SAN MATEO COUNTY HEALTH SYSTEM
BEHAVIORAL HEALTH AND RECOVERY SERVICES

DATE: April 2, 1991

BHRS POLICY: 91-05

SUBJECT: Compliance with Documentation Standards for Mental Health System of Care Clients/Programs

AUTHORITY: 42 CFR, 456.180; CCR, Title 9, Chapter 11, Sections 1830.205, 1830.210, and 1840.314; County contract with DHCS; BHRS Quality Management Plan; BHRS Documentation Manual; BHRS Policy 03-14 Compliance Policy for Funded Services

AMENDED: February 11, 2004; Technical Edits 11/13/13, 1/23/14
Amended 5/1/16

PURPOSE

- To provide policies and procedures for clinical record documentation related to the delivery of specialty mental health services within San Mateo County BHRS directly operated and legal entity contracted programs. This policy applies to all Mental Health staff, trainees, volunteers and independent clinical contractors working at BHRS owned or operated sites.
- This policy applies to all services provided by the Mental Health System of Care Programs. This includes county and contracted providers, regardless of payer source, unless a specific exception is made in the BHRS Mental Health Documentation Manual.

GOALS

- To describe expectations for documentation standards and practices based on cited authorities.
- To identify the BHRS Mental Health Documentation Manual as the policy source for documentation standards.
- To describe processes at the clinical level for monitoring compliance with documentation standards and practices.
- To identify consequences for failure to meet minimum standards and practices defined in the policy.

Documentation standards promote quality of care in the following ways:

- Comprehensive clinical documentation facilitates complete and appropriate assessment, efficient and effective treatment planning and delivery, client

involvement in goal development and service delivery, peer review, medication monitoring, training and supervision.
- Liability issues can be minimized by clear and timely documentation of uses and disclosures of Protected Health Information.
- Medi-Cal, Medicare and other funding streams can be utilized appropriately to provide maximum revenues to support ongoing client services.

NOTES/EXCEPTIONS

Fee-for-Service providers must adhere to the Network Providers Manual.

For all clients in the BHRS MH System of Care, documentation in the clinical record must support medical necessity and the reasons why the services were provided in order to be eligible for reimbursement.

All assessments, progress notes, and treatment plan forms used to claim for services and document medical necessity must be compliant with San Mateo County BHRS requirements and approved by Quality Management.

Each legal entity must have a quality assurance process in place to ensure that all documentation requirements of the BHRS Mental Health Documentation Manual are met and occur within the established timeframes set forth within this policy.

POLICY

1. Applicability

    - Medi-Cal documentation standards apply to all clients except where these are preempted by alternate documentation practices for Medicare or other payer sources.
        - More stringent or additional documentation requirements may be implemented for certain programs to meet conditions imposed by the California Department of Health Care Services (such as for Therapeutic Behavioral Services or Pathways to Mental Health-Care Practice Model) or by other insurers.
        - Grant funded programs may have additional documentation requirements (such as unique assessment forms).
        - State regulations mandate obtaining client signature (or signature of the client's legal representative) on treatment plans whenever the client is determined to be in long-term treatment or is receiving more than one type of specialty mental health services.
        - In San Mateo County, such signatures are required on all treatment plans, without consideration of the above exceptions.
        - The definition of a Long-Term Client is any client admitted to an outpatient treatment episode.

- The documentation standards referenced in this policy and detailed in the Documentation Manual apply to services provided by contracted providers, within the conditions of each agency's contract with Behavioral Health Services.

