Contra Costa County Health Services Department **Behavioral Health Services Division** **Mental Health Plan**	POLICY NO. 709-MH
	Effective as of: January 1, 2022 Next Review Date: January 31, 2025 Policy Expires On: January 31, 2026
POLICY: **UTILIZATION MANAGEMENT/UTILIZATION REVIEW: MENTAL HEALTH DOCUMENTATION STANDARDS**	By: Suzanne Tavano Suzanne Tavano, PhD Behavioral Health Director

POLICY: UTILIZATION MANAGEMENT/UTILIZATION REVIEW: MENTAL HEALTH DOCUMENTATION STANDARDS

I. PURPOSE:

The purpose of this policy is to establish documentation standards for Contra Costa Behavioral Health Services-Mental Health Plan (CCBHS-MHP) County Owned and Operated Clinics and Community Based Organizations (CBOs) and to ensure that CCBHS-MHP complies with current State and Federal regulations.

II. REFERENCES:

- CFR, Title 22
- CFR, Title 42
- CCR, Title 9, Chapter 11, Section 1810.204, Section 1840.112(b)(1-4), Section 1840.314 (d)(e)
- CCR, Title, 9, Chapter 11, Section 1830.205 (b)(1)(A-R) and 1830.210
- CCR, Title 9, Chapter 4, Section 851, Lanterman-Petris-Short Act
- California Welfare & Institutions Code § 14184.402(f)
- California Department of Health Care Services (DHCS), Behavioral Health Information Notice (BHIN) No. 22-013
- DHCS, Behavioral Health Information Notice (BHIN) No. 22-016
- DHCS, Behavioral Health Information Notice (BHIN) No. 22-019
- Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services
- Policy 509-MH, Criteria for Beneficiary Access to Specialty Mental Health Services, Medical Necessity and Other Coverage Requirements (CalAIM Initiative)
- Policy 706-MH, Utilization Review: Specialty Mental Health Service Authorization Process
- Policy 815, Notice of Adverse Benefit Determination
- Policy 831-MH, Scope of Practice and Clinical Supervision Standards

III. POLICY:

It is the policy of CCBHS-MHP that all interactions with clients are documented in client records, that documentation is completed in a timely manner following established documentation standards in order to provide evidence that the beneficiary meets medical

and service necessity criteria, as indicated in CCR, Title 9, Chapter 11, Section 1830.210, for authorization and reimbursement of service.

IV. AUTHORITY/RESPONSIBILITY:

Behavioral Health Medical Director
Mental Health Program Chiefs
Program Managers/Supervisors
Utilization Review (UR) Manager
UR Coordinators
UR Mental Health Clinical Specialists
UR Clerical Staff
Mental Health Service Providers

V. PROCEDURE:

A. Mental health service providers are required to produce timely, accurate and complete documentation of client's history and current treatment.

B. CCBHS-MHP County Owned and Operated Clinics must use County forms for documentation.

C. CCBHS-MHP CBOs may use either County forms or their own forms that have been approved by CCBHS-MHP for documentation.

D. Treatment services shall be provided and documented in a culturally competent, age-appropriate manner and be in accordance with Federal and State regulations.

E. **Documentation Requirements.**

1. Assessments.

a. Clients seeking mental health services shall be assessed by a licensed (within scope of practice), license-eligible or waivered clinician to establish need for services, appropriate level of care and that medical/service necessity criteria established in Title 9 are met.

b. Starting July 1, 2022, the following requirements will be in effect:

i) Clinical Assessments shall include the following domains:

a) Domain 1:

i. Presenting Problem(s)

ii. Current Mental Status

iii. History of Presenting Problem(s)

iv. Beneficiary-Identified Impairment(s)

b) Domain 2:

i. Trauma

c) Domain 3:

i. Behavioral Health History

ii. Comorbidity

d) Domain 4:

i. Medical History

ii. Current Medications

iii. Comorbidity with Behavioral Health

e) Domain 5:

i. Social and Life Circumstances

ii. Culture/Religion/Spirituality

f) Domain 6:

i. Strengths, Risk Behaviors, and Safety Factors

g) Domain 7:

i. Clinical Summary and Recommendations

ii. Diagnostic Impression

iii. Medical Necessity Determination/Level of Care/Access Criteria

h) Coverage for, or reimbursement of, a clinically appropriate and covered mental health or substance use disorder prevention, screening, assessment, treatment, or recovery service shall not be denied on

the sole basis that services were provided or rendered prior to:

i. The completion of an assessment; and/or

ii. The determination of a diagnosis. In other words, appropriate claims for services provided prior to the completion of an assessment or the determination of a diagnosis are allowed.

