



Date: November 17, 2017

Policy Memo 11-17: Chart Documentation Requirement Updates

To BHRS Clinical Staff, Supervisors, Managers and Contracted Agencies/Providers providing specialty mental health services in San Mateo County.

Implementation Date: By January 1, 2018 all components of this memo must be fully implemented.

Authority: All BHRS Specialty Mental Health Agencies and county run programs are required to follow the requirements stated in notice 17-040 and 17-050.

DHCS Notice [17-040](#) Chart Documentation Requirement Clarifications and [Attachment 1](#)

DHCS Notice [17-050](#) Annual Review Protocol for Specialty Mental Health Services and Other Funded Services for FY 2017/2018

[Enclosure 1](#), [Enclosure 2](#), [Enclosure 3](#), [Enclosure 4](#)

DHCS Notices located at: <http://www.dhcs.ca.gov/formsandpubs/Pages/2017-MHSUDS-Information-Notices.aspx>

Subject:

The purpose of this memo is to set forth new documentation requirements to ensure compliance with DHCS Notice 17-040: Chart Documentation Requirement Clarifications. The following changes are to be fully implemented as soon as possible and no later than January 1, 2018.

Statement of documentation requirement changes and/or clarifications related to the following areas:

1. Assessment and Treatment Plan Timelines- assessment and treatment plans must be completed within the first few sessions. No planned services may be billed/provided prior to the assessment/treatment plan completion.
2. Assessment/Diagnosis- Inpatient diagnosis may not be utilized for outpatient/residential programs.
3. Treatment Plan (Client Plan) - More details have been added to the treatment plan about each service type.
4. Medication Consents- No change, this notice just confirms this requirement. Only the official BHRS Medication consent forms may be utilized. The Avatar Medication Consent is no longer valid.
5. Group Progress Notes with Co-Provider- The need for more than one provider must be documented and each person's activities must be documented in each progress note.
6. Mental Health Rehabilitation Specialists (MHRS) - No change, this notice just confirms the requirements for MHRS.

1. Assessment and Treatment Plan Timelines:

It is expected that all programs complete the assessment and treatment planning process prior to providing planned services.

If the assessment was already completed by another program and is current, it is to be reviewed in or before the first session. A progress note is to be written confirming this review. If updates are needed, there should be a reassessment completed. Within the first few sessions, the current assessment should be reviewed and/or completed and then the treatment plan should be developed with the participation of the client/guardian whenever possible. *Although it is expected that in most cases the assessment/treatment planning process will be conducted within the first few sessions, the assessment/treatment planning process must be completed no later than 60 days after admission or billing will be blocked.*

Residential and crisis residential programs should complete the assessment/treatment planning process within the first 3 treatment days.

Residential/crisis residential programs may bill the first 3 days of programming while the assessment and treatment plan are being completed- no billing will be permitted after 3 days without assessment and treatment plan completion.

Prior to the client plan being approved, the following service activities are reimbursable:

- Assessment
- Plan Development
- Crisis Intervention
- Crisis Stabilization (PES)
- Medication Support Services for Assessment/Evaluation/Plan Development (14) or if there is an urgent need (15) which is clearly documented in the progress note.
- Case Management and Intensive Care Coordination (ICC): For assessment plan development, and referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services.

If the client being treated does not have an approved client treatment plan, the following services (considered as "planned services") will be disallowed if they are billed to BHRS.



For MD/NPs prior to completion of assessment and treatment plan the only billable codes in AVATAR that are reimbursable are “14” (assessment) or “15” (urgent).

An approved client plan must be in place prior to service delivery for the following:

- Mental health services (except assessment, client plan development): including collateral, group or individual rehab, and group or individual therapy.
- Intensive Home Based Services (IHBS)
- Specific component of TCM and ICC: Monitoring and follow up activities to ensure the client treatment plan is being implemented and that it adequately addresses the client's individual needs (except for assessment/treatment plan/ an initial referrals).
- Therapeutic Behavioral Services (TBS)
- Day treatment intensive
- Day rehabilitation
- Adult residential treatment services
- Crisis residential treatment services
- Medication Support (non-emergency)

2. Assessment/Diagnosis: ***This following section only applies to programs that have been using Inpatient assessments to meet medical necessity (i.e., Caminar Redwood House, and contractors).

Outpatient and residential programs may not use an inpatient diagnosis to meet medical necessity.

Outpatient/residential programs must complete their own assessment and diagnosis upon admission to their program. The diagnosis and assessment must be completed in an outpatient/residential setting by an outpatient or residential care coordinator/clinician.

However, an outpatient/residential program may accept another outpatient/residential program's assessment/diagnosis as their own only after meeting with the client and confirming whether the assessment/diagnosis is still correct. A progress note should document that this review was done and confirm whether the information was current and complete. A reassessment is required if there were significant changes since the last assessment.

3. Treatment Plan (Client Plan).

All BHRS clients are long-term clients and are expected to participate in their treatment plan development whenever possible. **The client's signature or the signature of the client's guardian is expected on the treatment plan unless the client refuses or is unavailable (in limited cases).**

Ways to document the client/guardian's participation in the development of, and agreement with the client plan include:

- Reference in the treatment plan to the client's participation in the development of, and agreement with the plan.
- The client's signature on the treatment plan.
- In all cases, a progress note should be written to describe the client's participation in the development of, and agreement with the client plan.

