OUTPATIENT DOCUMENTATION REFORM: INTRODUCTION

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EXPECTATIONS FOR TODAY

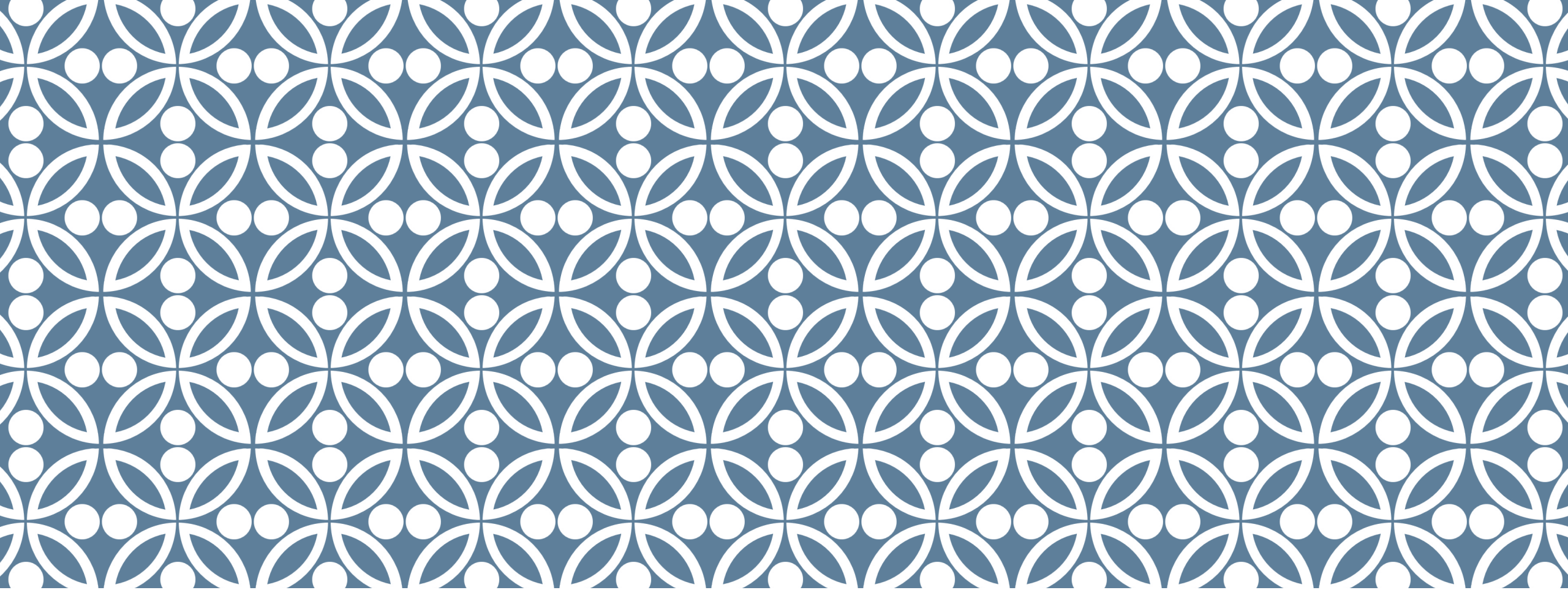
This is an introduction, not a full training.

We are working to develop our policies and guidance as we continue to get information from DHCS and CalMHSA.

More trainings will be available soon on-demand from CalMHSA.

Topics

- Assessments
- Problem List
- Progress Notes
- Treatment Plans
- Telehealth/Telephone Consents



OVERALL THEMES

Moving from “compliance” to “quality”

