MARIN BEHAVIORAL HEALTH AND RECOVERY SERVICES

Photo Credit: Jeff Wong

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California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM has three primary goals:

- **Manage Risk**
  - Through whole person care approaches and addressing Social Determinants of Health (SDOH)

- **Reduce Complexity**
  - Move Medi-Cal to a more consistent and seamless system and increasing flexibility

- **Improve Outcomes**
  - Reduce health disparities, and drive delivery system transformation and innovation
BHRS will go live with new EHR “Streamline” on July 1, 2023.
Web-Based Documentation Training Videos

CalMHSA is developing a series of web-based documentation training videos on the following topics:

- CalAIM Overview
- Assessment
- Access to SMHS/DHCS/DMC-ODS
- Diagnosis/Problem List
- Care Coordination
- Progress Notes
- Discharge Planning
- Screening & Transition Tools (in late 2022)

Link to CalMHSA documentation guides: [California Mental Health Services Authority Documentation Guides (calmhsa.org)](http://calmhsa.org)
<table>
<thead>
<tr>
<th>MH</th>
<th>SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Staff: [Click Here]</td>
<td>Alcohol &amp; Drug Counselors: [Click Here]</td>
</tr>
<tr>
<td>Medical Staff: [Click Here]</td>
<td>Clinical Staff: [Click Here]</td>
</tr>
<tr>
<td>Mental Health Rehabilitation Staff and Others: [Click Here]</td>
<td>Medical Staff: [Click Here]</td>
</tr>
<tr>
<td>Peer Support Specialists: [Click Here]</td>
<td>Peer Support Specialists: [Click Here]</td>
</tr>
</tbody>
</table>

Link to CalMHSA documentation guides: [California Mental Health Services Authority](calmhsa.org) | [Documentation Guides](calmhsa.org)
Benefits of CalAIM Changes:

- Less time spent on documentation
- More time to focus on direct services/client care
- Fewer audit recoupments/disallowances
- Reduced anxiety/less stress
- More focused, streamlined documentation
- Increased alignment across counties

Link to DHCS Behavioral Health Information Notice No. 22-019 Documentation Requirements for all SMHS, DMC, and DMC-ODS services: BHIN 22-019 (ca.gov)
Where We HAVE BEEN

- A Note for Every Service
- Treatment Plan Start and End Dates
- Client Signature Requirements
- Only Select Services Prior to a Treatment Plan
- No Services Prior to a Diagnosis
Where We Are GOING

- A Note for Every Service
- Treatment Plan Start and End Dates
- Client Signature Requirements
- No Therapy Prior to a Treatment Plan
- No Services Prior to a Diagnosis
Where We WILL BE GOING

Compliance  Quality  Optimized Outcomes

Measuring Performance on Key Metrics:
• Follow Up Post Psychiatric Hospitalization
• Initiation and Engagement for Substance Use Treatment
• Follow Up Post ED Visit for Mental Illness (FUM)
• Follow Up Post ED Visit for Substance Use Disorder (FUA)
• Pharmacotherapy for Opioid Use Disorder (POD)
Why We All Got Into This Business

- Increased Life Expectancy
- Reduced Suffering In Response to Early Detection and Treatment
- Recovery
- People
- Place
- Purpose
# Examples of Fraud, Waste & Abuse

BHRS Utilization Review (UR) disallowances will be focused on Fraud, Waste, and Abuse.

<table>
<thead>
<tr>
<th>Fraud</th>
<th>Waste</th>
<th>Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliberately claiming for services that were not provided</td>
<td>Large scale duplicative services</td>
<td>Billing for a non-covered service</td>
</tr>
<tr>
<td>Prescribing/ordering/providing unnecessary medications, treatments, labs, etc.</td>
<td>Providing services/procedures/medications that are not medically necessary</td>
<td>Inappropriately allocating costs on a cost report</td>
</tr>
<tr>
<td>Claiming reimbursement for treating an individual other than the eligible individual</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What is NOT Fraud, Waste or Abuse?

- Selecting the incorrect service code/CPT
- Entering incorrect service/documentation/travel time
- Billing when the client was a “no show” or the session was cancelled
- The service does not meet the definition of a SMHS
- The content of the progress note does not justify the amount of time billed
What is NOT Fraud, Waste or Abuse? (cont.)

BHRS UR reports will provide quality improvement feedback and require Corrective Action Plans (CAPS) for these type of items:

1. The note that was billed is not present in the chart
2. The date of service of the progress note does not match the date of the service claimed
3. Documentation of non-reimbursable services, including mention of “non-billable” interventions during an otherwise billable note
4. Service provided was not within the scope of the person delivering the service
5. Documentation was completed but not signed
6. Group services not properly apportioned to all clients present
What Is Fraud, Waste or Abuse?