2. Documentation

2.1 Progress Notes/Services:

- All services provided will be documented as described in the BHRS Documentation Manual and any policy memos issued prior to the incorporation of the new information into the manual. Any services provided which do not meet standards and requirements cannot be submitted for reimbursement.
- All services provided will be documented in a timely manner.
- Progress notes are due within 3 working days of the date of service; otherwise, they are late. Staff that have a pattern of writing progress notes late, after 3 working days from the date of service, are to be counseled by their supervisor. Progress notes completed more than 30 days after the service date are considered excessively late and should be coded as non-billable unless otherwise approved by BHRS Quality Management.
- It is the professional responsibility of all staff working directly with clients/families to document services in a timely and accurate fashion. Failure to document services in a timely fashion is unprofessional conduct and is grounds for progressive disciplinary action.
    - In the infrequent situation where a personal or clinical emergency prevents timely recording of services, the service shall be entered as soon as possible and clearly identified as a "late entry". **The actual date a late entry is written will be clearly identified in the documentation**.
- Every service entry will comply with requirements for medical necessity, signatures, licensure, and scope of practice.
- All claims for services submitted for reimbursement will be provided and documented based on the Client Treatment and Recovery Plan that will be completed and updated in a timely manner, as specified in the Documentation Manual.
- All claims for services submitted for reimbursement are based upon allowed diagnoses, appropriate activity/billing codes, eligibility of the providing clinician and compliance with all other requirements for documentation of service.

2.2 Assessments

New Clients
The Assessment for a new client not already open to any treatment program must be completed within 60 days of the episode opening. Use the Initial Assessment Form.

If the client is already open to a treatment program, any additional program accepting a client is responsible for ensuring that there is a current and accurate Assessment in the Clinical Record.

When there are two or more treatment programs treating the same client, the teams should coordinate care and determine which team will be the lead in developing and completing the Assessment. However, it is every program's responsibility to ensure that there is a complete, current Assessment meeting medical necessity. No team may bill for services without a completed Assessment in place that meets medical necessity. If the Assessment is overdue, the receiving program must complete an Initial Assessment for clients without a completed Assessment, or complete a Re-Assessment for a continuing client.

Assessments must address all required elements listed in the BHRS Mental Health Documentation Manual and must document medical necessity for services. This includes clearly documenting symptoms supporting the primary DSM 5 diagnosis, describing functional impairments in various spheres of the client's life, as well as explaining why continued mental health treatment is necessary.

Re-Assessments
Re-Assessments for continuous clients with ongoing services (no lapse of services over 180 days) must be completed at least every 3 years or when there is significant change in clinical condition. Use the Re-Assessment form.

Clients returning to services after termination of services for over 45 days, and inactive clients without billable services for over 180 days, must have a completed Re-Assessment within 60 days of the admission. Use the Re-Assessment form. Any program treating a client continuously is responsible for ensuring that there is an Assessment in the clinical record with all required sections completed. It is not sufficient to state "no change," "see progress notes" or "see previous assessment." All treatment programs are responsible for ensuring that there is a complete assessment meeting all requirements even if the program is not considered the lead/care coordinating episode. If the client returns to services beyond one year, a new Initial Assessment is required.

An Assessment is completed on the date a Licensed Practitioner of the Healing Arts (LPHA) signs and submits it as final. Definition of LPHA: Licensed Physician, Licensed/Waivered Clinical Psychologist, Licensed/Registered Clinical Social Worker, Licensed/Registered Marriage and Family Therapist, and Registered Nurse with Masters in Psych (note- Registered Nurse without Masters in Psych may complete treatment plans without co-signature, but not assessments). Assessment Addendums do not count as the Re-Assessment and draft documents do not count as completed.

Re-Assessment – Diagnosis Update
To update the diagnosis between assessments, complete the Re-Assessment Form, select assessment type "UPDATE." You may then only complete the diagnosis tab. This will not reset the assessment timelines.

2.3 Treatment Plans

The Initial Client Treatment and Recovery Plan will be completed within 60 days of the client's entry to a treatment program. All Long-Term Clients are required to have a Client Treatment and Recovery Plan within 60 days of admission, and annually on or before the expiration date for each treatment episode.

Staff from each treatment program/episode are required to complete their own Client Treatment and Recovery Plan. The deadline above applies both to clients who are new to the system and existing clients who enter a new program (i.e., a second provider is added or the client transfers to a new program).

The Client Treatment and Recovery Plan must be authorized by an LPHA, whose signature and date of signature/approval establishes the completion of that plan.