FOCUS ON QUALITY OF SERVICES & DOCUMENTATION

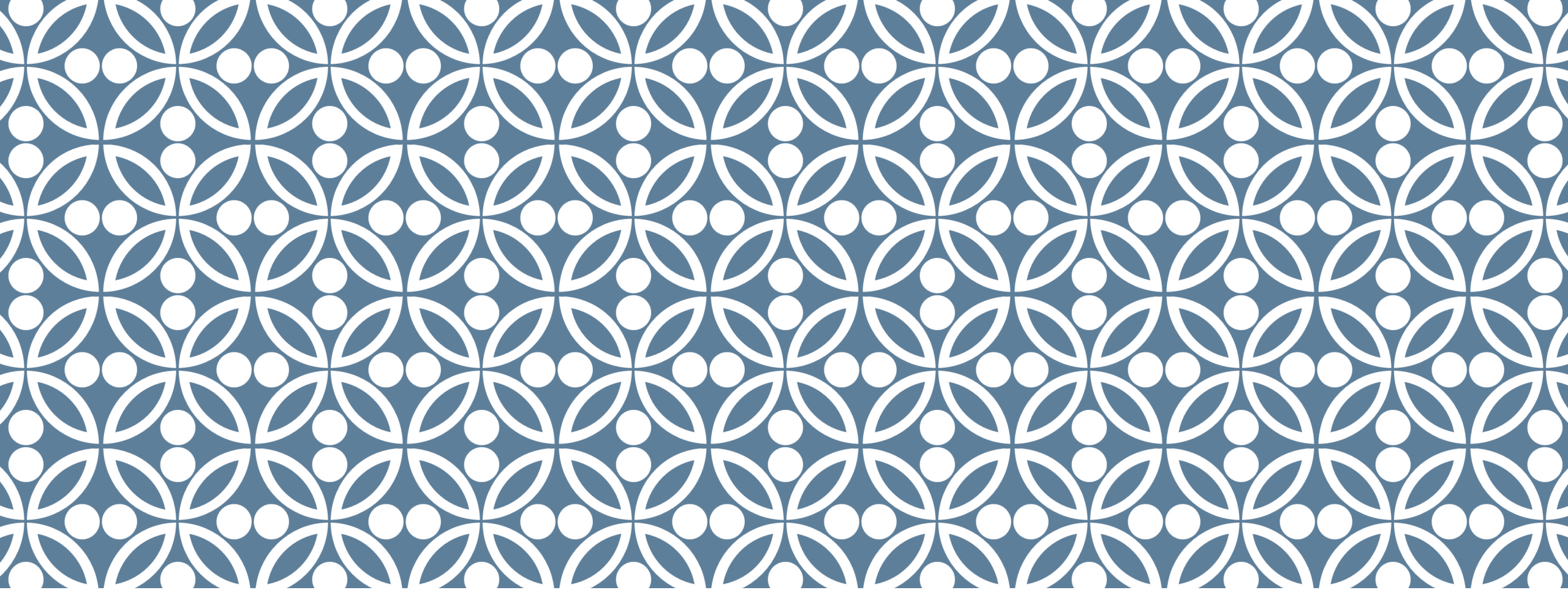
DHCS guidance is moving away from super-detailed and prescriptive.

Reasons for recoupments are moving toward fraud, waste & abuse, rather than simple errors or misunderstandings.

While DHCS is eliminating a lot of "musts," Sonoma County and CBOs will have – and should take! – the opportunity to focus on clinical quality of services and documentation.

Do think about quality! Even if a documentation requirement has been removed as a "must," we probably want to be thinking about standards of care, ease of communication among providers, and what's best for the client.

- Example: "CBT therapy session to address Naomi's anxiety around school. Next session in one week." might *technically* meet DHCS requirements, but it's not really a useful or clinically sound note.



ASSESSMENTS

Domains
Timelines
Providers

NEW ASSESSMENT DOMAIN REQUIREMENTS

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 & Life Circumstances
- Culture/Religion/Spirituality

Domain 6:
- Strengths, Risk Behaviors & Safety Factors

Domain 7:
- Clinical Summary & Recommendations
- Diagnostic Impression
- Medical Necessity Determination / Level of Care

WILL THE ASSESSMENTS BE CHANGING?

Maybe!

For now, we think the current assessment items map well into the new required domains.

Any changes are likely to be minimal and will be rolled out via DCAR.

(Remember, new DHCS focus on recouping for fraud, waste, and abuse – not good-faith misunderstandings – gives us a bit of grace in figuring this out.)

ASSESSMENT TIMELINES

Must be completed "within a reasonable time and in accordance with generally accepted standards of practice"

Medically necessary services provided during assessment period or before a diagnosis is established are covered and reimbursable, even if the completed assessment determines the client does not meet criteria for SMHS

- Example: A client is referred for assessment for Schizophrenia. They present with disorganized thoughts and blank affect. They are being evicted and require help obtaining emergency shelter. The clinician begins the assessment and also provides Targeted Case Management (301 TCM) to link the client to housing, as well as medical care. With the client's permission, the clinician also works to locate the client's sister and speak with her regarding the client's condition (311 Collateral). While finishing the assessment paperwork, the clinician receives a report from the client's new primary care physician diagnosing the client with Traumatic Brain Injury and Dementia. The 301 Targeted Case Management and 311 Collateral provided by the clinician would still be covered and reimbursable, as they were medically necessary services provided in good faith while the assessment was being completed.