1. The establishment of a diagnosis is required to be made by a licensed provider working within their scope of practice. Waivered clinicians and/or interns/trainees may assign a diagnosis under the direction of a Licensed Mental Health Professional (LMHP).

2. Diagnosis is within the scope of practice for the following LMHP provider types:

   a. Physicians.

   b. Licensed Psychologists (PhD, PsyD).

   c. Licensed Clinical Social Workers.

   d. Licensed Marriage and Family Therapists.

   e. Advanced Practice Nurses (Nurse Practitioner), in accordance with the Board of Registered Nursing.

3. County Owned and Operated Clinics use ccLink, an Electronic Health Record system to maintain beneficiary records. In ccLink, the

assignment of the mental health diagnosis is completed through the Problem List function, episodes of Care Activity, and /or documenting diagnosis in the Navigator Smart Form.

4. Completion of the Initial Assessment, Annual Update and/or Reassessment must be in compliance with CCBHS-MHP's scope of practice guidelines detailed in Policy 831-MH, Scope of Practice and Clinical Supervision Standards.

5. The diagnosis shall be established on the initial assessment, updated annually for clinical/case-managed beneficiaries and updated every two years for beneficiaries with medication support services only.

6. Providers are required to use the most recent approved ICD-10 code diagnoses.

ii) The plan for continued care.

iii) The date of service and date of completion (signature date).

iv) The signature of the person providing the service (or electronic equivalent), the signer's professional degree and licensure or job title (must be completed by a licensed/license-eligible or waivered clinician).

v) For beneficiaries under the age of twenty-one (21), Child and Adolescent Needs and Strengths (CANS), Form MHC-118, must be completed in conjunction with the clinical assessment (both initial and annual), as required elements are located within the CANS form.

F. **Initial Assessment.**

1. Providers shall complete and electronically sign the following:

a. One of the following: Adult (21 and older) Clinical Assessment (County providers), Child (0-20) Clinical Assessment (County providers), Clinical Assessment – 21 and Over (CBO providers), Clinical Assessment – Under 21 (CBO providers), or another assessment completed within the last twelve (12) months of episode opening.

b. For beneficiaries under the age of twenty-one (21), the Child and Adolescent Needs and Strengths (CANS) form must be done in conjunction with the Initial Clinical Assessment for Children.

c. For beneficiaries age 3-18, the BHS Pediatric Symptom Checklist – PSC35 form (County providers) or Form MHC-120, Pediatric Symptom Checklist-PSC-35 (CBO providers) must be completed in conjunction with the clinical assessment.

2. Completion of the Initial Assessment shall be done within the following time frames:

a. Within sixty (60) days of the initial opening date, if this is the client's initial contact with CCBHS-MHP.

b. Within twenty-four (24) hours of admission to a crisis residential program, a Psychiatric Assessment must be completed by an MD/DO/NP.

i) Crisis residential programs must include as part of their assessment and intake documentation the admission agreement describing the services to be provided and the expectations and rights of the client.

3. Assessments by clinicians (LMFT, LCSW, PsyD, etc.) are valid for twelve (12) calendar months from the date of completion. Assessments by medical staff (MD, DO, NP) are valid for twenty-four (24) calendar months from the date of completion.

4. Diagnosis.

a. Providers are required to use appropriate ICD-10 diagnosis code(s) to submit claims and receive reimbursement.

b. Coverage for, or reimbursement of, a clinically appropriate and covered mental health or substance use disorder prevention, screening, assessment, treatment, or recovery service shall not be

denied on the sole basis that services were provided or rendered prior to:

i) The completion of an assessment,

and/or

ii) The determination of a diagnosis.

c. Appropriate claims for services provided prior to completion of either (1) an assessment or (2) a "reasonable timeframe" of the determination of a diagnosis are allowed.

d. Providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:

i) ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

ii) ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

a) In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMHP in the CMS approved ICD-10 diagnosis code list, which may include Z codes. LPHAs and LMHPs may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

