COUNTY OF SAN MATEO
HEALTH SYSTEM

Behavioral Health & Recovery Services

Quality Management
1950 Alameda de las Pulgas
Suite 157
San Mateo, CA 94403
650-573-3431 T
650-525-1762 F
www.smchealth.org
www.facebook.com/smchealth

POLICY MEMO

Policy Memo: Removal of Anniversary Date, Changes to Assessment and Treatment Plan Timelines, and Progress Note Timeliness Update

Memo Date: April 6, 2016

Effective Date: May 1, 2016

The San Mateo County Health System webpage http://www.smchealth.org contains a link to all San Mateo County BHRS Policies and Memos.

Memo Subject: Updates to Clinical Documentation for Mental Health Services, all Payer Sources, System of Care Contractors and County Clinics.

Change/Effective Date: Anniversary Date is no longer in place as of May 1, 2016.

Anniversary dates will no longer be utilized to trigger due dates for San Mateo County System of Care clients/programs providing mental health services. Documentation due dates will be determined as described below.

Change/Effective Date: Assessment Timelines changes are effective May 1, 2016.

Any completed Initial or Re-Assessment (Annual Assessment) completed after January 1, 2016 will not be due for 3 years from the date of Approval/Finalization by the Licensed Practitioner of the Healing Arts (LPHA).

New Clients

Assessments for new clients 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 there is a current and accurate Assessment in the Clinical Record.

Behavioral Health & Recovery Services

Quality Management
1950 Alameda de las Pulgas
Suite 157
San Mateo, CA 94403
650-573-3431 T
650-525-1762 F
www.smchealth.org
www.facebook.com/smchealth

When two or more programs are treating the same client, the teams should coordinate care and determine which team will be the lead in developing and completing assessments. However, it is every program's responsibility to ensure that there is a complete and current assessment meeting medical necessity. After 60 days of admission to a treatment episode, no treatment team may bill for services without a completed assessment in place that meets medical necessity. (*If the assessment is overdue, the receiving/treating program must complete an Initial Assessment if it has not been completed previously or a Re-Assessment for a continuing client.*)

Assessments must address all of these required elements:

- Presenting problems and relevant conditions affecting the client's physical health and mental health status, for example: precipitating event, intensity, duration and response as well as current living situation, daily activities, and social support.
- A mental health history, including: previous treatment dates, providers, therapeutic interventions including medications, responses, sources of clinical data, relevant family information and results of relevant lab tests and consultation reports.
- Documentation of medications (including OTC/supplements), dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client's self-report of allergies and adverse reactions to medications, or if none, the absence of any known allergies/sensitivities.
- Cultural, linguistic, religious/spiritual, legal and other relevant factors affecting service delivery should be included where appropriate.
- Information concerning client's gender identity and sexual orientation.
- For children and adolescents, prenatal and perinatal events and a complete developmental history.
- Relevant physical health conditions reported by the client.
- For clients of all ages, information concerning past and present use of tobacco, alcohol, caffeine, and illicit, prescribed, and over-the-counter drugs.
- Information about the client being a past and/or present victim and/or perpetrator of abuse and/or violence.
- Special status situations that present a risk to the client or others.
- Description of client strengths in achieving client's treatment and recovery goals. Identify the strengths inherent in the client/family or available through established community supports.
- Mental Status Examination.
- One or more valid DSM 5 diagnoses.
- Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data. The formulation is a hypothesis and provides a framework to develop the most suitable

Behavioral Health & Recovery Services

Quality Management
1950 Alameda de las Pulgas
Suite 157
San Mateo, CA 94403
650-573-3431 T
650-525-1762 F
www.smchealth.org
www.facebook.com/smchealth

treatment plan and approach for diagnostic considerations. The formulation is a narrative that describes the overall condition and plan for client's wellness.

Assessment Addendum

An Addendum to the Assessment may be completed when there is additional information gathered or a change occurs after the completion of the Initial Assessment or between required Assessments. The Addendum does not substitute for a full Assessment and does not restart the timeline.

