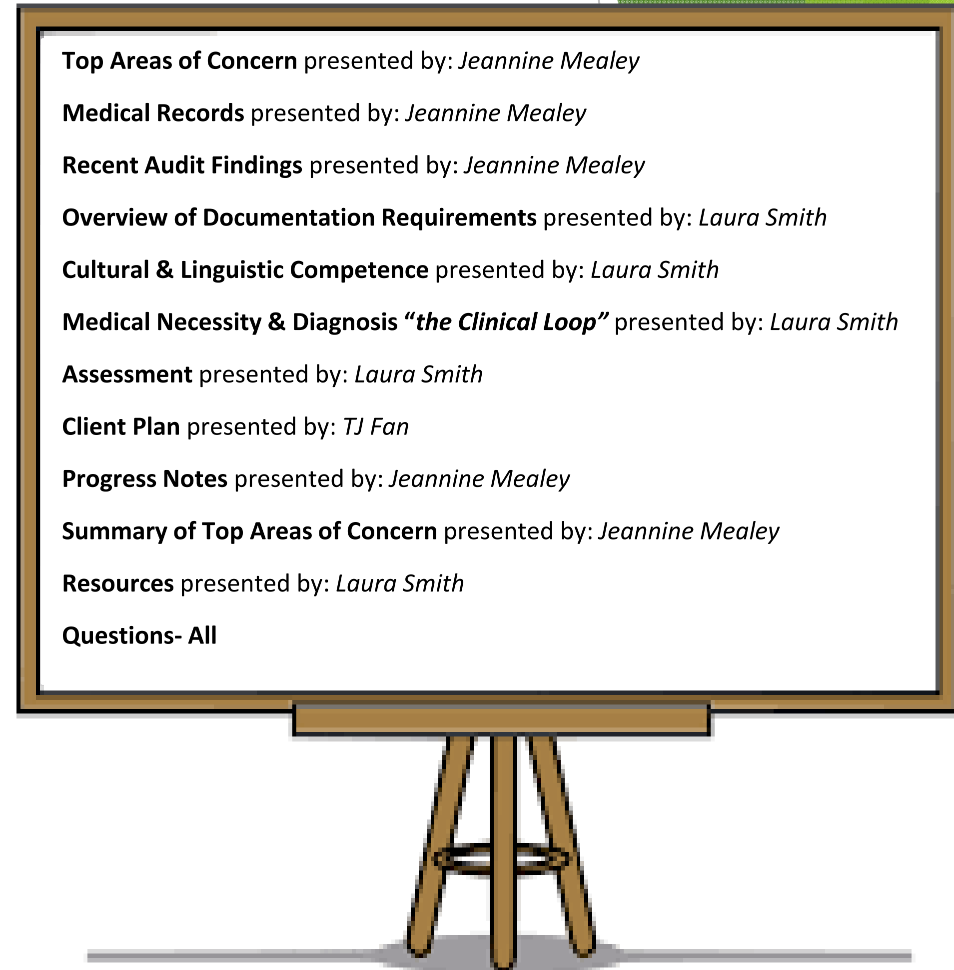
San Mateo County BHRS Private Provider Network (PPN) Documentation Requirements



Presented by BHRS Quality Management & Access Call Center 2019

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V11.12.19

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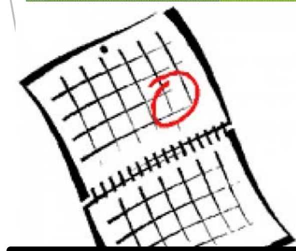
Top Areas of Concern

- Difficulty getting charts in a timely fashion from providers
- Providers not having official charts
- Some providers not writing Progress Notes
- Documents not signed by provider
- Documents missing key information to identify the client and/or service

