MARIN BEHAVIORAL HEALTH AND RECOVERY SERVICES

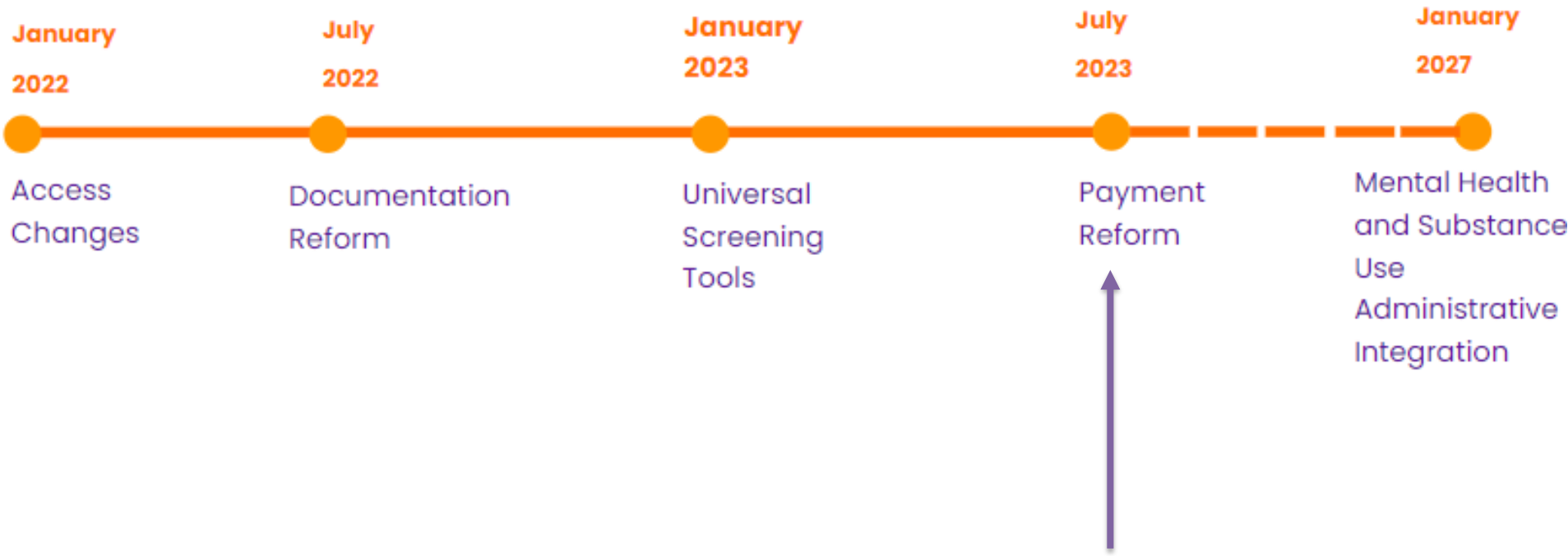
Photo Credit: Jeff Wong

BHRS Clinical Documentation Training **February 6, 2024**

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

Presenters: *Lauren Schliesmann, LMFT, Kristin Gordiejew, LMFT, Jesse Silverstein, LCSW, and Lyn Blodgett, LCSW*

Timeline of CalAIM Changes



BHRS went live with new EHR “Smartcare” on July 1, 2023.

Fraud, Waste & Abuse

BHRS Utilization Review (UR) disallowances will be focused on Fraud, Waste and Abuse. Examples of each include:

Fraud

- Deliberately claiming for services that were not provided.
- Prescribing/ordering/providing unnecessary medications, treatments, labs, etc.
- Claiming reimbursement for treating an individual other than the eligible individual.
- Intentionally billing for an ineligible individual.

Waste

- Large scale duplicative services.
- Providing services/procedures/medications that are not medically necessary.

Abuse

- Billing for a non-covered service.
- Inappropriately allocating costs on a cost report.

Most mistakes made in clinical documentation are not fraud, waste or abuse.
If you make a mistake, it's okay, we will work with you to correct it.

Access to Specialty Mental Health Services (SMHS)

January 1, 2022

"Access to SMHS" Guidelines have been revised.

What do service providers need to know?

- "Access criteria for individuals" has been separated from "medical necessity for services"
- There is no longer a list of "included diagnoses" to qualify for care
- Access criteria are based on level of distress/impairment, except for ages 0 through 20 which does not require impairment
- Trauma qualifies individuals who are under age 21 for SMHS

BHRS 89 Criteria for Beneficiary Access to SMHS, medical necessity and other coverage requirements

No Wrong Door for Mental Health Services

July 1, 2022

People can easily access services through both Mental Health Plan (MHP) as well as Managed Care Plan (MCP)

What do service providers need to know?