The Addendum can be used to add clinical information to the Assessment but cannot be used to document a change in diagnosis or other significant change. In these circumstances use the Re-Assessment (Assessment Type UPDATE).

Re-Assessments

Re-Assessment 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 mentioned above.

For clients returning to services after termination of all services for over 45 days but within one year, conduct an assessment using the Re-Assessment Form within 60 days of re-admission. If the client returns to services beyond one year, a new Initial Assessment is required.

Clients without billable services over 180 days must have a completed Re-Assessment when the client re-engages with services. Use the Re-Assessment form.

Any program treating a client continuously is responsible for ensuring 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."

An assessment is completed on the date the LPHA signs and submits it as final. Assessment Addendums do not substitute for the Re-Assessment and draft documents are not accepted as complete.

Re-Assessment – Diagnosis Update

To update the diagnosis in between Assessments use the Re-Assessment Form, select "Assessment Type UPDATE." You may then only complete the diagnosis tab. This will not reset the assessment timeline.

Behavioral Health & Recovery Services

Quality Management
1950 Alameda de las Pulgas
Suite 157
San Mateo, CA 94403
650-573-3431 T
650-525-1762 F
www.smchealth.org
www.facebook.com/smchealth

Change/Effective Date: Treatment Plan Timelines are effective May 1, 2016 ONLY for treatment plans completed on and after this date.

Treatment Plans

The initial Treatment Plan shall be completed within 60 days of the client's entry to a treatment program.

This deadline applies to clients who are new to the system as well as existing clients who enter a new program (i.e., a second provider is added or the client transfers to a new program). Each treatment program/episode is required to complete its own Treatment Plan.

Each Treatment Plan can be authorized for a maximum of one year. A new Treatment Plan supersedes the previous plan. If the covered period passes and the next Treatment Plan is completed late, there will be unauthorized days that are not claimable (e.g., the renewal date is July 1st but the Treatment Plan is completed on July 7th; then July 1st through 6th would be unauthorized for all services during that time period.)

It is expected that the client will participate in developing the Treatment Plan and sign it before the LPHA signs the plan. If the client does not sign the plan, write a detailed progress note explaining why. Write a detailed progress note explaining the client/family's role in developing the plan before finalizing the Treatment Plan. It should be a rare exception that the client, family, or a significant support person does not participate in developing the Treatment Plan.

The Treatment Plan must be authorized by an LPHA, whose signature and date of signature/approval/finalization establishes the completion date of that plan. Drafts are not considered to be complete.

Start Date: For the initial Treatment Plan, the start date is the date the Treatment Plan begins and must be completed before the due date (within 60 days of admission). For the annual Treatment Plan, the start date should be the first day after the end date of the previous plan. Do not back date; make the start date the completion date.

End Date: The end date cannot exceed 12 months from the start date.

The effective date of a treatment plan is either the start date on the plan or the date an LPHA signs/submits the plan as final, whichever is later.

Behavioral Health & Recovery Services

Quality Management
1950 Alameda de las Pulgas
Suite 157
San Mateo, CA 94403
650-573-3431 T
650-525-1762 F
www.smchealth.org
www.facebook.com/smchealth

Annual Update: Treatment Plans can never be backdated. For the annual Treatment Plan, the start date should be the first day after the end date of the previous plan; the plan should be finalized before the new start date. For example, if the previous plan ended on June 30th, then the next plan would start on July 1st. The authorization period would be from July 1st through June 30th of the following year.

Treatment Plan Addendum

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

Change/Effective Date: Progress Note Timeliness Changes are effective as of May 1, 2016

Progress Notes Timeliness

All services shall be documented in a timely manner.

Progress Notes are due within 3 working days of the date of service, otherwise they are considered late. Progress Notes completed more than 30 days after the service date are 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 may result in progressive disciplinary action.