Effective Date: Each Client Treatment and Recovery Plan can be authorized for a maximum of one year. A new Client Treatment and Recovery Plan supersedes the previous plan. If the covered period passes and the next Client Treatment and Recovery Plan is completed late, there will be unauthorized days that should not be claimed. For example, the renewal date is July 1st but the Annual Client Treatment and Recovery Plan is completed on July 7th. All services from July 1st through 6th would be unauthorized and unbillable

A Client Treatment and Recovery Plan's effective date is based on the LPHA's signature/approval and finalization date. Drafts do not count as completed. **It is expected that the client participates in the formulation of the plan and, if possible, signs the treatment plan before the LPHA signs it.** The treatment plan is considered completed on the day that the LPHA approves the plan; there should be a client signature or a detailed progress note stating why the client did not sign the plan before the LPHA signs/approves the plan. It should be a rare exception that the client, family, or a significant support person does not participate in the development of the treatment plan. Write a good, detailed progress note explaining the client/family's role in developing the plan before finalizing the treatment plan. Drafts do not count as completed.

2.4 Treatment Plan Addendums

The Treatment Plan Addendum may be used to collect a client's signature or add/modify a goal, objective or intervention. The Treatment Plan Addendum may be used at any time. It is not a substitute for a new completed Client Treatment and Recovery Plan and does not reset the due date for the next Client Treatment and

Recovery Plan.

3. Responsibilities

- Clinical Staff
    - For the purposes of this policy, clinical staff are defined as those personnel that directly provide a clinical service to a client, and that document the provision of services in a behavioral health record.
    - Clinical staff will ensure that all documentation is based on the clinical standards and documentation requirements included in the Documentation Manual and other distributed memos and bulletins.
    - Clinical staff will take on-line documentation training upon employment, other mandated documentation trainings, and any additional appropriate trainings as directed.
    - In the event that the clinician discovers that inappropriate billing occurred, the clinician will inform the supervisor immediately so that remedial action can be taken.

- Supervisory (Clinical) Staff
    - For purposes of this policy, Supervisory (Clinical) Staff are defined as those supervisory personnel responsible for the performance of subordinate clinical staff as defined above.
    - Supervisory staff will ensure that subordinate clinical staff are aware of all requirements for appropriate and accurate billing and that the staff are trained in this regard.
    - The supervisor is responsible for ongoing supervision, regular evaluations, staff meetings and individual training to ensure that staff are appropriately documenting services.
    - Supervisors of trainees will not co-sign progress notes that do not meet documentation standards and will ensure that such notes are not submitted for billing until they are complete.
    - In the event that any supervisor becomes aware of inappropriate billing practices, it is the supervisor's responsibility to inform in a timely manner the appropriate Program Manager. The Program Manager will inform in a timely manner the Business Systems Manager, Financial Services Manager, and the Compliance Officer. The supervisor will take immediate action to ensure that the inappropriate practice does not reoccur.

4. Corrective Action

- Occasional Non-Compliance
    - The clinician will be referred to the appropriate Documentation Manual section so that the standards are known and understood.
    - The clinician may be directed to retake the on-line documentation training provided by Quality Management staff, as indicated by the nature or severity of the inappropriate practice.

- The supervisor will maintain a written file of the documentation errors and the actions taken.
- The supervisor will regularly review the clinician's documentation until the supervisor is assured that the inappropriate practice has been corrected.

- Persistent Non-Compliance
  - The supervisor will document the clinician's persistent non-compliance with documentation standards and discuss this with the Program Manager, Quality Manager and Compliance Officer, and consult with them concerning a Plan of Correction. (If Quality Management staff finds persistent or significant non-compliance, the supervisor will be notified immediately and the same consultation will occur.)
  - Quality Management staff will audit up to 100% of the clinician's caseload. Closed cases may also be reviewed.
  - The supervisor will meet with the clinician and review the audit findings and expectations concerning documentation.
  - The supervisor and the clinician will jointly agree upon a Plan of Correction (including timelines) which might include such activities as routine co-signing of notes, increased supervision, special tutoring, and ongoing chart audits.
  - Continuing documentation errors will trigger further steps along the established progressive discipline procedure, up to and including termination of employment or contract.

Approved: *(Signature on File)*
Stephen Kaplan, LCSW
BHRS Director