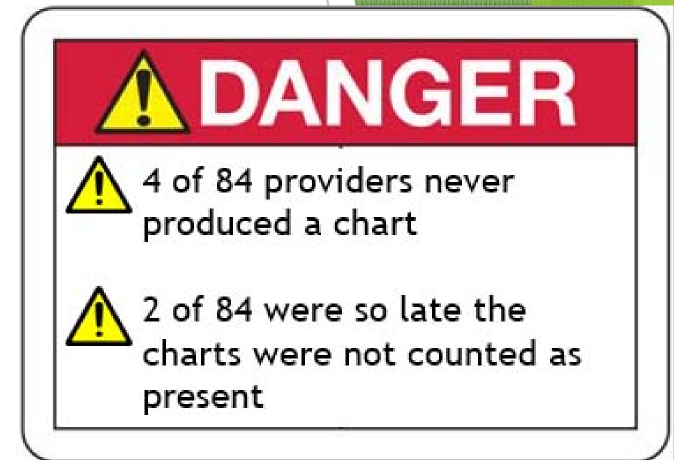


Providers are **REQUIRED** to produce charts for audits within the requested timeframe

Fillable forms are located at BHRS Managed Care webpage - https://www.smchealth.org/bhrs/contracts

Maintenance of Medical Records

- **Official Medical Record -** You must maintain an "OFFICIAL" medical record of your care
- **Signed-** With INK or Certified Electronic Signature
- **Legible-** Records must be legible (typing is strongly recommended)
- **Secured-** Records should be securely stored, behind 2 locks
- **Maintained-** All clinical records are to be maintained **for at least 10 years** from the last date of service
- **For Minors-** Records MUST be kept at least one year AFTER the minor has reached the age of 18, but in no case less than 10 years from last date of service



Source Electronic Signature
https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2019/19-17.pdf

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What is an "Official Medical Record?"

Option 1

- An old fashion binder or medical record folder
- All papers are secured in the folder in a systematic order

Option 2

- An external software program (not on your computer)
- The charts must be backed-up and secure

List of EMRs:
https://www.capterra.com/sem-compare/electronic-medical-records-software?gclid=CjwKCAjw3c_tBRA4EiwAICs8Cj5ffAmjN2Yp6D1KYRJbkuJIWFKI3Zv1ZTb75K3CgSBS9Gt2nIufqhoCrQkQAvD_BwE

- ~~Folder on your computer with word docs and PDFs~~
- ~~A legal pad with progress notes written on them~~
- ~~A bunch of papers in a loose folder or drawer~~

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What goes in the Clinical Record?

Providers must maintain a clinical record for each client. Every document related to the client's care must be maintained in the chart.

Examples:

- Consent to Treatment
- Release of Information (as needed)
- BHRS Managed Care Assessment and Treatment Plan
- Progress Notes (BHRS template strongly recommended)

Fillable forms are located at BHRS Managed Care webpage - https://www.smchealth.org/bhrs/contracts

Every Page of the Medical Record MUST Include:

- Client's name, DOB, & MR # or Billing #
- "Date of service" & "Signature date"
- Provider's name & signature with license type & number
- **Your name and credentials must be clear:**
  - **printed and signed** when written in ink OR you must have a valid **electronic signature**

NOT an Electronic Signature

- ~~Signing in Word by typing your name~~
- ~~Signing in a PDF~~

Source Electronic Signature
https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL/2019/19-17.pdf