ASSESSMENT PROVIDERS

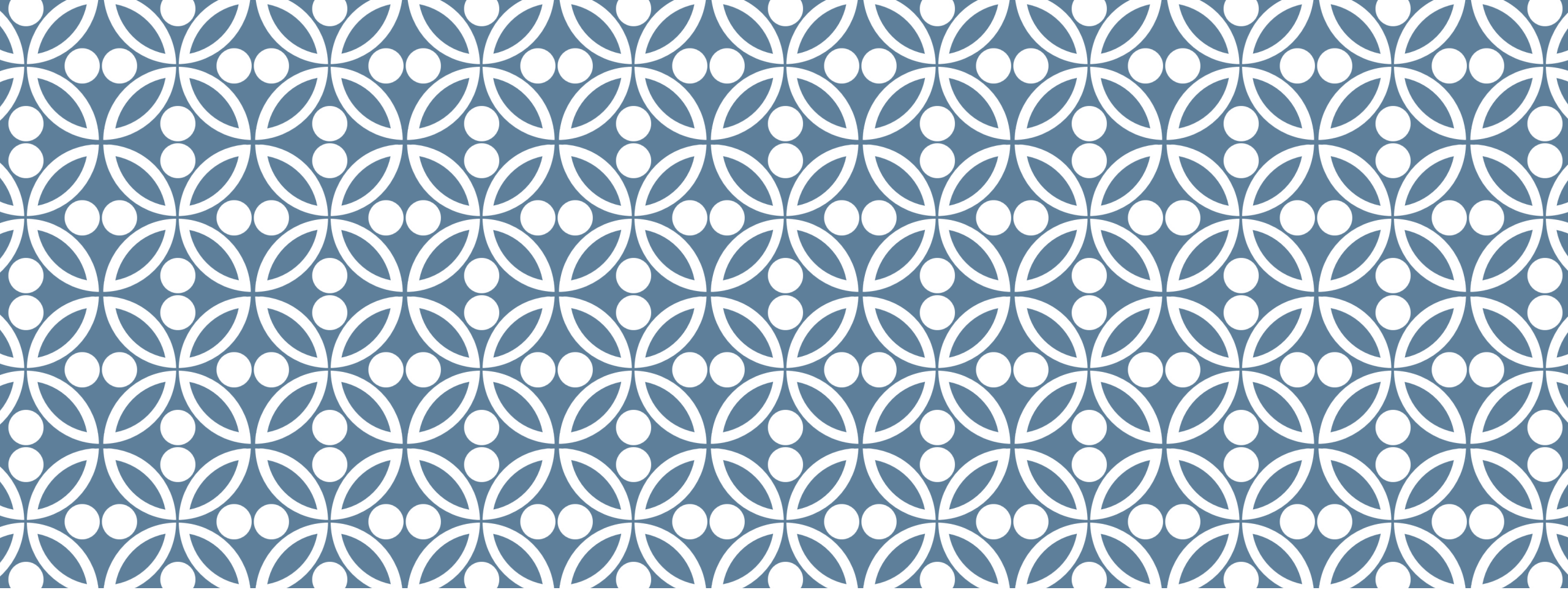
Assessments must include:

- Typed or legibly printed name
- Signature of provider (or electronic equivalent)
- Date of signature

Diagnosis, Mental Status Exam (MSE), medication history, and rationale for diagnosis can be completed only by clinicians

MHRS may contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals

(This is all the same as it has been! No changes in who can do what.)



PROBLEM LIST

What?
When?
Who?

WHAT IS A PROBLEM LIST?

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

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

HOW OFTEN DOES THE PROBLEM LIST GET UPDATED?

Updated on an ongoing basis to reflect the current presentation of the client

Updated “when there is a relevant change to a client’s condition” by adding or removing from the list

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 does not need to be listed *before* addressing it

