plan or when there is only one Service Modality).**
Client Plan	• 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: o 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. o 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	• 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.

	○ The Provider may add the date the client signed, initial it, and indicate the reason that they added the date for the client in the Progress Note (e.g. client forgot to date).
Client Plan	• If Client (or representative) noted as not available (or refuses) to sign the Plan--the Plan (and/or PN) shall include a written explanation as to the reason why the Plan was not signed. ○ It is required to make additional attempts to obtain the client's signature and to document the attempts in the client record unless clinically contraindicated and that must be documented in the record. ▪ Follow-up attempts must occur and be documented (unless the clinical contraindication is documented) or the services are at risk of disallowance and audit recoupment. (This is new clarification from DHCS.) ○ When the client signature is not yet obtained on the Client Plan, the progress note must indicate the date that: the client participated in the creation of the plan, their agreement with, and that they were offered a copy of the plan. ▪ 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	• No planned services may be provided until the completion of a Client Plan. • Non-planned services that may be provided until the Client Plan is completed are outlined below.
Client Plan	• Client Plans must be rewritten when there is a significant change in the client's life. • DHCS has provided additional specific examples of a "significant change": ○ A beneficiary who has never been suicidal makes a suicide attempt. ○ A beneficiary who regularly participates in client plan services suddenly stops coming to appointments. ○ Major Life events: Job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), change in residence/living situation.
Client Plan	• Change: the following are added to unplanned services (and allowable before completion of the Client Plan): ○ TCM and ICC (case management/brokerage) for *linkage and referral* purposes (only) to community supports, and ○ Medication services when documented as an "urgent need". • The Client Plan is due by 60 days from the EOD with the following exceptions: ○ It is not required for Crisis Stabilization Services (<24 hrs).

	○ Inpatient MH Services: it is due within 72 hours-excluding Saturday and Sunday, signed by MD and client (or reason client refused) WITH a completed full MH Assessment ○ Crisis Residential and Adult Residential: 72 hours (NOT excluding Saturday and Sunday), signed by LPHA and Client (or reason Client refused) WITH either a completed full MH Assessment or an Interim MH Assessment (described below). If an Interim Assessment is done, a completed Full MH Assessment is required by day seven. ○ Day Rehabilitation & Day Treatment Intensive: First billed day, signed by LPHA and Client (or reason Client refused) WITH either a completed full MH Assessment or an Interim MH Assessment (described below). If an Interim Assessment is done, a completed Full MH Assessment is required by day seven.
Client Plan	• An approved client plan must be in place prior to service delivery for the following SMHS: ○ Mental health services (planned services, see included list at end of this document), ○ Intensive Home Based Services (IHBS), ○ 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, ○ Therapeutic Behavioral Services (TBS), ○ Day treatment intensive—see time requirement above. ○ Day rehabilitation—see time requirement above. ○ Adult residential treatment services—see time requirement in above. ○ Crisis residential treatment services—see time requirement in above. ○ Medication Support (non-emergency), ○ Psychiatric Health Facility Services and, ○ Psychiatric Inpatient Services.
Client Plan	• When the Client Plan is past due the following SMHS may be claimed: ○ unplanned services, including urgent medication & TCM/ICC (case management/brokerage) services for linkage and referral (when documented per DHCS guidelines) are allowed during "gaps" of the Client Plan due date. ▪ Exceptions include: Day Treatment Intensive, Day Rehabilitation, Adult & Crisis Residential ○ A gap is any time period for which the Client Plan is delinquent and may be due to any reason.
Client Plan	Although this should not be a routine occurrence: a full Initial MH assessment is not required in advance of providing planned services (but is due by 60 days of EOD-or earlier when required) if an initial client plan is in

	place, and consistent with the documented Medical & Service Necessity in an Interim MH Assessment
	• A Initial "Interim" Client Plan may be created if the following are included:
	  o Client Plan must meet all required Client Plan elements.
	  o If a Complete MH Assessment is not in place an Interim MH Assessment must be completed which includes:
	  ▪ M/C Included Primary Dx
	  ▪ Signs and symptoms of the Dx that meet DSM criteria,
	  ▪ Functional impairments as a result of that Dx,
	  ▪ Level of impairment, and
	  ▪ Client's ability to benefit from treatment.
	Please note the required time deadlines for the creation of some programs' completed full (vs. Interim) MH Assessment as indicated above.

Medica-tion (Rx) Consents	• **It is HIGHLY RECOMMENDED that all providers use the Medication Consent Forms posted on the ACBHCS website.**
	• Per DHCS guidance (that the following be allowed, but it is best practice to have everything written out on the Med Consent):
	  o The medication consent may 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.
	  ▪ 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."
	  ▪ 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.
	  ▪ The provider and beneficiary must sign and acknowledge the statement of attestation (Med Consent Form).

Rx Consents	• **It is HIGHLY RECOMMENDED that all providers use the Medication Consent Forms posted on the ACBHCS website.**
	• Per DHCS guidance (the following below is allowed, but it is best practice to have everything written out on the Med Consent):
	  o The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the beneficiary (and a copy is in the Medical Record with the Med Consent form).
	  o 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.

Family Therapy	• "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.
	  ○ The Family Therapy (449) code is ONLY claimed when client is present.
	  ○ The Family Therapy without Client Present (413) will be changed to Collateral—Family Counseling code (413).
	  ○ The Multi-Family Group Psychotherapy (455) code is ONLY claimed when the client is present.
	  ○ A Multi-Family Group without the Client Present may be claimed as Collateral Family Group (317).
	  ○ Collateral Family Group (317) may be provided with or without the Client present.

Travel Time	• 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 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.)
	  ○ A "field location" for a Provider Entity does NOT include any sites that are Medi-Cal certified that are the umbrella of the same Agency/Corporation Tax ID#.
	  ○ All ACBHCS Owned and Operated programs are under the same Tax ID #, and as such travel time cannot be claimed between sites.

Client Plan	<u>1.) Unique Service Modalities that must be listed separately</u> in the Client Plan for Planned Services: • Collateral (Includes: Collateral, Collateral-Caregiver, & Collateral-Health Care Provider) • Case Management (Follow-up services are Planned) • Individual Rehabilitation • Group Rehabilitation • Individual Psychotherapy • Group Psychotherapy • Family Psychotherapy WITH Client Present • Multi-Family Group Psychotherapy WITH Client Present • Collateral Family Group (With or Without Client Present) • 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 for a detailed intervention. (i.e. For Individual Psychotherapy also indicate “Cognitive Behavioral Therapy”, or for Individual Rehabilitation also indicate “Social Skills Training”).