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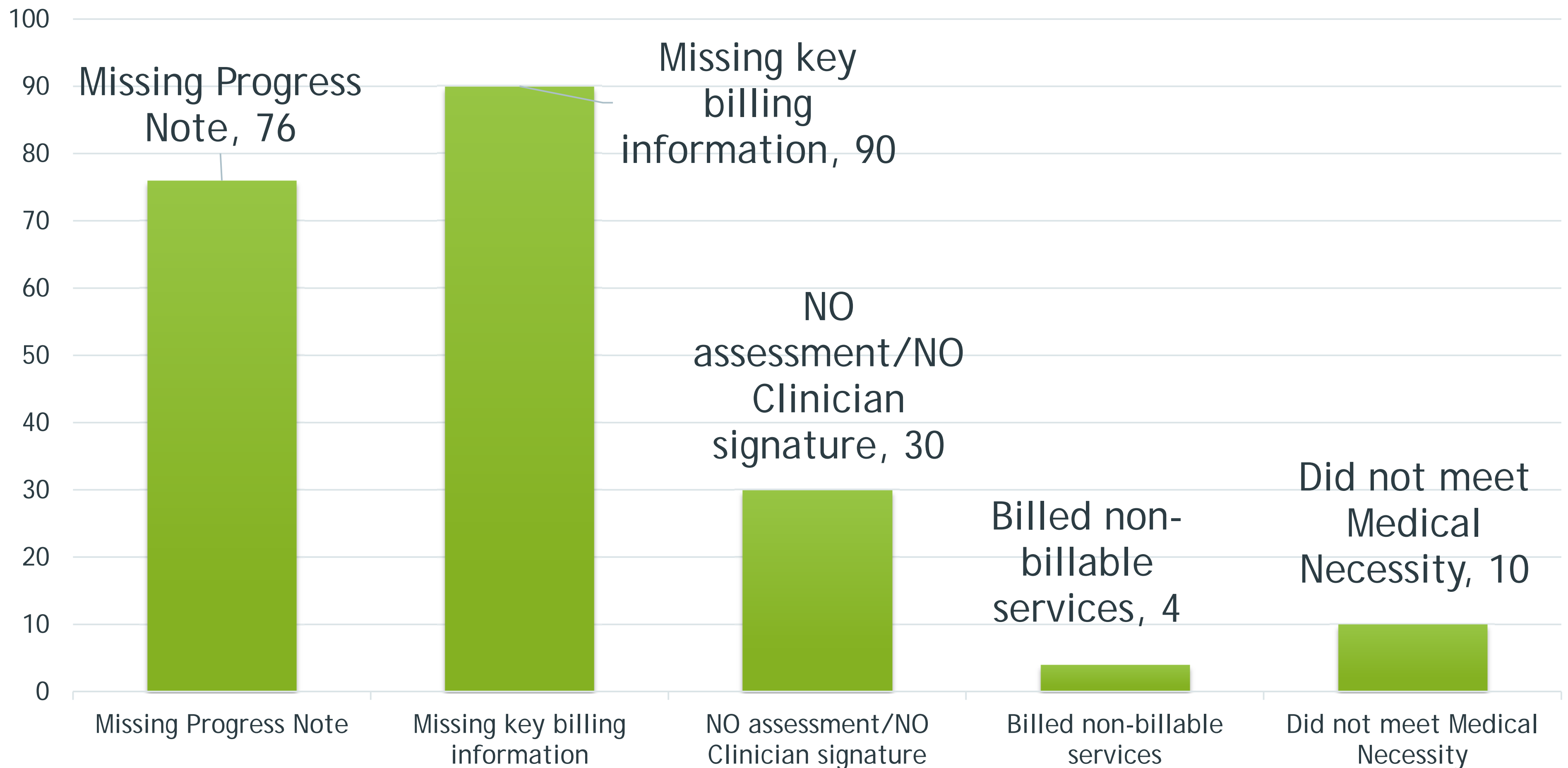