G. **Annual Updates.**

a. Service Providers must perform a clinical or psychiatric re-assessment by completing the one of the following:

H. Providers shall complete, sign (electronically if applicable), and submit (CBO providers) the following during the last month of the current authorization:

a. One of the following: Adult (21 and older) Clinical Assessment (County providers), Child (0-20) Clinical Assessment (County providers), Clinical Assessment – 21 and Over (CBO providers), or Clinical Assessment – Under 21 (CBO providers).

b. For beneficiaries under the age of twenty-one (21), the CANS form (County providers) or form MHC-118, Child and Adolescent Needs and Strengths (CANS) (CBO Providers) must be completed in conjunction with the clinical assessment.

c. For beneficiaries age 3-18, the BHS Pediatric Symptom Checklist – PSC35 form (County providers) or Form MHC-120, Pediatric Symptom Checklist-PSC-35 (CBO providers) must be completed in conjunction with the clinical assessment.

2. The annual assessment must be completed prior to the expiration of the authorization period listed on the Service Authorization Form or the BHS Service Authorization Form.

I. The clinical annual assessment shall be conducted and completed within the last month of the authorization.

J. For Medication Services Only clients, the psychiatric assessment shall be conducted and completed every two (2) years within the last month of the authorization.

K. **Child and Adolescent Needs & Strengths (CANS) Form.**

1. The Child and Adolescent Needs and Strengths (CANS) form is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

2. The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

3. For beneficiaries under the age of twenty-one (21), the CANS (County providers), BHS CANS Update Form (County providers), or form MHC-118, Child and Adolescent Needs and Strengths (CANS) (CBO Providers) must be completed at the following timeframes:

   a. Within sixty (60) days of the initial opening date for every initial contact with a CCBHS-MHP provider.

   b. At the six (6)-month mid-track marker.

   c. Annually, must be completed before the current authorization period expires. The annual CANS must be conducted/completed within the last month of the authorization.

   d. At discharge.

      i) If discharge occurs during the initial sixty (60) days, the completion of the CANS requirement is waived.

      ii) If client is administratively discharged, the service provider should copy the most recent CANS that was done (so there basically have been no changes in the CANS items unless they have that information) and indicate that this is an administrative discharge and the CANS has not been updated.

L. **Pediatric Symptom Checklist – PSC-35.**

   a. The PSC-35 is designed to detect behavioral and psychosocial problems.

2. Form BHS Pediatric Symptom Checklist – PSC35 (County providers) or Form MHC-120, Pediatric Symptom Checklist-PSC-35 (CBO providers) shall be completed by or with the caregiver.

   a. Caregivers include: Foster parents, group home/board and care operators.

   b. If the client is self-referred or caregivers are not involved, this must be indicated on the PSC-35 itself and the form may be submitted blank.

   c. In order to be considered valid, the form may not have more than three (3) unanswered questions.

3. For beneficiaries ages 3-18 years, the PSC-35 must be completed at the following timeframes:
    a. Within 60 days of the initial opening date for every initial contact with a CCBHS-MHP provider.
    b. At the six (6)-month mid-track marker.
    c. Annually, before the current authorization period expires. an annual PSC-35 shall be conducted/completed within the last month of the authorization.
    d. At discharge.
        i) If discharge occurs during the initial 30-60 days, the completion of the PSC-35 requirement is waived.
        ii) If client is administratively discharged, the service provider should check the "no caregiver/no caregiver involvement", note that this is an administrative discharge and submit the form.

M. **Problem List.**

1. The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.
2. A separate problem list shall be completed for each facility/program, which shall be individualized to the beneficiary's needs.
3. 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.
4. 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.
5. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.
6. The problem list shall include, but is not limited to, the following:
    a. Diagnoses identified by a provider acting within their scope of practice, if any.

i) Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.

b. Problems identified by a provider acting within their scope of practice, if any.

c. Problems or illnesses identified by the beneficiary and/or significant support person, if any.

d. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

7. Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

8. The problem list is not required to be updated within a specific timeframe, and there is no 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.

N. **Treatment and Care Planning Requirements**

1. Targeted Case Management (TCM).

a. 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:

i) 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.

ii) 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.

iii) Identifies a course of action to respond to the assessed needs of the beneficiary.

iv) Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

b. These required elements shall be provided in a narrative format in the beneficiary's progress notes.