- Repeated pattern of unnecessary services
  
  Example: “assembly line” non-individualized treatment patterns, or “cookie cutter” progress notes

- Pattern of knowingly false statements on billings, or corresponding progress notes
  
  Example: deliberately listing wrong location of service or provider to conceal license/eligibility issues

Most mistakes made in clinical documentation are not fraud, waste or abuse.
<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Access to SMHS” The guidelines that dictate whether a person can access specialty mental health services (SMHS) have been revised</td>
<td>• “Access criteria for individuals” has been separated from “medical necessity for services”</td>
</tr>
<tr>
<td></td>
<td>• There is no longer a list of “included diagnoses” to qualify for care</td>
</tr>
<tr>
<td></td>
<td>• Access criteria are based on level of distress/impairment, except for ages 0 through 20 which does not require impairment</td>
</tr>
<tr>
<td></td>
<td>• Trauma qualifies individuals who are under age 21 for SMHS</td>
</tr>
</tbody>
</table>
Access to Substance Use Services

Criteria for persons aged 21 years and older

- At least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
- OR at least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

Criteria for persons under 21 years of age

- Appropriate and medically necessary services needed to correct and ameliorate health conditions. Services need not be curative or completely restorative to ameliorate a condition. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and thus covered as EPSDT
DEFINITION OF MEDICAL NECESSITY

All Medi-Cal services provided to persons in care need to meet the standard of being “medically necessary”. The definitions of medical necessity are somewhat different, based upon the age of the person in care. For individuals age 21 and older, a mental health service is considered “medically necessary” when it is “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.” For individuals under age 21, the definition of whether a mental health service is considered “medically necessary” falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) Services language under a specific section of Title 42. This section requires provision of all Medicaid (Medi-Cal) coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not the service is covered under the State Plan. These services need not be curative or restorative, and can be delivered to sustain, support, improve or make more tolerable a mental health condition.
# No Wrong Door for Mental Health Services

<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
</table>
| "No Wrong Door" People can easily access services through both the Mental Health Plan (MHP) as well as Managed Care Plan (MCP) | • Beneficiaries can receive timely services without delay regardless of where they seek care  
• You can provide and claim for clinically appropriate treatment in one system without worrying whether the client is currently in the “best” system (MHP vs MCP)  
• Clients can receive mental health services from both the MCP and the MHP if treatment is coordinated and non-duplicative |
# Treatment Prior to Establishing Diagnosis

<table>
<thead>
<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Services not reimbursable prior to diagnosis</td>
<td>Services are reimbursable prior to an official diagnosis</td>
<td>• Providers can be reimbursed for services provided</td>
</tr>
<tr>
<td>• Providers not reimbursed for extensive time spent conducting assessments</td>
<td>• Flexibility regarding timeline for diagnosis</td>
<td>• Supports more accurate diagnosing</td>
</tr>
<tr>
<td>• Confusing rules about what services can be provided prior to diagnosis</td>
<td>• Not rushed into diagnosing before getting to know an individual and their needs.</td>
<td>• Less provider confusion regarding what is and is not billable prior to a diagnosis determination</td>
</tr>
<tr>
<td></td>
<td>• Can utilize Z codes when appropriate</td>
<td></td>
</tr>
</tbody>
</table>
## Treatment Prior to Establishing Diagnosis

<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
</table>
| Outpatient Services are now reimbursable prior to the determination of a diagnosis | • You can provide the full range of SMHS and DMC/DMC–ODS services (except NTP/OTP) during the assessment phase of treatment  
• ICD–10 “Z codes” and “Unspecified”/Other Specified F codes” can be used |
# Co-Occurring Treatment

<table>
<thead>
<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Services would be disallowed if a co-occurring condition was as part of the individual’s treatment</td>
<td>• Co-Occurring Treatment allows for treatment to begin “through any door” regardless of co-occurring diagnoses that may be present</td>
<td>• Individuals experience streamlined process for obtaining services</td>
</tr>
<tr>
<td>• Confusing experience for individuals seeking services</td>
<td>• Treatment in the presence of a co-occurring disorder is reimbursable</td>
<td>• Providers can take time to assess the needs of the individual</td>
</tr>
<tr>
<td>• Fiscal implications</td>
<td></td>
<td>• Fewer services disallowed</td>
</tr>
</tbody>
</table>
Co-Occurring Treatment

<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Co-occurring disorders&quot; (mental health and substance use disorders) can be addressed where the client seeks care&quot;</td>
<td>• Staff can address and document both substance use and mental health concerns (if clinically appropriate and within scope of competence) without concern that acknowledging/addressing co-occurring disorders will lead to an audit finding</td>
</tr>
<tr>
<td></td>
<td>• Note: This change does not alter the responsibilities, or the benefits packages provided by the MHP and/or the DMC/DMC-ODS Plan</td>
</tr>
</tbody>
</table>
## Documentation Reform

<table>
<thead>
<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
</table>
| Lengthy documentation requirements:  
  - Stringent requirements for clinical documents  
  - “Treating chart instead of the individual” to avoid disallowances  
  - Provider spending more time on documentation than on treating individuals | Lean documentation:  
  - Streamlined standards  
  - Improved efficiency |  
  - Less time documenting  
  - More time to focus on direct services  
  - Decreased provider burnout |
## Documentation Reform (continued)

<table>
<thead>
<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Static treatment plans:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Complex content requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Strict signature requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Firm due dates/renewal dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Recoupments for services provided under an incomplete/expired treatment plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No treatment plan (replaced by dynamic problem list):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- “Treatment plan” required via a progress note</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Targeted Case Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Peer Support Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Less time spent on unnecessary documents
- Simplified internal auditing processes
- Decrease in unnecessary recoupments
# Documentation Reform (continued)

<table>
<thead>
<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disallowances for quality problems:</td>
<td>Disallowances focused on fraud, waste, abuse</td>
<td>• Decrease in unnecessary recoupments</td>
</tr>
<tr>
<td>• Excessive processes to avoid recoupments</td>
<td>Corrective action plans for quality</td>
<td>• Decreased provider burnout</td>
</tr>
<tr>
<td>• “Treating chart instead of the patient” to avoid disallowances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provider spending more time on documentation than treating</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Documentation Reform (continued)

<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation requirements have become “leaner” to reduce burden and allow staff more time for providing services</td>
<td>Progress note narratives can be simplified to focus on the intervention and planned next steps</td>
</tr>
</tbody>
</table>
**Assessments**

<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment requirements have changed</td>
<td>• Specialty Mental Health Assessments now contain seven (7) standard domains</td>
</tr>
<tr>
<td></td>
<td>• All SMHS assessment domains will be standardized across counties and providers making documentation and information exchange easier</td>
</tr>
<tr>
<td></td>
<td>• DMC Plans will now use the American Society of Addiction Medicine (ASAM) and DMC-ODS Plans will continue to use the ASAM</td>
</tr>
</tbody>
</table>

The assessment template will be updated in new Streamline EHR by July 2023.
STANDARDIZED ASSESSMENTS FOR SMHS—WHAT ARE THE REQUIREMENTS?