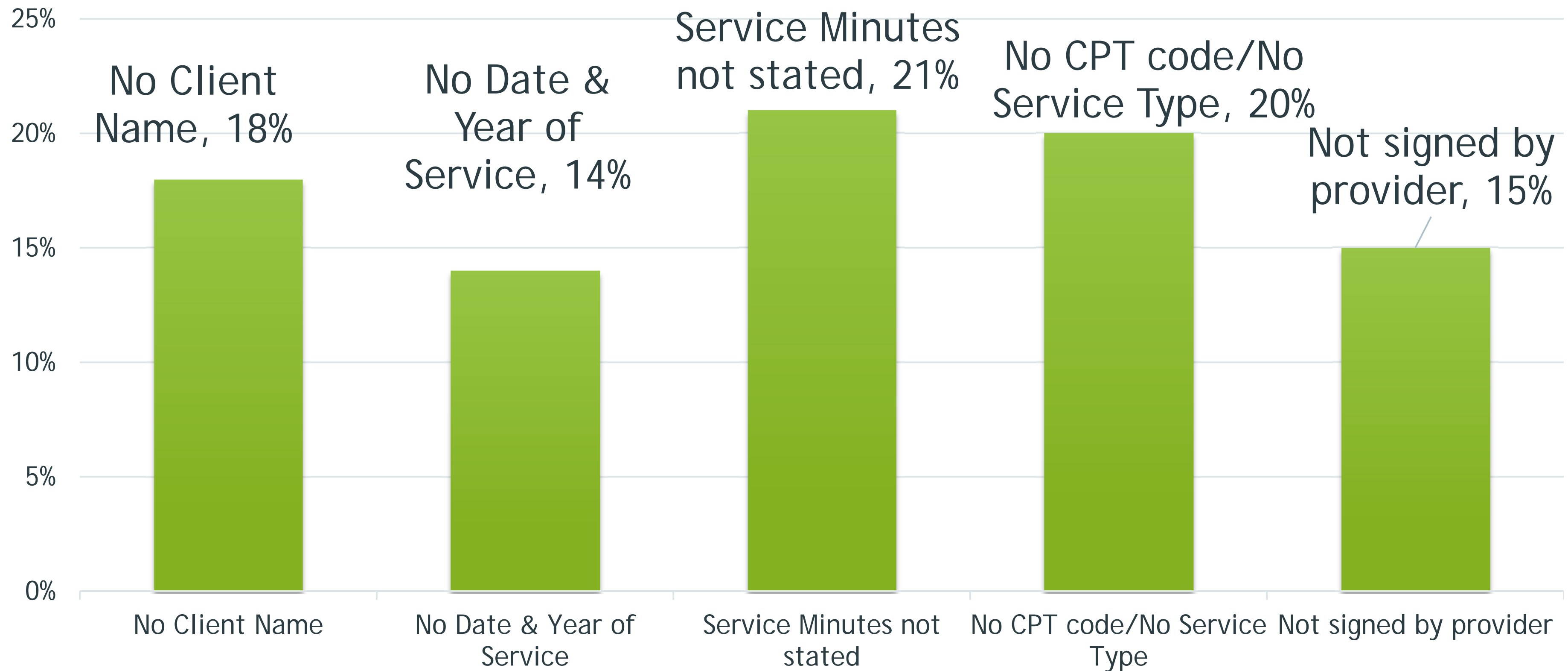
Who has the right to the Clinical Records?