2. Peer Support Services.

a. Peer support services must be based on an approved plan of care.4 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 Medi-Cal services.

O. **Medication Consent.**

1. Form MHC-029, Informed Consent for Psychotropic Medication form must be obtained for every prescribed psychotropic medication.

a. Consent must be signed/dated by the following:

i) Beneficiary/legal responsible party agreeing to each prescribed medication.

ii) The prescribing MD/DO/NP.

b. Required information will be provided either verbally and/or in writing and must include the following:

i) The reason(s) for medication prescribed.

ii) Reasonable alternative treatment(s) available, if any.

iii) Type of medication (e.g., antipsychotic, anti-anxiety, etc.)

iv) Range of frequency (of administration).

v) Dosage.

vi) Method of administration, oral or injection.

vii) Duration of taking the medication.

viii) Probably side effects.

ix) Possible side effects, if taken for longer than three months.

c. Beneficiary must be given the Medication Information Sheet(s) for each prescribed medication.

d. Consents can be withdrawn at any time by the beneficiary/legal responsible party/guardian.

e. Consents are valid for a period of two (2) years.

f. Authorization Committee will grant full service authorization starting on the date when medication consents are considered complete with all required signatures.

2. For County Owned and Operated Clinics, once the UR Committee has reviewed and authorized services, the completed and signed Medication Consent must be scanned into ccLink media.

3. For minor clients who are under legal guardianship, JV220 and JV223 must accompany a signed Medication Consent Form.

P. **Service Authorization Form.**

1. Form MHC-036, Service Authorization Form, must be completed for each client receiving Specialty Mental Health Services, Case Management Service, Medication Support Services, Adult Residential Services, Crisis Residential Services, Day Treatment Services, Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), Therapeutic Foster Care (TFC) and Therapeutic Behavioral Services (TBS).

2. The Service Authorization Form must be completed by the CCBHS-MHP authorizing agent within sixty (60) days for initial admissions and within thirty (30) days of the annual authorization thereafter.

3. The Service Authorization Form details the following:

a. Utilization Review (UR) Track.

b. The length of service authorization.

i) Start and End Dates.

ii) (Up to) the number of months/days approved.

a) The maximum number of approved months is twelve (12) for Outpatient Specialty Mental Health Service authorizations.

b) The maximum number of approved months is twelve (12) for ICC services.

c) The maximum number of approved months is twelve (12) (allotted in six [6] month authorization periods) for IHBS.

i. An extension request must be submitted for extension past the initial twelve (12) months.

d) Day Treatment Intensive Programs: Maximum number of approved months is three (3) months/ninety (90) days.

e) Day Treatment Rehabilitative Programs: Maximum number of approved months is six (6) months/ one hundred eighty (180) days

f) Authorizations for Evidence-Based Programs (EBP) and Short-Term Programs will be limited to an authorization period based on current work/service plan and program description and/or requirements.

i. An extension request must be submitted for extension past the initial authorization.

g) Crisis Residential Programs: Maximum number of days is thirty (30).

i. Two (2) thirty (30)-day extensions may be granted if circumstances require a longer length of stay to ensure successful completion of the treatment plan and appropriate referral.

1. Must complete Justification for Continued Authorization Form

ii. Length of stay cannot exceed three (3) months per admission.

iii) Authorized types of services to be provided to the client.

iv) The Service Provider Agency facility/program numbers.

v) Changes in Authorization, e.g., denial or reduction in services necessitate the completion of a Notice of Adverse

Beneficiary Decision (NOABD). Indication of NOABD is marked on the Service Authorization Form, if applicable.

vi) Authorizing Committee member initials and signature.

vii) Date Authorization was granted.

4. In the event that any additional Service Providers are authorized by the Committee, the Service Provider will be added to the original Service Authorization Form and given a copy of the Service Authorization Form for their records after review of their required documentation.

   a. If there is a change in therapist/provider for a client already receiving mental health services, authorization will not be granted to bill for time spent completing the UR paperwork.

Q. **Progress Notes**

1. Providers shall create progress notes for the provision of all SMHS services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

2. Progress notes shall include:

   a. The type of service rendered.

   b. 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).

   c. The date that the service was provided to the beneficiary.

   d. Duration of the service, including travel and documentation time.

   e. Location of the beneficiary at the time of receiving the service.

   f. A typed or legibly printed name, signature of the service provider and date of signature.

   g. ICD-10 code.

   h. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

   i. 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.