• Assessments for mental health services for adults aged 21 years and older shall cover all the domains listed in the section below.

• Assessment for mental health services for persons under the age of 21 years old shall include the Children and Adolescent Needs and Strengths (CANS-50) and Pediatric Symptom Checklist (PSC-35) in addition to the domains listed in the section below.

BHRS’ current assessment template (both child and adult) meets this standard in CG. The assessment template will be updated in new Streamline EHR by July 2023.
Behavioral Health & Recovery Services
2022 Documentation Training

SMHS ASSESSMENT TIMELINESS GUIDELINES

The time period for MHPs to complete an initial assessment and subsequent assessments is up to clinical discretion (reasonable and in accordance with generally accepted standards of practice).

BHRS will no longer require assessments to be completed on an annual basis. Medication assessments no longer required every 3 years. Re-assessments should be done based on clinical judgement when a significant change occurs.
Diagnosis

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

  - **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).

  - **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.

  - 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. LPHA and LMHP 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.”
## Problem List

<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
</table>
| Medical Records now include a “Problem List” – a list of codes that treating staff can use to add or remove issues that are being addressed in treatment. Your EHR may use ICD-10 and/or SNOMED codes | Problem List codes consist of:  
  - Mental Health and Substance Use Disorder Diagnoses, i.e., Mental, Behavioral and Neurodevelopment Disorders  
    - (ICD-10 F Codes)  
  - Factors Influencing Health Status and Contact With Health Services  
    - (ICD-10 Z Codes)  
  - Physical Health Codes |
PROBLEM LIST REQUIREMENTS

- 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.

- Providers shall add to or end date problems from the problem list when there is a relevant change to a beneficiary’s condition.
WHAT IS INCLUDED IN A PROBLEM LIST?

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 added, or removed.
SDOH Codes

Social Determinants of Health

- Education Access and Quality
- Health Care Access and Quality
- Economic Stability
- Neighborhood and Built Environment
- Social and Community Context
PROBLEM LIST

- LPHA
- Rehab Specialist
- Peer Specialist/Recovery Coach
- Psychiatrist
- Primary Care
PROBLEM LIST TIMELINESS

- The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.

- 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.
# Problem List Example

A problem list which codifies a person’s needs showing the entire care team the focus of services.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Identified by</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>F33.3</td>
<td>Major Depressive Disorder recurrent, severe with psychotic symptoms</td>
<td>01/19/2022</td>
<td>Current</td>
<td>Name</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>F10.99</td>
<td>Alcohol Use Disorder, unspecified</td>
<td>01/19/2022</td>
<td>Current</td>
<td>Name</td>
<td>Licensed Clinical Social Worker</td>
</tr>
<tr>
<td>I10</td>
<td>Hypertension</td>
<td>02/25/2022</td>
<td>Current</td>
<td>Name</td>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>Z62.819</td>
<td>Personal history of unspecified abuse in childhood</td>
<td>04/16/2022</td>
<td>Current</td>
<td>Name</td>
<td>Licensed Clinical Social Worker</td>
</tr>
<tr>
<td>Z59.02</td>
<td>Unsheltered homelessness</td>
<td>05/01/2022</td>
<td>Current</td>
<td>Name</td>
<td>Peer Support Specialist</td>
</tr>
<tr>
<td>Z59.41</td>
<td>Food insecurity</td>
<td>05/01/2022</td>
<td>Current</td>
<td>Name</td>
<td>Peer Support Specialist</td>
</tr>
</tbody>
</table>
Problem List example in Clinician’s Gateway (CG)