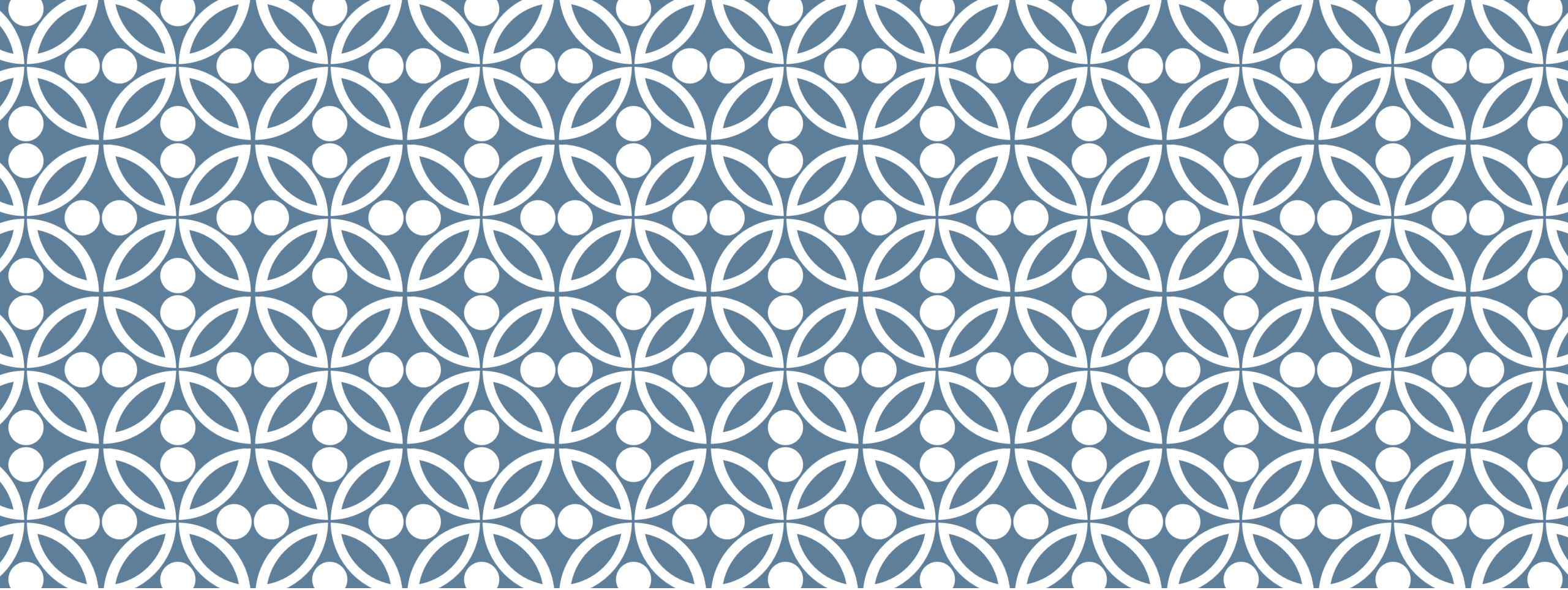
Providers shall update the problem list “within a reasonable time and in accordance with generally accepted standards of practice”

WHO CREATES OR EDITS THE PROBLEM LIST?

"The provider(s) responsible for the beneficiary's care shall create and maintain a problem list"

Providers must work within their scope of practice in identifying and adding problems:

- MHRS and "other qualified providers," including Peer Specialists, can add problems like "lack of housing" or other psychosocial conditions
- DSM-5/ICD-10 diagnoses can only be added or removed by clinicians or MDs
- Other physical health conditions should only be added by MDs or RNs working within the scope/expertise



PROGRESS NOTES

Content
Timelines
Recoupments

INDIVIDUAL PROGRESS NOTE REQUIREMENTS

Each service still requires a progress note

Each progress note shall provide sufficient detail to support the service code selected (e.g., description of intervention)

Progress notes shall include:

- The type of service rendered (TCM, therapy, etc.)
- 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 of service
- Duration, including travel and documentation time
- Location of the beneficiary at the time of receiving the service
- A typed or legibly printed name, provider signature (or electronic equivalent) and date of signature
- Next steps (e.g., Plan)

All notes must be associated on the claim with:

- ICD 10 code
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code

GROUP PROGRESS NOTE REQUIREMENTS

If more than one group facilitator, one facilitator may write and sign each note

Notes for services with multiple providers must “clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time”

List of participants required (maintain separately from clients’ charts)

