SOLANO COUNTY MENTAL HEALTH DOCUMENTATION MANUAL

2017

This Documentation Manual provides information about Medi-Cal billing codes for Specialty Mental Health Services, Scope of Practice for using these codes, and directives regarding necessary components of progress notes

Why We Have a Documentation Manual

The Solano County Mental Health Plan's (MHP) objective is to provide mental health (MH) services and supports in Solano County that are person-centered, safe, effective, timely, and equitable. This Documentation Manual establishes and emphasizes documentation standards to help ensure provision of sound and ethical clinical care and service, as well as to comply with State and Federal regulatory requirements. Good documentation also helps the Solano County MHP to obtain payment for services provided, which is important to maintain programs' financial sustainability. To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, justify treatment, and record observations, plans, outcomes and interventions, as well as the client's response to treatment. Ultimately, good documentation creates and maintains a comprehensive record of treatment for mental health clients that acts as a communication tool among providers working with a client.

Medical Necessity

For a client to receive mental health services through the MHP, Medical Necessity must be established through a clinical assessment at the initial, periodic, and annual marks. Medical Necessity must continue to be reestablished and documented throughout treatment. There are three criteria of Medical Necessity that must be clearly documented for treatment to be reimbursed through Medi-Cal:

A. Diagnostic Criteria: The focus of the service is related to functional impairments related to an included DSM-5/ICD-10 Diagnosis, which includes onset, frequency, duration, and list of symptoms
B. Impairment Criteria: The client must have at least one of the following as a result of the mental disorder(s) identified in the diagnostic criteria A:
    1. A significant impairment in an important are of life functioning, or
    2. A probability of significant deterioration in an important area of life functioning, or
    3. Children also qualify if there is a probability the child (a person under the age of 21 years) will not progress developmentally as individually appropriate. Children under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated
C. Intervention Criteria: All three criteria below must be met:
    1. The focus of the proposed intervention is to address the condition identified in criteria B above, and
    2. It is expected that the proposed intervention will benefit the client by significantly diminishing the impairment, or prevent significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enable to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated)
    3. The condition would not be responsive to physical health care based treatment

Scope of Practice

Scope of Practice refers to how the law defines what members of a licensed profession may do in their licensed practice. It is imperative that staff working within the Solano MHP ONLY provide services that are within their score of practice and scope of competency.

Throughout this Documentation Manual, you will see tables entitled "Who Can Use This Code?" These tables identify who in the MHP can bill certain service codes based upon their professional scope of practice. Please make sure to reference these tables as you utilize the Documentation Manual to determine who is allowed to bill each service code and when co-signatures are required.

Who Can Use This Code?

	Physician	PA	NP	RN	RN with MH/MA	LVN or Psych Tech	L/R/W Psych	L/R/W LCSW/ASW, MFT/MFTI, LPCC/LPPCI	Trainee - post BA/BS and pre MA/MS/PhD	MHRS	Other, Unlicensed
Code											

Abbrev. Title	Actual Title
Physician	Physician
PA	Physician Assistant
NP	MH Nurse Practitioner
RN	Registered Nurse
RN with MH/MA	Registered Nurse with Masters in MH Nursing or Related Field
LVN or Psych Tech	Licensed Vocational Nurse or Psychiatric Technician

Abbrev. Title	Actual Title
L/R/W Psych	Licensed, Registered, or Waivered Psychologist (post PhD)
L/R/W LCSW/ASW, MFT/MFTI, LPCC/LPCCI	Licensed, Registered, or Waivered LCSW, ASW, MFT, MFTI, LPCC, or LPCCI (post MA/MS)
Trainee – post BA/BS and pre MA/MS/PhD	Trainee (post BA/BS and pre MA/MS/PhD) – Psychologist Intern, Psychologist Trainee, MSW Intern, MFT Trainee, LPCC Trainee
MHRS	Mental Health Rehabilitation Specialist (staff with BA/BS in MH related field and 4 years of experience in MH)
Other, Unlicensed	Staff without BA/BS and 4 years of experience or AA and 6 years of experience

Please Note: Some services are provided under the direction of another licensed practitioner (or in some cases, a registered or waivered practitioner). This means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery (this includes review and cosigning of clinical documentation). An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the MH service provided.

Progress Notes

A good progress note creates a clinical history in the MH client's medical record, ensures that State and County documentation standards are met, which protects you as a provider. The Solano County Quality Improvement Unit has adopted the BIRP standardized method of documenting a progress note for all providers. All billable notes, including some notes that are not reimbursable to Medi-Cal, are to be written in the BIRP format (see specific procedure codes for clarification).