<table>
<thead>
<tr>
<th>Number</th>
<th>Code</th>
<th>Description</th>
<th>Added By</th>
<th>Job Title/Credential Level</th>
<th>Begin Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E63.1</td>
<td>Imbalance of constituents of food intake</td>
<td>56780 - Platton, David A</td>
<td>Physician</td>
<td>2022-07-24</td>
<td>Current</td>
</tr>
<tr>
<td>2</td>
<td>Z99.81</td>
<td>Dependence on supplemental oxygen</td>
<td>103789 - Test Demo, Staff</td>
<td>Physician</td>
<td>2022-07-24</td>
<td>Current</td>
</tr>
<tr>
<td>3</td>
<td>C81.32</td>
<td>Lymphocyte depleted classical Hodgkin lymphoma, intrathoracic lymph nodes</td>
<td>103789 - Test Demo, Staff</td>
<td>Physician</td>
<td>2022-07-24</td>
<td>Current</td>
</tr>
<tr>
<td>4</td>
<td>Z59.812</td>
<td>Housing instability, housed, homelessness in past 12 months</td>
<td>104442 - Jones, Steven</td>
<td>Licensed Social Worker</td>
<td>2022-07-27</td>
<td>Current</td>
</tr>
<tr>
<td>5</td>
<td>F20.0</td>
<td>SCHIZOPHRENIA PARANOID TYPE</td>
<td>56780 - Platton, David A</td>
<td>Physician</td>
<td>2022-08-04</td>
<td>Current</td>
</tr>
<tr>
<td>6</td>
<td>F42.3</td>
<td>Hoarding disorder</td>
<td>56780 - Platton, David A</td>
<td>Physician</td>
<td>2022-08-04</td>
<td>Current</td>
</tr>
<tr>
<td>7</td>
<td>Z28.9</td>
<td>Immunization not carried out for unspecified reason</td>
<td>56780 - Platton, David A</td>
<td>Physician</td>
<td>2022-08-21</td>
<td>Current</td>
</tr>
<tr>
<td>8</td>
<td>F08.31</td>
<td>Mood disorder due to known physiological condition with depressive features</td>
<td>103789 - Test Demo, Staff</td>
<td>Clinician (Medicare Waivered)</td>
<td>2022-07-27</td>
<td>2022-07-27</td>
</tr>
<tr>
<td>9</td>
<td>F43.21</td>
<td>Adjustment disorder with depressed mood</td>
<td>104442 - Jones, Steven</td>
<td>Licensed Social Worker</td>
<td>2022-07-27</td>
<td>2022-07-27</td>
</tr>
<tr>
<td>10</td>
<td>Z59.00</td>
<td>Homelessness unspecified</td>
<td>104442 - Jones, Steven</td>
<td>Licensed Social Worker</td>
<td>2022-07-27</td>
<td>2022-07-27</td>
</tr>
</tbody>
</table>
Problem Lists for Existing Clients

• All open BHRS clients will need to have problem lists regardless of current client plan end date.

• Please work on creating problem list for all clients within reasonable time frame.
# Treatment Plan Requirements

<table>
<thead>
<tr>
<th>What Has Changed?</th>
<th>What do service providers need to know?</th>
</tr>
</thead>
</table>
| Treatment Plans: Some outpatient services require no treatment plans, some require “simplified” treatment plans. Other services retain the existing treatment plan requirements | • Most service types do not require a treatment plan  
• Targeted Case Management (TCM) and Peer Support Services require a simplified treatment plan documented narratively in a progress note  
• Services for which treatment plan requirements have not changed include:  
  • Therapeutic Behavioral Services (TBS)  
  • Intensive Home-Based Services (IHBS)  
  • Intensive Care Coordination (ICC)  
  • Therapeutic Foster Care (TFC)  
  • Short-Term Residential Therapeutic Programs (STRTPs)  
  • Narcotic Treatment Programs (NTPs) |
Treatment Plan Requirements

• Targeted Case Management (TCM) requires a treatment plan to meet federal regulations. **Need to do 1 time not every TCM note.**

• Targeted Case Management [Brokerage] requires development (and periodic revision) of care/treatment plan embedded in a progress note:
  - 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.

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

• TCM treatment Plan in progress note does NOT require Client’s signature

• Treatment plans are in addition to the Problem List.
Peer Support Services

- Peer Support Services (PSS) must be based on approved plan of care. These are for the upcoming certified peer services and do not affect current peer providers.
- 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.
Child/Youth Treatment Plans: ICC, IHBS, TFC, TBS

- No change in current Treatment plan requirement for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC), Therapeutic Behavioral Health Services (TBS) due to Katie A settlement requirements.

- These services still require current version of treatment plan in CG with documentation of client/caregiver participation and agreement. (signature requirement still exists).

- Problem list still required in addition to treatment plan.
3 KEY FUNCTIONS OF A PROGRESS NOTE

- Care Planning
- Communication
- Reimbursement
3 KEY FUNCTIONS OF A PROGRESS NOTE (CONTINUED)

CARE PLANNING
- Used as a basis for planning treatment among practitioners and across programs.
- Should be understandable when read independent of other progress notes.
- Should provide an accurate picture of the treatment provided, and plan for future care.

COMMUNICATION
- Used to communicate with other care providers.
- Provide a quick exchange of information to coordinate care, reduce duplication of services, and improve outcomes.
- Should reflect what is up next and what is needed.

REIMBURSEMENT
- Used as verification of billed services for reimbursement.
- Are a legal record to describe treatment provided.
- Must include sufficient documentation of the intervention to justify payment.
Progress Notes

Providers shall complete progress notes within 3 business days of providing a service. (This is our existing policy)

• Notes for crisis service shall be completed within 24 hours.
• Notes that require co-signature shall be completed within 3 business days in draft form and should be finalized as soon as possible after co-signature.
• Late notes need to include notation of “Late Note” in the body of the note and it is good practice to document the reason a note is delayed. Late notes should include documentation time.
WHEN SHOULD NOTES BE COMPLETED

FREQUENCY

- A note is required for **each service** that is billed based on minutes of time, such as mental health services (e.g., assessment, therapy), targeted case management (TCM), care coordination, therapeutic behavioral services (TBS), intensive care coordination (ICC), intensive home-based services, crisis intervention, and medication support.

- For Peer Support services, a note is required for **each service** that is billed, based on 15-minute increments of time.

- A **daily note** is required for services that use a daily rate for billing, such as some residential services, day treatment, day rehabilitation, and therapeutic foster care. Weekly summaries are no longer required for these programs.