All individual progress note requirements must also be met

PROGRESS NOTE TIMELINES

Due within 3 business days for all non-crisis services

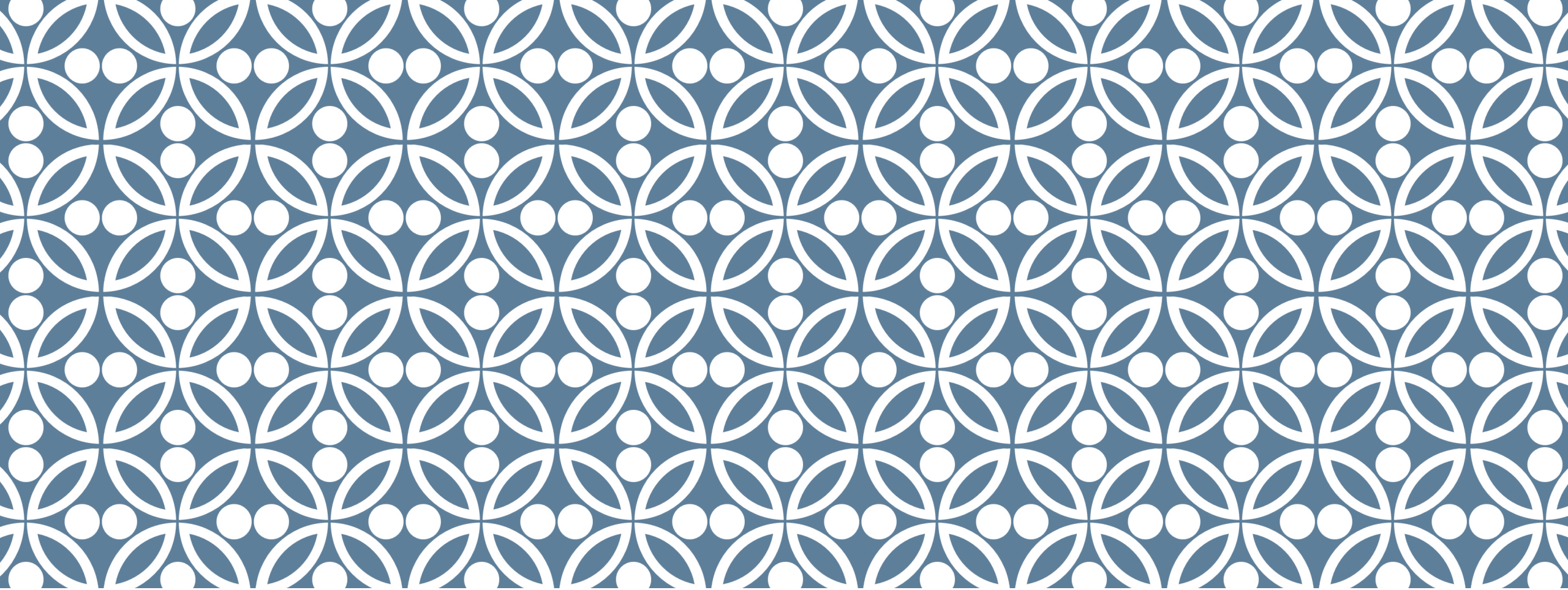
Due within 24 hours for crisis services

Daily progress note required for services billed on a daily basis (e.g., residential treatment services, therapeutic foster care, etc.)

REASONS FOR RECOUPMENT – PROGRESS NOTES

We cannot predict FY22-23, but even for now the FY21-22 reasons are less "picky":

- Recoupment if no service was claimed but no note exists
- Recoupment if services were not actually a mental health service (e.g., No Show, clerical)
- Recoupment if service was outside provider's scope of practice
- Recoupment if note is not signed
- Recoupment if service with multiple providers doesn't document the individual involvement of each
- Recoupment if service description doesn't match service code
  - BUT! Payments will be recouped only if there was overbilling (e.g., you provided TCM but billed for Therapy)
- Recoupment if date of service on note doesn't match actual date of service
  - BUT! Payment will be recouped only if the provider can't provide other evidence of the correct date or that it was clerical error
- Recoupment if time claimed is higher than duration documented on note
  - BUT! Payment will only be recouped for *over*billing
- Recoupment if group service was not divided correctly among group participants
  - BUT! Payment will only be recouped for *over*billing



TREATMENT & CARE PLANS

Going
Staying
Changing

CLIENT PLANS GOING, STAYING, CHANGING:

No longer needed for:

- Collateral
- Therapy
- Medication Support
- Rehabilitation

Have never been needed for:

- Assessment
- Plan Development
- Crisis Intervention

Still required as separate plan for:

- TBS
- IHBS (CFT Plan)
- Therapeutic Foster Care (TFC)
- Peer Support Services
- STRTPs
- Social Rehabilitation Programs
- PHF/Psychiatric Hospitals/Inpatient
- Mental Health Rehabilitation Centers (MHRC)

Required as part of the note for:

- Targeted Case Management
- ICC

TARGETED CASE MANAGEMENT & ICC PLANS

Do not require a separate plan; the care plan "shall be provided in a narrative format in the beneficiary's progress notes"

The narrative must:

- Specify 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;
- Include 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;
- Identify a course of action to respond to the assessed needs of the beneficiary; and
- Include development of a transition plan when a beneficiary has achieved the goals of the care plan.