- Clients (*there are a few exceptions)
- BHRS
- Payer/Insurance (DHCS, HPSM , etc.)
- Concurrent providers may receive copies of documents, when appropriate.

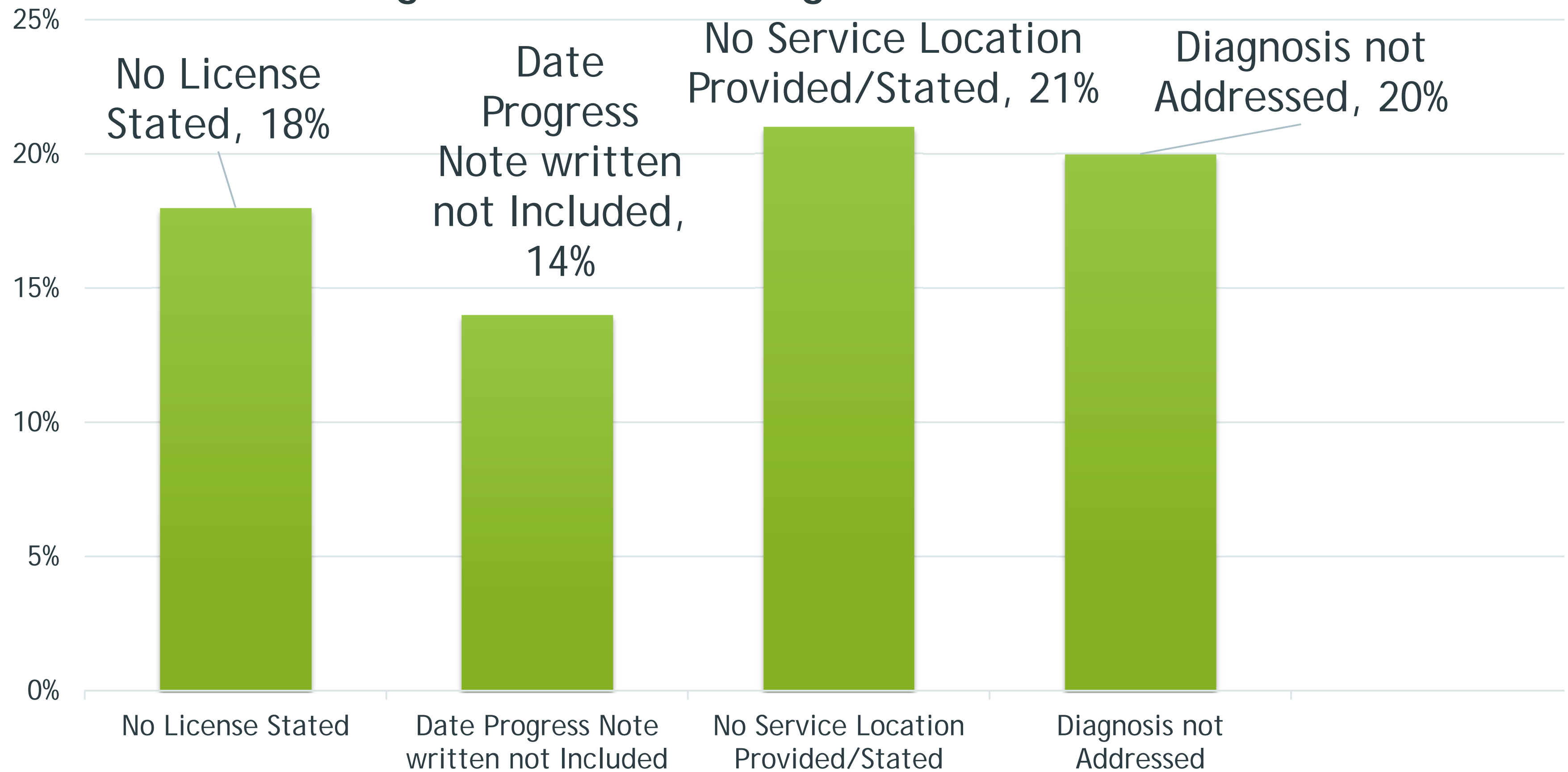


Recent Audit Finding of PPN

(N= 640 Services)



Immediate Cause for Disallowance

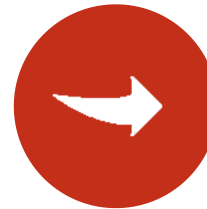


At Risk of Disallowance

Consent to Treatment NOT present: 36%

Assessment form completed but missing key components: 59%

Client Plan did NOT describe Intervention details.
Frequency: (17%)
Duration: (15%)
How the Intervention will address the diagnosis-related impairments: (13%)



Client not offered a copy of Treatment Plan: 31%

Many Progress Notes were late & many Progress Notes not dated

Many Progress Notes were missing key elements

Charts Submitted for Audit

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Documentation Overview

- The Initial ASSESSMENT authorization allows for 60 days & 2 assessment sessions (or 3 for youth), to complete the assessment and treatment plan.
- Complete/submit the **assessment** and **treatment plan** to request additional services.
- Once you receive your treatment authorization, treatment/billing for therapy services may start.
- A new assessment is due **every three years.**
- An updated treatment plan is due **every time you request additional services.**
- Authorized time can vary, but is never longer than a year.
- Progress notes are completed every time that you provide a service.

Fillable forms are located at BHRS Managed Care webpage - https://www.smchealth.org/bhrs/contracts

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Cultural & Linguistic Competence

- **Indicate and Document** whether services in a language other than English were provided, the language needed, and whether an interpreter was used.
- **Consent Forms** must be provided in the client's preferred language.
- **Treatment Plan Goals** should be written in client's preferred language.