- Based on program / facility type, additional requirements may be required by state regulation (e.g., Short Term Residential Therapeutic Programs [STRTP]).
WHAT NEEDS TO BE INCLUDED

Progress Note Requirements

- The type of service rendered and a narrative describing the interventions, including how the service addressed the individual’s behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors)
- Sufficient detail to support the service code selected for the service type
- Next steps including, but not limited to, planned action steps by the provider or by the individual, collaboration with the individual, collaboration with other provider(s), and any update to the problem list as appropriate

- The date that the service was provided
- Duration of the service, including travel and documentation time
- Location of the client 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***

*** ICD 10 code needed for claiming of the service but does not need to be entered on the progress note itself
WHAT IS THE GOLDEN THREAD?

The Golden Thread is the consistent presentation of relevant clinical information throughout all documentation for a client. The Golden Thread begins with an intake assessment that clearly identifies an appropriate clinical problem and corresponding diagnosis. Next, the treatment plan should reflect a clear series of goals for helping the client through the identified problem. Each goal should have specific interventions prescribed that reflect best practices and evidenced-based treatments to help guide the client along the path to recovery. Finally, the Golden Thread includes progress notes that demonstrate that the services you deliver match what was prescribed in the treatment plan. Each note should lead into the next, creating a comprehensive story of the client's progress through treatment.

The Golden Thread is not only important for compliance and reimbursement, but it can also be an important tool for delivering quality care.
Progress Notes

ACTIVITIES THAT CAN NOT BE CLAIMED USE OTHER NON-BILLABLE CHART NOTE

- Transportation
- Activities that are clerical, paying bills, money management services (i.e. cashing checks, bringing money, buying clothes for client, etc)
- Leaving messages
- Calling to schedule appointment with client
- No show by client- Use No Show Procedure code
- Client cancellation – Use cancellation Procedure code
Progress Notes

LOCKOUTS

- IMD, Jail or Juvenile Hall*
  - No claimable service allowed- Can use “non-billable procedure codes” for IMD, use Jail/Juv Hall location and regular service code for Jail or Juvenile Hall in CG.
  - *Juvenile Hall lockout exceptions (services are billable only if):
    1. A dependent minor in Juvenile detention center prior to disposition, if there is a plan to make the minor’s stay temporary is medical eligible
      **OR**
    2. After adjudication for release into the community.
      In these instances, choose location of “other location” and clearly document above reasons and that minor is in Juvenile Hall in body of note

- Acute psychiatric inpatient- ex. At Marin Health Unit A
  - Only Linkage/Brokerage related to placement

- Crisis Residential
  - Linkage/Brokerage and Meds ok. **No other MH services**

- Unless billable per above limitations, use non-billable procedure codes (i.e. non-billable rehab, non-billable assessment, etc)

- Acute medical inpatient- ex. At Marin Health medical floor
  - No lockouts
BHRS-09 Integrity of the Electronic Health Record

Do not double bill for same service. Review procedure on how to delete duplicate note:

A. Electronic health records may only be deleted from the Designated Record Set (DRS) under one or more of the following circumstances:
   
   a. A note written for the wrong service date.
   b. A note written for a client under a different client’s name.
   c. Two notes were written for the same service

B. If a note must be deleted due to any of the reasons outlined above, the clinician must do the following:

   a. Write a note for the correct date or for the correct client and finalize it;
   b. Notify their Supervisor of the service number of the note that was incorrect, as well as the finalized replacement note;
   c. Supervisor should review the circumstances and the notes;
   d. If the supervisor approves, they will send an “attestation” to Quality Management (QM) confirming that the note can be deleted and the reason for this action. Note: the email to QM must include service number to be deleted and the finalized replacement service number
   e. QM will review the request, and, if approved, send authorization by email to the CG System Administrator.
   f. CG System Administrator will delete note only after receiving approval from QM staff.
Progress Notes

Procedure Code

- The procedure code must be consistent with the specific service activity actually documented in the progress note
GROUP PROGRESS NOTES
SMHS, DMC & DMC-ODS

- 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.
GROUP PROGRESS NOTES
SMHS, DMC & DMC-ODS

• Groups notes should also include information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity, including time spent traveling to/from the service and documenting the service.

• A list of group participant names shall be maintained

• Due to confidentiality standards, the full list of group participants must not be kept in any single participants personal health records. Keep the full participant list outside of any participant's health records.
Group Sign-In Sheets

Sign-In Sheets

Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:

- The typed or legibly printed name and signature of the LPHA(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
- The date of the counseling session.
- The topic of the counseling session.
- The start and end time of the counseling session.
- A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

If there are multiple pages to a sign-in sheet, they must be kept together so it is clear who attended group counseling. They shall be provided in their entirety when requested by BHRS staff as part of clinical documentation reviews, contract monitoring and/or service verification activities.
Progress Notes

• For intensive outpatient and residential treatment services, the LPHA or counselor shall record at a minimum one summary progress note, per day for each beneficiary participating in structured activities including counseling sessions or other treatment services.

• This service should include all services provided to client on that day.
Residential Progress Note example:

Background—Client attended 2 groups. Staff B is writing the daily note after communicating with Staff A.

Staff A facilitated Mindfulness group in the morning with three participants. Led guided imagery exercises to reduce anxiety. Client reported reduction in anxiety from an 8 to a 5 following group. They shared that their use has always been a coping mechanism for their anxiety.

Staff B led Relapse Prevention in the afternoon and there were 5 participants. Staff provided psychoeducation about triggers associated with negative social influences. Client stated that they used to use with their roommate and is concerned about returning to that unsupportive living environment after completing program.

Plan is for staff to continue to provide active support and residential level services to client based on client’s current needs. Staff will take client to scheduled appointment on Wednesday to meet with housing specialist.
Crisis Intervention

“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit.