- 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

BHRS 92 No Wrong Door for Mental Health Services

Co-Occurring Treatment

July 1, 2022

Mental health and substance use disorders can be addressed where the client seeks care.

What do service providers need to know?

- 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
- Note: This change does not alter the responsibilities, or the benefits packages provided by the MHP and/or the DMC/DMC-ODS Plan

BHRS 92 No Wrong Door for Mental Health Services

Treatment Prior to Establishing Diagnosis

July 1, 2022

Outpatient Services are now reimbursable prior to the determination of a diagnosis.

What do service providers need to know?

- 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

BHRS 92 No Wrong Door for Mental Health Services

Diagnosis

During the assessment phase, when a diagnosis has yet to be established, Z codes can be used.

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate.
- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP.
- In cases where there is a suspected disorder that has not yet been diagnosed, LPHA/LMHPs can use Z codes found in SmartCare by using search terms such as **"Other specified problems", "Unspecified disorders", "Other personal risk factors"**, or **"Health Circumstances."**

BHRS 25 Documentation Requirements for all SMHS services; BHRS 92 No Wrong Door for Mental Health Services

Diagnosis update Oct. 1, 2022

- Other Specified Trauma and Stressor Related Disorder(**F43.8**) is no longer a billable Medi-Cal reimbursable code because there are other codes that contain a greater level of detail. ***Clients with this diagnosis will need an updated diagnosis.***
  - **Post Traumatic Stress Disorder, unspecified (F43.10) could be used for these clients.**
  - **Reaction to severe stress, unspecified (F43.9) could be used.**

Common-Diagnoses-Codes.pdf (calmhsa.org)

Diagnosis Document in SmartCare

- All clients need a diagnosis document for each program that they are enrolled in.
- Make sure that the client's diagnosis document is affiliated with your program, otherwise you will need to create one. If you are having a billing error due to diagnosis, this may be the issue.
- Check the diagnosis document for your clients to confirm it is up to date with client's current presentation.

Diagnosis Document

Assessments

July 1, 2022

Assessment requirements:

What do service providers need to know?

- Specialty Mental Health Assessments now contain seven (7) standard domains
- All SMHS assessment domains will be standardized across counties and providers making documentation and information exchange easier
- DMC Plans will now use the American Society of Addiction Medicine (ASAM) and DMC-ODS Plans will continue to use the ASAM

BHRS 25 Documentation Requirements for all SMHS services

SMHS ASSESSMENT TIMELINESS GUIDELINES

- BHRS **no longer** requires assessments to be completed on an annual basis.
- Medication assessments are **no longer** required every 3 years.
- **Initial and subsequent assessments are up to clinical discretion and are based on reasonable and generally accepted standards of practice.**
- Re-assessments should be done based on clinical judgement when a significant change occurs.
- Per updated policy, DMC-ODS assessment timelines now also align with the above and assessments shall be updated as clinically appropriate.

BHRS 25 Documentation Requirements for all SMHS services; BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS

Assessment Requirements *Clarifications*

Effective January 1, 2024

Some assessments are distinct and **do not** replace a comprehensive mental health or substance use disorder assessments. Types of assessments include:

- Assessments performed during delivery of crisis intervention or crisis stabilization services
- Assessments performed during the delivery of Mobile Crisis Services (BHIN 23-025)
- Medications for Addiction Treatment (MAT) assessments (BHIN 23-054)
- Multidimensional level of care assessments required in residential treatment programs

BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services.pdf

Problem List

July 1, 2022

What do service providers need to know?