Document how you address cultural/linguistic needs in:

- Consents
- Progress notes
- Assessment
- Client plans

"Today's session was provided in the client's preferred language of Spanish by this clinician." OR "language line was utilized."

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Medical Necessity & Diagnosis

"The Clinical Loop"

The Assessment, Treatment Plan, & Progress Notes should all tie together to demonstrate Medical Necessity AND:

- Include a **Covered** mental health diagnosis.
- Demonstrate significant **Functional Impairment** (present, or expected if untreated).
- Include the **Intervention** proposed, (*on a Treatment Plan*) that addresses the impairment.
- Supported by **symptoms and functional impairments** as documented on the most current assessment.

Medical Necessity & Diagnosis

All tie together in the "Clinical Loop"

1. Assessments **MUST** document Medical Necessity
2. Treatment Plans **MUST** address Medical Necessity
3. Progress Notes **MUST** address Medical Necessity

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"Managed Care Assessment & Treatment Plan"

Includes both Assessment & Treatment Plan

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MANAGED CARE-ASSESSMENT & TREATMENT PLAN

Confidential Patient Information: See California Welfare and Institutions Code Section 5328

CLIENT NAME Jolly Test MH# 938760 DOB 12/4/1962
PROVIDER Dr. Drew PROVIDER PHONE # 650-123-4567 ASSESSMENT DATE 2/1/2019

Client Address: 1950 Alameda Ave., San Mateo 94403 **Age** 56

Phone Number: Home # 650-765-4321 **Cell #** ____ **Work #** ____

Emergency Contact: Name Happy Test **Phone Number** 650-765-432

Source of Information: ☑ Client interview ☐ Previous Records ☐ Other ____

Ethnicity White **Primary Language Client** Spanish

Language of Family Spanish/English If Primary Language is not English, how will language needs be met? provider

Is Client able to communicate in English? ☐ **Yes** ☑ **No** **Interpreter Name** (if needed) N/A

Other people or agencies actively involved in the client's care:
(Name): Dr. Doogie Howser Other PCP
Case Manager (from where): ____ Other ____

Presenting Problem and Current Symptoms:

Assessment Key Facts

The ***Assessment*** must:

- Be **current** and **updated.**
- Provide a clear picture of the client's mental health status and functional impairments.
- Include provider's signature (ink or E-Signature) with degree/license number & job title/date of provider signature (*i.e., date document completed*).

Assessment

Must include all 10 Elements below:

- Presenting problem
- Relevant conditions and psychosocial factors affecting the client's physical and mental health (Medical Necessity)
- Mental health history
- Medical history
- Medications (even for non-prescribers, per client report)
- Substance exposure and use
- Mental Status Exam
- Strengths
- Risks and Barriers relevant to achieving treatment plan goals
- DSM diagnosis (and/current ICD code)

Treatment Plans

- Based on **current assessment** and present mental health condition/diagnosis.
- Describes the client's goals, the therapy goal, objectives, your **interventions;** expected **duration** and **frequency.**
- Must be developed **with the client** and **individualized** to address the client's **specific mental health needs.**

Treatment Plan: Goal

- Addresses the problem
- Is the development of new skills or removal of the barrier/problem
- Must relate to the diagnosis and case formulation
- Must be specific and measurable

GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments.
Ct will increase her ability to cope with her depression and worries and as a result will decrease her depressive sx from 5 days per week to 3 days per week.

Treatment Plan: Objectives

- Include what client will do to accomplish the goal
- Must be specific, observable, and measurable

SMART

Simple, Measurable, Accurate, Realistic, Time-bound.

OBJECTIVES - Client's next steps to achieving goal. Must be **observable, measurable and time-limited** objectives that address **symptoms/impairments** linked to the **primary diagnosis**.
Ct will identify depressive thoughts and feelings and use CBT techniques to manage distressing thoughts at least 2x/week. Ct will engage in health-promoting social activities (ex: socialize with a friend, attending a class in the community) at least 1x/week. Ct will take a 20-minutes self care (ex: walking, yoga, listening to music etc) at least 3x/week.