These are federal requirements, which is why DHCS cannot eliminate them.

More guidance from Sonoma County and/or CalMHSA soon.

REASONS FOR RECOUPMENT – CLIENT PLANS

Recoupments will no longer be made for outpatient services due to lack of client plan.

We will still be auditing as a “Quality Finding” for client plans for TBS, IHBS, TFC, STRTPs, Social Rehabilitation Programs.

We will be auditing as a “Quality Finding” for client plans within the note for TCM/ICC.

TELEHEALTH CONSENT

Telehealth & Telephone

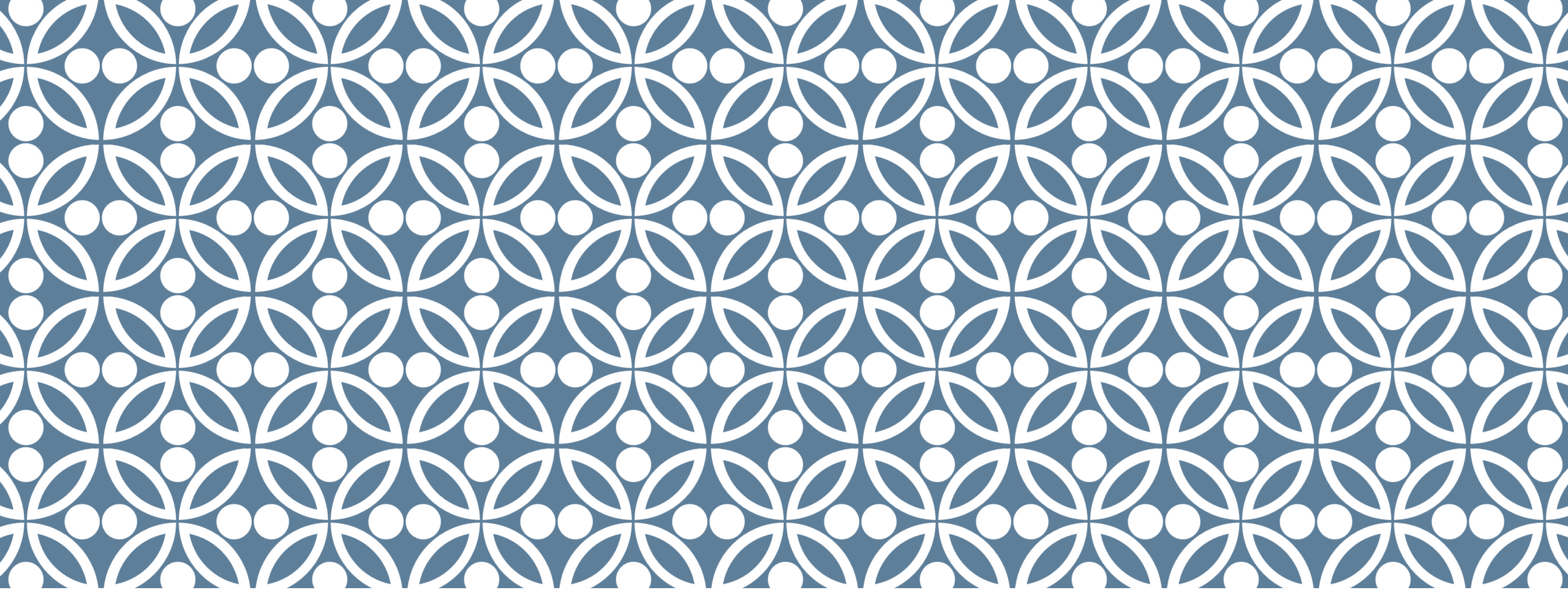
FOR TELEHEALTH & TELEPHONE SERVICES

Providers must confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating those services.

Consent must include:

- An explanation that clients have the right to access covered services that may be delivered via telehealth through an in-person, 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 without affecting their ability to access covered 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
- The 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.



ADDITIONAL RESOURCES & INFO

DHCS Info Notice
CalMHSA Trainings

FOR MORE INFORMATION

DHCS Behavioral Health Information Notice 22-019

- https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

Upcoming

- CalMHSA's Documentation Manuals
- CalMHSA online LMS (learning management system) documentation trainings
- Support and Technical Assistance from Sonoma County/CalMHSA