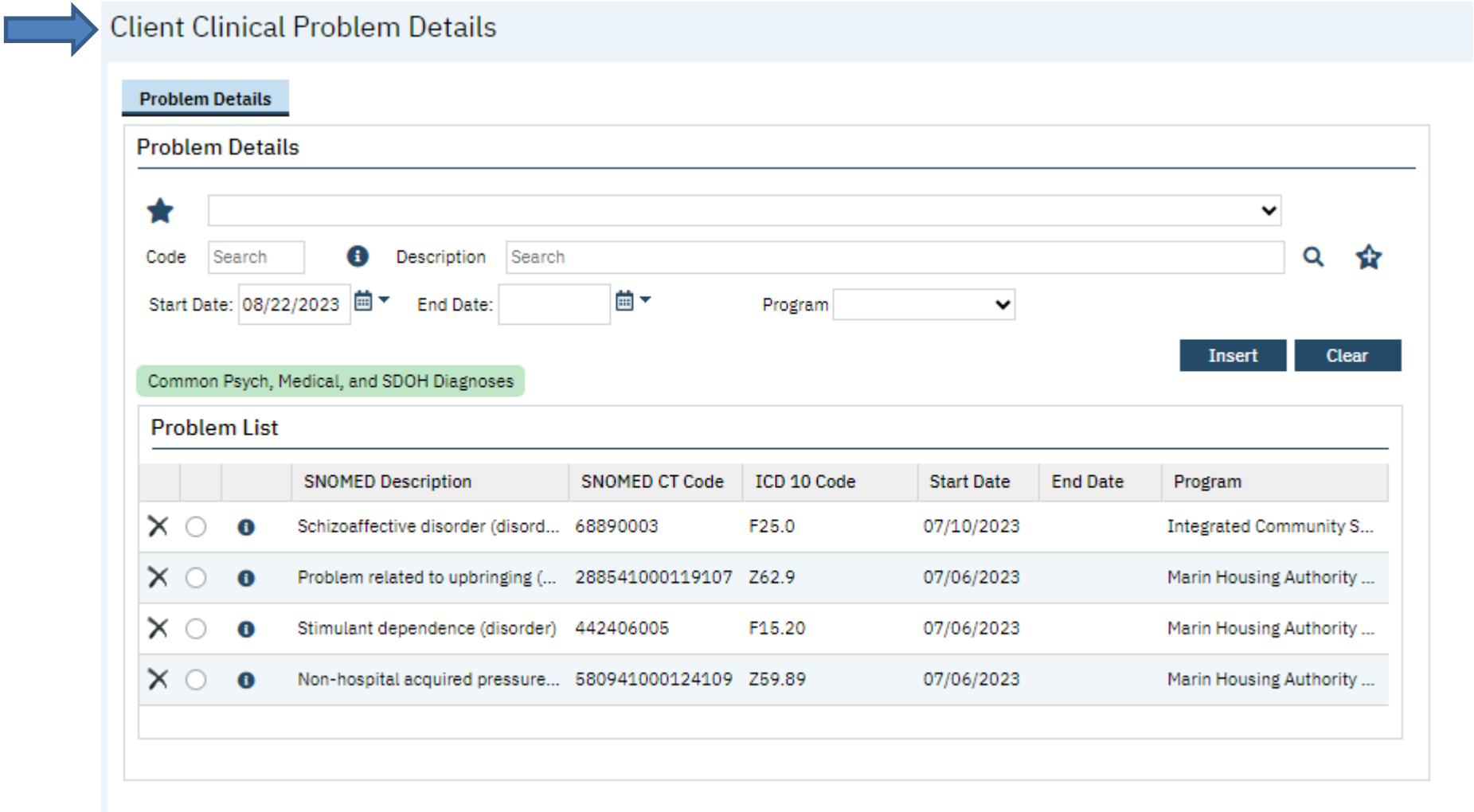
Problem List codes consist of:

- 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

Providers should add or end date problems from the problem list when there is a relevant change to a beneficiary's condition. There is no set timeline for when to update the Problem List, rather it should be monitored to make sure it reflects the client's current presentation.

BHRS 25 Documentation Requirements for all SMHS services

Problem List in SmartCare



* Problem Lists were not carried over from Clinician's Gateway. Please enter a new Problem List for each of your clients in SmartCare if you have not already.

Treatment Plan Requirements

July 1, 2022

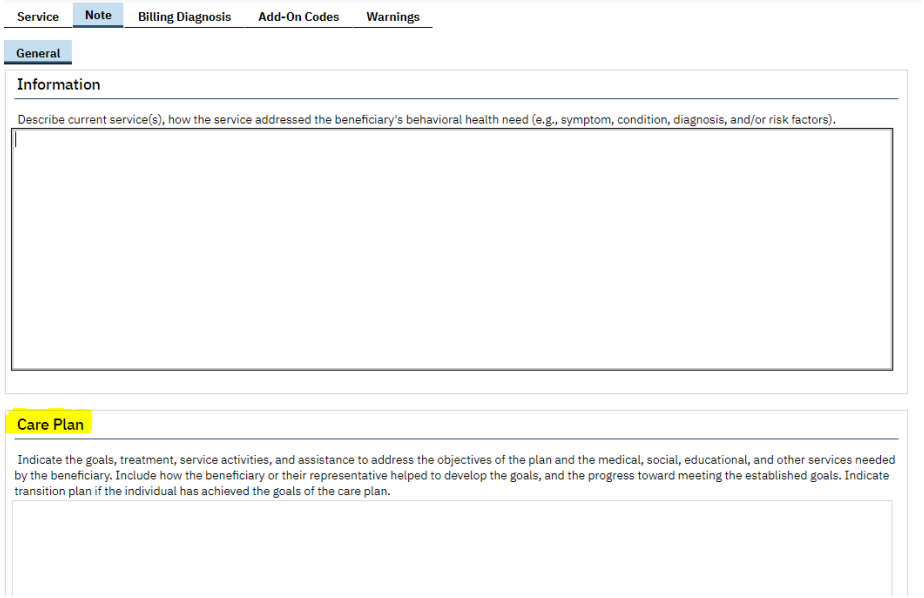
What Has Changed?	What do service providers need to know?