3. 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.

4. 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.

5. When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider.

    a. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider.

    b. 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.

    c. All other progress note requirements listed above shall also be met.

6. Adult/Crisis Residential programs are required to complete the following:

    a. **Daily** Progress Notes, which must address the plan goals.

    b. **Weekly** Clinical summaries, which document progress towards goals.

        i) Clients shall be involved in the ongoing review of progress towards reaching established goals and be involved in the planning and evaluation of their treatment goals weekly.

        ii) Clinical Summaries must be reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker or marriage and family therapist, or a registered nurse who is either staff to the crisis residential program or the person directing the service.

R. **Discharge Summary.**

1. The discharge summary is the documentation source for the ultimate outcome of service provided by the program to the client.
2. Discharge Summary notes should be written on the last day of services if the discharged was planned. Discharge Summary should be submitted for billing within 24 hours.
    a. If extenuating circumstances exist and discharge documentation is not completed within three (3) business days of service, a late entry notation shall be documented.
    b. Discharge Summary must be completed within 5 calendars from last contact or notification of planned discontinuation of service in order to claim for services.
3. In those cases when the consumer terminates in an unplanned manner or have not received services for 6 months, the discharge summary must be written to administratively discharge the client. Administrative discharges are not reimbursable and the clinician must use a non-billable procedure code.
4. For medication-only beneficiaries, if there has been no contact for 1 year, the discharge summary should be completed and the episode closed.
5. For Crisis Residential Programs, the discharge summary must include the following elements: goals accomplished, reason and plan for discharge, and referral follow-up plans.

S. **CCBHS-MHP Documentation Standards.**

1. Documentation must be legible.
2. Signatures (or electronic equivalent) shall include at a minimum the service provider's first initial and full last name followed by licensure or County designation.
3. Hard-copy forms shall be fully completed using black or blue indelible ink pens.
    a. The following are not allowed:
        i) Erasable ink pens.
        ii) Pencils.

iii) Correction fluid (e.g., Liquid Paper) or tape.

iv) Ink pens in a color other than black or blue.

4. All CCBHS-MHP forms must be completed fully.

   a. The Service Provider shall fill in all lines, fields and spaces on a form.

      i) If the statement does not fit a certain situation or an answer cannot be obtained, the Service Provider shall indicate with N/A, a hyphen ("-") or "UTO" (unable to obtain) or another similar phrase to indicate that the question was asked and not answered.

5. Use of abbreviations in clinical documentation should be limited to those on the "approved abbreviation list".

   a. Should the clinician want to use an abbreviation that is not on the approved list, the clinician may do so but must first define the abbreviation and at that point can use the abbreviation in the remainder of the progress note.

   b. The "definition" and use of the abbreviation is good for only that clinical note. The process must be done on all subsequent notes.

   c. Diagnosis narrative must be completely written out. No abbreviations are allowed.

6. Once entered into the medical record, documentation becomes a legal document. Service Providers, therefore, cannot do the following once entered:

   a. Obliterate material in the medical record.

   b. Erase documentation from progress notes.

   c. Remove pages from documentation.

   d. Use correction fluid or tape.

7. If an error is made, the error must be corrected in the following manner:

   a. A single line is drawn through the error.

   b. The Service Provider shall write "error", initial, and date.

      EXAMPLE: ~~ERROR~~error cb 9-1-07

T. **Late entry of documentation.**

1. Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

2. When documentation of a service is not completed/electronically signed within three (3) business days of the date of service/encounter date, the service provider shall include a "Late Entry" notation in the body of the progress note that should be written as: "This is a late entry."

3. Claiming documentation time.

   a. Documentation time shall be proportionate to the amount of time spent and the amount of intervention provided.

4. Late documentation of services.

   a. Documentation requiring co-signature prior to billing is not considered late, if only the co-signature, or any corrections requested by the co-signer, is not obtained.

   b. Behavioral Health Program Managers and Supervisors are responsible for ensuring that each clinical staff member enters documentation in a timely manner on a monthly basis. If an individual staff member is not completing their documentation in a timely manner, the supervisor may take necessary corrective action, ranging from increased training to progressive disciplinary procedures. If necessary. Behavioral Health Program Managers and Supervisors will consult with the appropriate Program Chief prior to taking any formal disciplinary action.