— Generally thought of as a service provided in an acute situation where, without an immediate intervention, there is a high likelihood that the client will require a higher level of service, i.e. CSU or inpatient, due to danger to self, others or grave disability.
Crisis Intervention

- Maximum allowable in 24 hour period is 8 hours of staff time.
- Note contains documentation of:
  - Situation makes it clear that there is an immediate risk of something unfortunate happening if an intervention isn’t provided.
  - The risk can be danger to self, others, acute hospitalization or CSU, escalating behavior that will result in loss of housing, police intervention, etc.
- Medical emergencies don’t meet definition of Crisis Intervention.
- Plan should include any follow-up activities.
  - The plan section in a crisis intervention note is critical, and when providing subsequent services, should be reviewed to make sure that any planned follow-up activities are actually done. This is both a quality of care issue as well as a liability concern.
Plan Development

“Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.

• Involves actual writing of Client Plans, as well as determining what’s going to go on a plan revision or renewal.

• Submitting to supervisor, getting supervisor signature/approval are administrative, not direct service.
Targeted Case Management/Brokerage

“Brokerage” (Case Management/Brokerage, TCM) means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

- The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress, and placement services.
CHARTING TIPS FOR CASE MANAGEMENT

- Tie service into the identified symptoms on the treatment plan
- Use a verb that describes the case management activity (see below)
- Comment on the individual’s functioning in one of the following spheres: living arrangement, social support, health, daily activities
- Document plan for future services and explain how information from the case management session will impact future plans for the individual’s care

CASE MANAGEMENT IS NOT:

- Skill Development
- Assistance In Daily Living
- Training a Beneficiary to Access Services

CASE MANAGEMENT—KEY PHRASES:

- Linked
- Assisted To..., For..., With...
- Monitored...
- Brokered For..., In Regards To..., Concerning...
- Advocated For..., In Regards To..., On Behalf Of...
Collateral

“Collateral” means a service activity to a significant support person in a beneficiary’s life with the intent of improving or maintaining the mental health status of the beneficiary.

The beneficiary may or may not be present for this service activity.
CHARTING TIPS FOR COLLATERAL SERVICES

- Tie the service into the identified behaviors or symptoms noted on the individual’s treatment plan. Do not focus on the significant support person’s behavioral issues.
- Describe how the interventions help a significant support person improve, maintain, or better understand the mental health status of the person served (i.e., putting together a behavioral chart with a parent, teaching how to better reinforce appropriate behaviors, discussing the mental health disorder with the care provider)
- Explain how the interventions are designed to help the significant support person assist the person served with learned interventions
- Document the significant support person’s response to the intervention(s)
- Document the plan for future services
- Document the plan for continued services
Rehabilitation

“Rehabilitation” means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

— Intervention must be explicit!
The goal of all mental health services, including Rehabilitation, is to improve the beneficiary’s quality of life and functioning in the community.

REHABILITATION SERVICES—KEY PHRASES:
- Offered Assistance With..., To..., For..., On Behalf Of...
- Offered Training To Consumer In Regards To...
- Counseled Consumer In Regards To...
- Offered Support For..., In Regards To...
- Offered Encouragement To..., For..., In Regards To...
“Therapy” means a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.
CHARTING TIPS FOR THERAPY SERVICES

- Tie the interventions to the identified symptoms/goals on the Plan of Care
- Include specific interventions used
- Focus documentation on how interventions resulted in symptom reduction, prevention of deterioration of functioning or developmental arrest
- Document the client’s response to the interventions and his/her general progress, or lack of progress
- Document your plan for continued services or complete a discharge summary
## Differentiating Procedures

<table>
<thead>
<tr>
<th>Rehabilitation</th>
<th>Brokerage (TCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Help develop, maintain, or restore skills.</td>
<td>• Coordinate, link, and refer. Monitor progress related to linked services</td>
</tr>
</tbody>
</table>
Compare & Contrast
Mixed Intervention

• Preponderance Rule
  – What took the most time during session
  – What is being written about the most
  – Which seems most important or beneficial to client

• Strategy: read then choose
  – Instead of choosing a procedure and trying to document to fit, write what happened, read it, and choose the procedure that fits best.
  – Write separate notes
Common Errors

- Documentation:
  - Contains “passive voice” only e.g. “observed client” as opposed to an explicit intervention by clinician
  - Doesn’t document a relationship to impairments or plan (stating working on named objective doesn’t give enough content or reflect evidence of intervention or client progress
  - That is purely clerical, transportation, payee related (money management services — cashing checks, delivering check, etc)
  - For service provided to client in a “lockout” situation, i.e., jail, IMD, juvenile hall, etc. without correct procedure code/location
  - Reflects clinician’s feelings or negative judgments about client.
  - Spells out every interaction that occurred, repeat whole conversation — “he said, she said, I said”
Individual Therapy and Rehab

• Scope of Practice- therapy can only be provided by licensed, registered, waivered individuals
• Therapy is focused on symptom reduction
• Rehab is focused on skill development.
• Example of overlap: learning anxiety reduction techniques is both a symptom reduction intervention and a skill development intervention.
  – Determination will depend on overall emphasis of session and practitioner
Progress Note Format

Components required for all notes

• Intervention

• Plan
Intervention

Intervention is what you did during the interaction with or for the client to achieve the purpose of your service.