Example progress note, The Client participated in treatment planning meetings on (date) and (date). The client participated in developing their treatment plan goals and interventions; in particular, the goals for (state goal or goals that the client gave specific input for). The client was satisfied with the client plan and stated agreement at the meeting held on (date).

If a client refuses to sign their client plan:

If the client refuses or is unavailable for signature, the treatment plan [or updated plan] shall include a written explanation of the refusal or unavailability. The written explanation should also be documented in a progress note. **Writing only “client refused to sign” or “client was unable” or “verbal approval,” is not sufficient.** Please write a more detailed description of their participation and/or refusal and how the plan was developed in their best interest. Although not required, it is best practice to make additional attempts to obtain client's signature and document the attempts in the client record. **Do not write, “Will get client to sign plan.”**

There is no minimum age for a minor to independently sign a treatment plan. The treatment plan is a collaborative process between the client and the provider. The client should understand what they are signing based on their participation in that process.

Treatment Plans are required to have specific details about the planned “proposed” interventions.

Proposed interventions (services) are the services a provider anticipates delivering to a client when preparing the client's treatment plan. Treatment plans must “identify the proposed type(s) of intervention/modality...to be provided” to the client. The actual interventions are those that are delivered to a client. The actual interventions are documented in progress notes. If new treatment modalities or service types are added the treatment plan should be updated as appropriate.

The frequency for delivery of an intervention in a treatment plan may not be “PRN,” “as needed,” or “ad hoc.”



Use of terms such as “as needed” and “ad hoc” do not meet the requirement that a treatment plan contain a proposed frequency for interventions. The proposed frequency for delivery of an intervention must be stated specifically (e.g., daily, weekly, etc.), or as a frequency range (e.g., 1-4 times monthly). Duration must also be documented in the client plan and refers to the total expected timespan of the service (e.g., the client will be provided with two individual therapy sessions per week for 12 months).

The official version of the BHRS Treatment Plan is required

No alternative will be accepted. Contractors may build their own EMR version of the BHRS treatment plan, however ALL fields and headers must be the same as the official BHRS Treatment Plan form.

The Avatar Treatment Plan form will be updated to meet the new requirements and must be utilized as of January 2018. BHRS staff completing the treatment form on paper and then entering it into Avatar are required to use this hard copy version:

<http://www.smchealth.org/post/bhrs-client-treatment-recovery-plan>

Contractors are required to use the official version <http://www.smchealth.org/post/bhrs-client-treatment-recovery-plan>

4. Medication Consents

All BHRS county run and Contract agency prescribers must utilize the official BHRS medication consent form.

No alternatives will be accepted. The current BHRS Avatar Medication Consent form is no longer valid. In the near future, the Avatar Medication Consent Form will be updated and providers will be informed when this happens. All guidelines stated in *BHRS Policy 16-12: Psychiatric Medication Consent for Adults and Youth*, must be followed. The medication consent forms are located here. <http://www.smchealth.org/bhrs-policies/psychiatric-medication-consent-16-12>

In addition, any Dependent Children must also have the appropriate JV-220 consent form(s) completed as specified in *BHRS Policy 99-02: Medication Authorization for Dependent Children*. <http://www.smchealth.org/bhrs-doc/medication-authorization-dependent-children-wi-code-section-300-99-02>

5. Group Progress Notes with 2 providers:

The justification/medical necessity to have two group co-providers must be documented for each group note in the context of the mental health needs of the clients. The group progress note must clearly document the specific involvement of each provider of the group.

One progress note for each client is completed for a group session with two providers- only one staff must sign the progress notes. The medical necessity to have two providers must be stated in the context of the mental health needs of the clients.

6. Mental Health Rehabilitation Specialists (MHRS)

BHRS recognizes Mental Health Rehabilitation Specialists (MHRS).

A MHRS is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting. A MHRS may provide mental health services including contributing to the assessment and treatment plan, however, these documents must still co-signed by an LPHA (MHRS may not complete the diagnosis, MSE, or clinical formulation). They may not provide therapy, but the MHRS may provide case management and mental health services (including rehab, collateral, assessment, plan development) crisis intervention, adult residential, and crisis residential treatment services.

Agencies are required to certify their own MHRS staff using the requirements listed above and keep records of that credentialing in the staff person's personnel folder. Once certified by their agency, MHRS staff shall sign their name with this credential, MHRS.

Additional information is located at:

Updated Documentation Manual: <http://www.smchealth.org/sites/main/files/file-attachments/bhrsdocmanual.pdf>

Updated treatment plans can be found at: <http://www.smchealth.org/post/bhrs-client-treatment-recovery-plan>

For San Mateo County Contractors <http://www.smchealth.org/bhrs/providers/soc> and for Out-Of-County Youth Contractors

<http://www.smchealth.org/bhrs/providers/occy>

Please address any questions to Jeannine Mealey at jmealey@smcgov.org

Sincerely,
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