Treatment Plan: Intervention

An **Intervention** is what YOU, the provider will do to:

- Diminish the impairment - IMPROVE level of functioning, *OR*;
- Prevent deterioration - MAINTAIN current level of functioning, *AND*;
- Address the goals/objectives on the treatment plan

Treatment Plan: Intervention

- The client treatment plan describes, in detail, the interventions proposed for each service type: Individual Therapy, Medication Support…etc.

INTERVENTIONS – Describe in detail the interventions proposed for each service type: Individual Therapy, Medication Support…etc. (E.g. – Clinician will provide individual therapy, utilizing cognitive-behavioral techniques, to assist client with decreasing his depressive symptoms.)
Clinician will provide weekly individual therapy, utilizing cognitive behavioral techniques, to assist client with decreasing his depressive symptoms.

Treatment Plan: Signatures

- Clients are expected to participate in developing their treatment plan.
- Clients must sign their plan or the provider must write a very good progress note explaining the missing signature.
- Document client participation, **agreement with the plan**, and if a copy was **offered** to the client.
- Provider must date the plan, include credentials & license number, and name must be **printed and signed.**

must be able to read name/credentials

Client Signature: ____________________ Date: __________

Parent/Guardian Signature: ____________________ Date: __________

Provider Signature: ____________________ License No. __________ Date: __________

☐ Copy offered to client/accepted, ☐ Copy offered/declined, ☐ Unable to offer Copy-See prog. note dated: __________

Fillable forms are located at BHRS Managed Care webpage - https://www.smchealth.org/bhrs/contracts

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Progress Notes & Billing

1500 HICF billing information MUST MATCH the Progress Note
Service code/CPT code, date, and/or units of time (minutes)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
								NPI	

MANAGED CARE SERVICE RECORD and PROGRESS NOTE

CLIENT NAME ______________________ MR# ______________________

PROVIDER NAME/AGENCY ______________________________________

Date/Year of Service		Face to Face Mins (Client Present)	
CPT Code		Service Time (Client Not Present)	
Location Code		Language (if language services provided)	

Progress Note Requirements

- Client's Name & MR#
- Date of Service, CPT code/service, number of minutes for service & documentation time, location where the service was provided
- Provider's signature, license
- **Your name and credentials must be clear:**
  - **printed and signed** when written in ink OR you must have a valid **Electronic Signature**
- Date the progress note was written

Printed Name/Signature & License or Job Title of Clinician Providing Service/Writing Note	**Date Signed**

Fillable forms are located at BHRS Managed Care webpage - https://www.smchealth.org/bhrs/contracts

Progress Notes

There must be a **Progress Note** in the medical record **for each** service billed to San Mateo County and:

- ✓ Written within **3 days** of service
- ✓ Be **clear, & concise**
- ✓ Describe service provided
- ✓ Diagnosis, goal/behavior addressed
- ✓ Provider's interventions to address the client's diagnosis and functional impairments
- ✓ Reflect how the service **diminished the impairment** or **prevented deterioration**
- ✓ Client's response and outcome
- ✓ Referrals or follow-up, when appropriate

Summary of Top Areas of Concern

- ✓ Providers **not maintaining official charts**
- ✓ Providers **not producing charts in a timely fashion**
- ✓ Progress Notes **not including all required billing elements**
- ✓ Providers **not signing documents**

Resources

Fillable forms and helpful resources are located at BHRS Managed Care Provider webpage: https://www.smchealth.org/bhrs/contracts

Consent Forms:
https://www.smchealth.org/consents

Information on interpretation services:
https://www.hpsm.org/provider/resources/language-services

DHCS Covered Diagnosis:
https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN-17-004E/MHSUDS_IN_17-004E_Enclosures_2.pdf

Complete forms are sent to the Access Call Center:
Fax to: 650-596-8065
Mail to Access Call Center – 310 Harbor Blvd., Bldg. E, Belmont, CA 94002

Questions