• Intervention is not a description of what’s going on with the client.
• Reminder that reimbursement is for staff time, not client behavior.
• Intervention should be explicit, not just implied
• Include assessment of risk factors when appropriate
• Document skills provided to client/family
Intervention

• Use Verbs!
  – Identified skills used to cope/adapt/respond/problem solve.
  – Reinforced new/more functional behaviors, strengths.
  – Pointed out problem behaviors/patterns that could be problematic.
  – Identified-modeled/practiced specific skills that decrease functional impairments.
  – Role played situation in a coffee shop, with landlord, etc.
Intervention Action Phrases

Assessed mental status
Acknowledged
Clarified Values
Commended clients report of
Conferred with
Explored triggers for anxiety
Facilitated access to
Modeled skills/behaviors
Offered feedback
Practiced role play
Problem solved
Reality Tested

Reassured; Recognized;
Recommended
Redirected client to
Reviewed (name) strategies for managing symptoms/situation, etc.
Supported client to
Taught and practiced coping skills
Taught and reviewed relaxation training skills- name skills
Worked together to develop goals and objectives
Plan

The plan section indicates what next steps will be.

- Specifies action or steps to be taken as a result of the service or contact provided
- Action can be by clinician or client
- Document recommended actions for follow up by client/family
Plan Examples

• Contacts to be made on behalf of the client (Brokerage)
• Skills the client will be practicing on own or action they will be taking (Rehab or Therapy)
• When the next service or contact will be and purpose of that service or contact
Rehabilitation Example

Individual Rehabilitation

In effort to monitor client’s moods and emotions, I engaged her in an open-ended conversation about her day and how she has been feeling. I praised her for her reported positive day. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (i.e., reading, listening to music, etc.). I normalized her need to take a break from difficult situations and reminded her to take time outside. Assisted client in practicing how to let others know that she needs to use her safety plan by engaging in a role play. Client was verbal and engaged throughout the session. I will meet with client next week for an individual rehabilitation session to support her with developing and utilizing coping skills.
Brokerage/Case Management Example

Case Management

This staff provided the following case management intervention to address the client’s inability to manage emotions due to their anxiety. This staff contacted Group Intervention Center and spoke with intake counselor (Susan) to obtain information about the appropriateness of their Healing Heart Program to meet client’s needs.

Staff completed the referral process by summarizing client’s anxiety symptoms and highlighting strengths, including supportive family members. Healing Hearts indicated client seemed appropriate for their program group and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend this support group.
Activities that can NOT be claimed
Use other non-billable chart note

• Transportation
• Activities that are clerical, paying bills, money management services (i.e. cashing checks, bringing money, buying clothes for client, etc)
• Leaving messages
• Calling to schedule appointment with client
• No show by client- Use No Show Procedure code
• Client cancellation – Use cancellation Procedure code
Person-Centered Language

A person is not their illness

- Person-centered language emphasizes the person first rather than the illness
- People are so much more than their substance use disorder, mental health disorder, or disability
- Using person-centered language is about respecting the dignity, worth, unique qualities, and strengths of every individual
- A person’s identity and self-image are closely linked to the words used to describe them
Person-Centered Language

Words are powerful.

Words can unintentionally lead to biases and further stigmatize individuals, which can become accepted as part of an agency’s culture over time.

Use them to empower.
Final Thoughts on Documentation

Documentation is the tangible measurement of your client’s recovery journey and your work with them. Remember the Golden Thread.

Following the standards described will help you provide the best service to your clients, while ensuring that there will be funding to support services in the future!
BEHAVIORAL HEALTH & RECOVERY SERVICES
2022 Documentation Training

HELPFUL TIP

Lockouts and non-billable activities remain unchanged.

BHRS has revised Clinical Documentation manual for reference.

Ask Yourself

☐ What service did I provide?
  • What specific service activities / interventions did I provide?

☐ How did the service address the client’s needs?
  • What symptoms, diagnosis(es), risk factors, and/or social determinants of health did we focus on?

☐ What is the plan?
  • What action steps will be taken by me and/or the client?
  • Is care coordination needed?
  • Do I need to make any updates to the problem list?
Questions?

• Clinical Documentation Guide | Marin BHRS
• California Mental Health Services Authority | Documentation Trainings (calmhsa.org)
• California Mental Health Services Authority | Documentation Guides (calmhsa.org)
• Staff-CalAIM-Communication-Materials-06212022.pdf (calmhsa.org)
• Email BHRSQM@marincounty.org
Subsequent Slides are for SUS
How does SUS differ from MH?

- ASAM
- Specialized types of services (NTP, WM, Residential) maintain same standards for medical necessity documentation
- Residential services require daily progress note

*Problem List & Progress Note expectations remain the same*
DIMENSION 1
1. ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL
   ✓ Exploring an individual’s past and current experiences of use and withdrawal.

DIMENSION 2
2. BIOMEDICAL CONDITIONS & COMPLICATIONS
   ✓ Exploring an individual’s health history & current physical condition.

DIMENSION 3
3. EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS & COMPLICATIONS
   ✓ Exploring an individual’s thoughts, emotions, & mental health issues.

DIMENSION 4
4. READINESS TO CHANGE
   ✓ Exploring an individual’s readiness and interest in changing.

DIMENSION 5
5. RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL
   ✓ Exploring an individual’s unique relationship with relapse or continued use or problems.

DIMENSION 6
6. RECOVERY/LIVING ENVIRONMENT
   ✓ Exploring an individual’s recovery or living situation, & the surrounding people, places, & things.
## Access to Care

### Who gets treated in DMC-ODS?

<table>
<thead>
<tr>
<th>For Beneficiaries aged 21 and older:</th>
<th>- Initial ASAM must be completed within 30 calendars days following the first visit with an LPHA or registered/certified counselor. Covered and clinically appropriate services may be provided during the 30-day initial assessment period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Beneficiaries under 21 years old:</td>
<td>- Initial ASAM must be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor. Covered and clinically appropriate services may be provided during the 60-day initial assessment period.</td>
</tr>
</tbody>
</table>
| For Adult beneficiaries experiencing homelessness: | - Initial ASAM must be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.  
  The practitioner must document that the beneficiary is experiencing homelessness and requires additional time to complete the initial assessment. |
Access to Care

Who gets treated in DMC-ODS?