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)

BHRS 25 Documentation Requirements for all SMHS services

Treatment Plan Requirements

- Brokerage services, otherwise know as, Targeted Case Management (TCM), require a treatment plan (referred to as Care Plan in progress note template) to meet federal regulations.
- **<u>If you provide TCM (previously brokerage) services to a client, you need a Treatment Plan attached to your progress note.</u>** (this pulls through to future notes and should be updated as relevant.)



- This Treatment Plan does not require a client signature. Must complete Treatment Plan in addition to Problem List.

Treatment Plan Requirements (cont'd)

Targeted Case Management Treatment Plans should include:

- 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;
- 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;
- A course of action to respond to the assessed needs of the beneficiary; and
- Development of a transition plan when a beneficiary has achieved the goals of the care plan.

Individual Service and Support Plan (ISSP)

- All Full-Service Partnership (FSP) clients must have an ISSP if they do not have a valid treatment plan in place (youth FSP clients receiving ICC/IHBS must have current treatment plan and do NOT need an ISSP).
- ISSP must be completed for all future FSP clients within first 60 days of opening.
- ISSP is very similar to the treatment plan except it does not expire and only needs to be completed once.
- Client must participate in the ISSP, check box that states they have been provided the 24/7 Administrator on Duty (AOD) number and sign the ISSP.
- Current ISSPs can be scanned into Smartcare. New ISSPs can be documented on the Interdisciplinary Treatment Plan in Smartcare.

Treatment Plan Requirements

Peer Support Services
by Certified Peer Providers

- Peer Support Services (PSS) must be based on approved plan of care.
- 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.
- If a client received Peer Support Services from a Certified Peer Provider, they also need a Care Plan attached to their note.

Documentation Reform

July 1, 2022

What Has Changed?	What do service providers need to know?
Documentation requirements have become "leaner" to reduce burden and allow staff more time for providing services	Progress note narratives can be simplified to focus on the intervention and planned next steps

Notes now only require an "I" and a "P" section – Intervention and Plan. Please include what specific Interventions you provided to the client and the Plan for next steps going forward.

BHRS 25 Documentation Requirements for all SMHS services

Progress Notes

Each progress note shall provide sufficient detail to support the service code.

Think Lean Documentation. Purpose-Intervention-Plan. SIRP format no longer a requirement.

Each note shall include:

- Type of service rendered
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors).
- Duration of the service, including separate travel and documentation time. Late notes may now include documentation time. Documentation time no longer limited to 15 minutes, but note should justify documentation time
- Location of the beneficiary at the time of receiving the service.
- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other providers, and any update to the problem list as appropriate.

Remember the Golden Thread!

Progress Note Requirements
Clarifications

Effective January 1, 2024

- DHCS does not require a "one-size-fits-all" approach to narrative notes
  - Notes must include minimum required elements (e.g., type of service, date, location).
  - The nature and extent of the narrative note may vary based on the service type and the member's clinical needs. Some notes may appropriately be less detailed than others.
- If information is located elsewhere in the record (e.g., care plan template), it does not need to be duplicated in the progress note.
- Notes shall support the procedure code(s) selected and effective clinical care and coordination among providers.

BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS

Progress Note Requirements
Clarifications

Effective January 1, 2024

Requirements that apply to all progress notes (individual and group)

Progress notes shall include:

- The type of service rendered;
- The date that the service was provided to the member;
- Duration of direct patient care for the service;
- Location/place of service;
- A typed or legibly printed name, signature of the service provider, and date of signature;
- Progress note shall provide sufficient detail to support the service code(s) selected for the service type(s); and
- Progress notes shall be completed within three (3) days, except for crisis services, which shall be completed within one day.[1] The day of the service shall be considered day zero.

BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS

Progress Note Timeliness

- Notes for crisis service shall be completed within 1 day
- 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 still record documentation time.

