**Documentation Requirements for SMHS, DMC and DMC-ODS, Non-Hospital Services**

**Effective 7/1/22**

**Resource:** [BHIN 22-019 Documentation Requirements for all SMHS DMC and DMC ODS Services](https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf)

**Note**: *This reference guide highlights the DHCS documentation requirements exactly as they are written in the Information Notice. As areas are clarified, the information will be added to training and FAQ documents.*

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| **Section** | **SMHS** | **DMC-ODS** |
| Standardized Assessment Requirements |
| General | * Typed or legibly printed name, signature of the service provider and date of signature
* Provider’s determination of medical necessity and recommendation for services.
* The diagnosis, MSE, medication history and assessment of relevant conditions and psychosocial factors affecting the beneficiary’s physical and mental health must be completed by a provider, operating in his/her scope of practice under CA State law, who is licensed, registered, waivered and/or under the direction of a licensed mental health professional as defined in the State Plan.
* The MHP may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary’s MH and medical history, substance exposure and use and identifying strengths, risks and barriers to achieving goals.
 | * Typed or legibly printed name, signature of the service provider and date of signature
* Provider’s determination of medical necessity and recommendation for services.
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| Timeline | * **Adult Beneficiaries (21 years or older):** Timeline for initial assessment completion and subsequent assessments will be up to clinical discretion with the expectation that they be completed within a reasonable timeframe and in accordance with generally accepted standards of practice.
* **Beneficiaries under 21 years of age:** Timeline for initial CANS completion and subsequent CANS will be up to clinical discretion with the expectation that they be completed within a reasonable timeframe and in accordance with generally accepted standards of practice.
 | * Covered and clinically appropriate DMC-ODS services (except residential) are Medi-Cal reimbursable whether or not a diagnosis for SUD is established
	+ for up to 30 days following the first visit with a LPHA, , or

up to 60 days if the beneficiary is under 21 or provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. |
| Domains | **Adult Beneficiaries (21 years of age or older):**Uniform assessment to include the following 7 domains:* Domain 1:
	+ Presenting Problem(s)
	+ Current Mental Status
	+ History of Presenting Problem(s)
	+ Beneficiary-Identified Impairment(s)
* Domain 2:
	+ Trauma
* Domain 3:
	+ Behavioral Health History
	+ Comorbidity
* Domain 4:
	+ Medical History
	+ Current Medications
	+ Comorbidity with Behavioral Health
* Domain 5:
	+ Social and Life Circumstances
	+ Culture/Religion/Spirituality
* Domain 6:
	+ Strengths, Risk Behaviors and Safety Factors
* Domain 7:
	+ Clinical Summary and Recommendations
	+ Diagnostic Impression
	+ Medical Necessity Determination/Level of Care/Access Criteria

**Beneficiaries under 21 years of age:** * The Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to *help inform the assessment domain requirements listed above.* The CANS may inform the mental health assessment but cannot replace it.
 | **Adult Beneficiaries (21 years of age or older):*** ASAM Assessment within 30 days

**Beneficiaries under 21 years of age or homeless:** * ASAM Assessment within 60 days
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| **Problem List** |
| **SMHS and DMC-ODS** |
| * The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
* A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.
* The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.
* The problem list shall include, but is not limited to, the following:
	+ Diagnoses identified by a provider acting within their scope of practice, if any.
	+ Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
	+ Problems identified by a provider acting within their scope of practice, if any.
	+ Problems or illnesses identified by the beneficiary and/or significant support person, if any.
	+ The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.
* Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary’s condition.
* DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.
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| **Progress Notes** |
| **SMHS and DMC-ODS** |
| * Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
* Progress notes shall include:
	+ The type of service rendered.
	+ A narrative describing the service, including how the service addressed the beneficiary’s behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
	+ The date that the service was provided to the beneficiary.
	+ Duration of the service, including travel and documentation time.
	+ Location of the beneficiary at the time of receiving the service.
	+ A typed or legibly printed name, signature of the service provider and date of signature.
	+ ICD 10 code.
	+ Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
	+ Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.
* Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.
* Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). Weekly summaries will no longer be required for day rehabilitation and day treatment intensive.
* When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements listed above shall also be met.
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| **Treatment and Care Plans** |
| **SMHS and DMC-ODS** |
| * DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, with the exception of:
	+ Targeted Case Management (TCM)
	+ Intensive Care Coordination (ICC)
	+ Intensive Home Based Services (IBHS) and Therapeutic Foster Care (TFC)
	+ Therapeutic Behavioral Services (TBS)
	+ Narcotic Treatment Program (NTP)
	+ Short-Term Residential Therapeutic Programs (STRTPs)
	+ Psychiatric Health Facilities (PHF)
	+ Special Treatment Programs within Skilled Nursing Facilities (STP-SNF)
	+ Mental Health Rehabilitation Centers (MHRCs)
	+ A Needs and Service Plan (NSP) is required for services provided to children in Community Treatment Facilities
	+ A treatment/rehabilitation plan is required for services provided in Social Rehabilitation Programs
	+ Peer Support Services
* **Targeted case management** services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment:
* The TCM Care Plan:
	+ Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary;
	+ Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary’s authorized health care decision maker) and others to develop those goals;
	+ Identifies a course of action to respond to the assessed needs of the beneficiary; and
	+ Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.
	+ The required elements of the TCM Care Plan *shall* be provided in a narrative format in the beneficiary’s progress notes.
* **Peer Support Services** must be based on an approved plan of care.
* The plan of care shall be documented within the progress notes in the beneficiary’s clinical record and approved by any treating provider who can render reimbursable MediCal services.
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| **Telehealth Consent** |
| **SMHS and DMC-ODS** |
| * If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once, upon initiation of telehealth services. This includes:
	+ An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an inperson, face-to-face visit;
	+ An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future;
	+ An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted;
	+ Potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.
* The provider must document in the patient record the provision of this information and the patient’s verbal or written acknowledgment that the information was received.
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| **Compliance Requirements** |
| **SMHS and DMC-ODS** |
| DHCS will continue to carry out its responsibility to monitor and oversee county SMHS, DMC, and DMC-ODS programs and their operations as required by state and Federal law. This oversight will include verifying that county and provider documentation complies with the requirements in this BHIN, that services provided to Medi-Cal beneficiaries are medically necessary, and that documentation complies with the applicable state and Federal laws, regulations, the MHP contract, DMC State Plan Contract, and the DMC-ODS Interagency Agreement/Contract. |