For Residential Treatment:
- Prior authorization is required within 24 hour of the prior authorization request being submitted by the provider.
- MHP will review the DSM and ASAM criteria to ensure that the beneficiary meets the requirements for residential service.
- Continuing and Extension Authorization forms must be submitted 7 calendar days before the expiration date of current authorization. The re-assessment ASAM must be attached to initial and subsequent TARs.

For Narcotic Treatment Programs:
- History and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for determination of medical necessity.
<table>
<thead>
<tr>
<th>ASAM Type</th>
<th>Adolescent RES</th>
<th>Adult RES</th>
<th>NTP</th>
<th>Other DMC-ODS Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>At Intake</td>
<td>At Intake</td>
<td>At Intake</td>
<td>At Intake</td>
</tr>
<tr>
<td>Update</td>
<td>Every 30 days</td>
<td>Ever 45 days</td>
<td>Annually</td>
<td>Every 90 days</td>
</tr>
<tr>
<td>Annual Update</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>Transitional</td>
<td>When change in LOC</td>
<td>When change in LOC</td>
<td>When change in LOC</td>
<td>When change in LOC</td>
</tr>
<tr>
<td>Discharge</td>
<td>At Discharge</td>
<td>At Discharge</td>
<td>At Discharge</td>
<td>At Discharge</td>
</tr>
<tr>
<td>Other</td>
<td>Whenever there are significant changes</td>
<td>Whenever there are significant changes</td>
<td>Whenever there are significant changes</td>
<td>Whenever there are significant changes</td>
</tr>
</tbody>
</table>
Medical Necessity Determination

The medical necessity determination form needs to be completed by the LPHA or medical director.

Clients enrolled in NTP programs require medical necessity determination form within 28 days of admission.

Clients enrolled in Residential programs require medical necessity determination form within 30 days (or 60 for under 18).
Discharge Plan

The discharge plan shall include, but not be limited to, all of the following:

- The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
- Includes a description of each of the beneficiary's relapse triggers.
- Includes a plan to assist the beneficiary to avoid relapse when confronted with each trigger.
- Includes a support plan.
- During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.
- If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30 calendar day lapse in treatment services.

Discharge Summary

- The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
- The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
- The discharge summary shall include all of the following:
  - The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
  - The reason for discharge.
  - A narrative summary of the treatment episode.
  - The beneficiary's prognosis.
Clinician’s Gateway

- Shared Electronic Medical Record
- Services claimed at time note is finalized
- Protect your password
- Notes, Assessments & Problem Lists are charted electronically
- Consents, Releases of Information are still hard copy and get filed in client’s paper medical record
- Refer to Clinician’s Gateway Online Progress note documentation guide
Adding Job title or credentials to your CG account

- Writer’s and co-signer’s title and/or credentials need to be listed in CG electronic signature.
- To change/add credentials or license information in CG:
  1. Log in to CG
  2. Scroll to the bottom and look for the link that says, “SECURITY (PASSWORD).”
  3. Click on the link and it should open your Profile tab.
  4. In that tab you can change your “Professional Suffix” to show your license information/credentials. Your credentials should then start showing up next to your name when you write a progress note.
Common questions and where to find templates on CG

• Assessments:
  – Which template do I use?
  – If I do a FSP assessment is that the required Clinical Assessment
  – What if I don’t have all the information?

• Problem Lists

• Notes
Problem Lists

![Problem List Interface]

**Client**
(9424883) Testcase, Adult

**ADD PROBLEM**

**Client Search**
Testcase, Adult (9424883)

**Problems**

<table>
<thead>
<tr>
<th>Number</th>
<th>Code</th>
<th>Description</th>
<th>Added By</th>
<th>Job Title/Credential Level</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Ended By</th>
<th>Job Title/Credential Level</th>
</tr>
</thead>
</table>

0 of 1 Results (filtered)
## Problem Lists

**Client**
(9424883) Testcase, Adult

### Diagnoses

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y37.011S</td>
<td>Military operations involving explosion of depth-charge, civilian, sequela</td>
</tr>
<tr>
<td>Z18.01</td>
<td>Retained depleted uranium fragments</td>
</tr>
<tr>
<td>Z65.82</td>
<td>Military deployment status</td>
</tr>
<tr>
<td>Z63.31</td>
<td>Absence of family member due to military deployment</td>
</tr>
<tr>
<td>Z63.6</td>
<td>Dependent relative needing care at home</td>
</tr>
<tr>
<td>Z63.71</td>
<td>Stress on family due to return of family member from military deployment</td>
</tr>
<tr>
<td>Z72.820</td>
<td>Sleep deprivation</td>
</tr>
<tr>
<td>Z74</td>
<td>Problems related to care provider dependency</td>
</tr>
<tr>
<td>Z74.8</td>
<td>Other problems related to care provider dependency</td>
</tr>
</tbody>
</table>

**Begin Date**: 07/21/2022

**End Date**: mm/dd/yyyy
Troubleshoot your Notes

• I can’t finalize my note:
  – Check if your intervention is the same facility program (Fac Prog) on the plan and the note
  – Check the face sheet to be sure client open your fac prog
CG & Things to Review

• How to start and find services
• How to record language field—interpreter or clinician?
• Finalizing note—by author!
• Late entries—how to document