BHRS 25 Documentation Requirements for all SMHS services

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

Progress Note Requirements
Clarifications

Effective January 1, 2024

- **Notes for individual services must include:**
  - A brief description of how the service addressed the member's behavioral health needs; and
  - A brief summary of next steps.
- **Notes for group services must include:**
  - A brief description of the member's response to the service.
  - All members attending a group service must have a progress note in their clinical record, and providers must also maintain lists of group participants.

BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS

HELPFUL TIP

Lockouts and non-billable activities remain unchanged.

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?

Consents in SmartCare

All clients need new consents that have wet or computerized signatures, verbal consent is not sufficient--or if they have previously signed consents from the paper chart, these can be scanned into SmartCare instead of getting all new signatures. These include:

- Consent to Treat
- Notice of Privacy Practices (if completed within SmartCare, this consent is included within the Consent to Treat document)
- Telehealth consent
- ROIs

CALAIM Payment Reform

Payment reform began on July 1, 2023.

- This transitions counties from cost-based reimbursement to fee-for-service reimbursement.
- Counties are now paid for services rendered instead of the cost of providing services.
- Counties must utilize CPT codes to improve reporting and support data-driven decision making.
- Smartcare will automatically manage the changes to coding brought about by payment reform. This means most of the changes are happening in the background of the Electronic Health Record.

CALAIM Payment Reform

- What happened to Collateral?

COLLATERAL SERVICES

CalMHSA
California Mental Health Services Authority

- Collateral services can STILL BE BILLED under Payment Reform.
- There is simply no longer a distinct service code called "Collateral".
- Collateral can be a component of many types of services including, but not limited to: Assessment, Rehabilitation, Plan Development, Peer Support Services, Targeted Case Management, TFC and Crisis Intervention.
- When documenting services provided to a collateral contact, providers should select the service code that most closely fits the service provided and it should be clear in the progress note that the service was provided to a collateral contact.

CALAIM Payment Reform

- **Many potential billing errors should be minimized as the CPT & HCPCS codes, modifiers, lockouts, etc. will be managed "behind the scenes" in your EHR.**
- When selecting a service code, be sure to select the service that refers to the appropriate service time/time range (time/time range selection is based on direct service time).
- Direct service time includes not only time spent with the individual in care, but can include contact with collateral sources and other service providers (even if the individual in care is not present). Some services do require that a client is present for the service to be claimed.
- Add-On codes cannot be utilized independently. They must be used in conjunction with a primary service code.
- Collateral services do still exist and you can document and bill for them. They simply no longer have a distinct service code called "Collateral".
- Travel and documentation time should be recorded separately in progress notes even though the time is not billable.

Payment Reform - California Mental Health Services Authority (calmhsa.org)Service Code Definitions - 2023 CalMHSA

Resources

- CalMHSA has created step-by-step trainings with detailed information regarding all the CalAIM changes and SmartCare user functionality.
- **CalMHSA CalAIM and SmartCare EHR trainings are required for all staff**: moodle.calmhsalearns.org/
- CalMHSA documentation guides: California Mental Health Services Authority | Documentation Guides (calmhsa.org)
- CalMHSA SmartCare user guides and training videos, live chat for support: https://2023.CalMHSA.org
- Chat Bot**:** CalMHSA Smartcare AI chatbot for questions
- Clinical Documentation Guide | Marin BHRS
- Marin County QM Team / Email BHRSQM@marincounty.org

- moodle.calmhsalearns.org/

Required CalAIM Documentation Trainings

All BHRS (county and CBO) direct service staff

There are 13 total CalMHSA documentation training modules. All direct service **(both MHP and DMC-ODS)** staff are required to complete 9 of the 13 online modules**.** Below is a list of the trainings. **The required trainings are numbers 1-7, 9, and 11 for all direct service staff (county and CBO, SMHS and DMC-ODS).**

1. CalAIM Overview
2. Access to Services
3. Assessment
4. Diagnosis & Problem List
5. Progress Notes
6. Care Coordination
7. Screening
8. Administering the Adult & Youth Screening Tools (*New in February 2023*)
9. Transition of Care Tool
10. Administering the Transition of Care Tool (*New in February 2023*)
11. Discharge Planning
12. CPT Coding for Direct Service Providers (SMHS) (*New in May 2023*)
13. CPT Coding for Direct Service Providers (DMC & DMC-ODS) (*New in May 2023*)

Please Note:

- If you administer either the **Adult and Youth screening tools** or the **Transition of Care tool**, please complete those supplemental trainings as well (for a total of at least 11 training modules).
- The CPT code training is not required by BHRS, however it is **strongly encouraged** for BHRS staff, especially for Supervisors.