<u>BIRP Format</u>

B: Behavior/Presenting Problem

The "B" section provides information about both the long-term presenting problems and a client's current presentation (e.g. appearance, mood, affect, behavior, speech, etc.) to document why the service is medically necessary. This section also identifies the location of the service, justification of any travel time, who participated, and the purpose of this service.

I: Intervention

The "I" section is used to capture interventions that the provider did during the service that are connected to and address the goals and treatment objectives of the Client Service Plan (CSP). These interventions tie each progress note back to the symptoms, functional impairment, and diagnosis documented in the Assessment and CSP. Clinical verbs can be used to capture these interventions and to describe the interventions being provided (see box below for examples). Therapeutic modality can also be identified in this section.

- Assessed	- Encouraged	- Normalized	- Conducted risk assessment
- Explored	- Reframed	- Clarified	
- Taught	- Contained	- Reflected	- Compiled
- Identified	- Role-played	- Prompted	- Counseled
- Processed	- Mirrored	- Contracted	- Explained
- Facilitated	- Challenged	- Prepared	- Guided
- Practiced	- Reflected	- Redirected	- Offered
- Reinforced	- Modeled	- Reassured	- Validated

R: Response/Results

The "R" section describes how the client and/or other people participating in the service responded to the interventions, tying back to and reflecting the Interventions in the "I" section. This section could also include results of a service activity without the client present.

P: Plan

The "P" section identifies the short term and long term plan with the client and for treatment. This could include what treatment objectives will be the focus of the next

session, alternative approaches that might be used, follow-up referrals to community resources, follow up appointments, plans for increasing level of care, or plans for discharge. Simply listing the next appointment is insufficient.

A Good Progress Note Will:

- Provide a clear, ongoing record of the client's condition, the interventions attempted, the client's response to the care provided, and the progress the client is making toward realizing his/her goals and objectives
- Facilitate the coordination of care and communication between team members
- Record a service for every billing activity, acting as a receipt to provide Medi-Cal with a clinical record of service that demonstrates medical necessity and justification for payment of service claims
- Show evidence of collaboration with community resources including primary care
- Be legible and signed/dated appropriately by clinical staff
- Include the license, title, or degree of service provider
- Be cosigned when necessary due to scope of practice
- Demonstrate ongoing medical necessity for each billable service
- Show that the amount of time billed is appropriate for the service provided
- Show that content within the note corresponds with the respective billing activity that is being claimed
- Be unique and non-repetitive in each section (i.e. Behavior, Intervention, Response, and Plan) from note to note, chart to chart
- Accurately document the use of a specific therapeutic modality whenever such interventions are utilized (e.g. Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Solution Focused Therapy, etc.)

A Good Progress Note Will NOT:

- Record start and stop times that overlap with other progress note activities. This includes any overlapping documented service activities involving a single provider and different clients
    - For consecutive services billed to the same client, either by a single provider or by multiple providers, a one minute overlap between services is allowable
- Bill for more hours than hours worked
- Bill for more than 60 minutes in one hour for a single provider
- Claim for two services during the same time frame
- Use a billable code for supervision time
- Copy and paste notes or a portion of a note from one progress note to another, from one client to another, etc. Each note must be unique to the client
- Fall below State and County standards for documenting service activities
- Be corrected with the use of "white-out". All corrections must have a single strike through and be initialed

- Combine multiple services under one procedure code/one progress note entry (i.e. do not combine Individual Therapy and Collateral, or Mental Health Rehab and Case Management)

Compliance

Good documentation practices are skills that are developed with time, practice and effort. Although everyone is expected to have a certain level of competence in their job, even seasoned practitioners make some occasional mistakes. To assist our Solano MHP providers to improve their documentation practices, the MHP provides regular and ongoing documentation training. Providers who adopt and utilize principles from documentation training and this manual minimize their disallowances in audits and eliminate risk of fraud.

As a state mandate, there are certain steps the MHP is required to take throughout the year to monitor MHP documentation practices as a matter of quality assurance:

Utilization Review Audits

The Solano MHP requires an annual utilization review audit of each Organizational Provider Reporting Unit (RU) that bills Short-Doyle/Medi-Cal, operating within the plan. Solano MHP Quality Improvement facilitates these audits using a standard technical and clinical review tool. Every provider will make some mistakes, but adhering to the documentation standards contained within this manual can help you lessen the amount of dollars recouped by the MHP and returned to the state of California for disallowed services.

Agency/Employee Investigations

A Quality Improvement investigation of an agency or employee's documentation practices will occur ONLY after a consistent and significant pattern of inappropriately documented services has been detected. Again, we realize that ALL clinicians make occasional mistakes in their documentation, and such investigations quickly separate the occasional mistake from consistent acts of fraud, waste or abuse. Investigations are a Quality Improvement and County Compliance mandate, and are intended to protect clients from unethical providers and the Mental Health Plan from potential penalties levied by the state and federal government.