



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Medi-Cal Documentation Training

TOPICS COVERED

Purpose of
Documentation/Medi-
Cal Standards

Assessment Basics

Treatment Plan Basics

Writing Progress
Notes

Your legal and ethical obligation as a
clinician or treatment provider is to
document

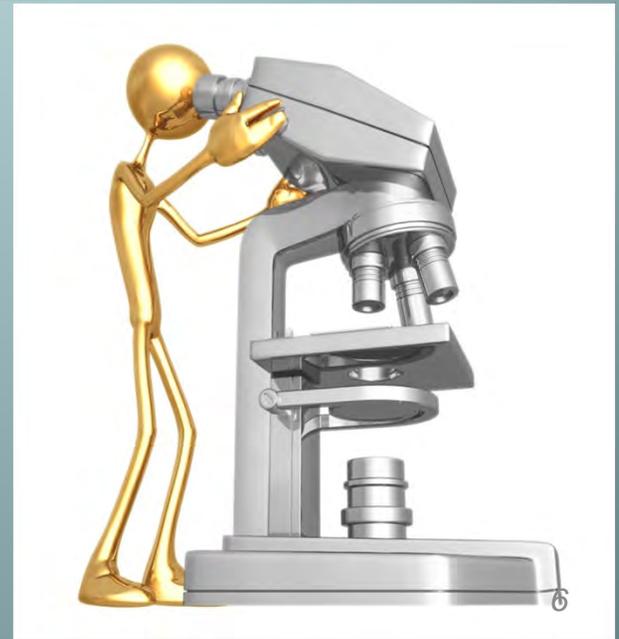
ALL SERVICES PROVIDED!

Best practice is to document immediately
after you provide the service.

Legal, Ethical, & Clinical Issues

- Maintaining client records is the law. Failure to maintain records is defined as unprofessional conduct in sections 4982(v)m 4992.3(s) and 4989.54(j) of the Business and Professions Code.
- Good documentation allows us to track the clinical presentation of the client as well as progress toward stated goals and success of interventions.
- We are professional health care providers and must maintain accurate records not only for billing purposes, but because we must give each client the best care possible by maintaining and updating their personal behavioral health record.

**When State reviewers
examine the record of our
client's care, they must find
quality of care and
compliance with State
rules reflected in our
paperwork and
documentation!**



Compliance- Staff must comply with all standards of care and documentation.

**COMPLIANCE
IS EVERYBODY'S JOB**

If you are aware of compliance violations, you **must** report them immediately to your Supervisor, ADMHS Quality Care Management at 681-5287, or the Compliance Officer, Celeste Andersen.

Compliance hotline: 884-6855

e-mail: candersen@co.santa-barbara.ca.us

The Clinical Loop

AKA The Golden Thread

**Symptoms
History
Impairments
Diagnosis**

ASSESSMENT

Goals

**to reduce
symptoms &
impairments
&**

Interventions

to achieve goals

**CLIENT
PLAN**

with

Culture,

Language, and

Special Needs

always integrated

SERVICES

**Things staff do to help clients
achieve their goals (and some
information about symptoms
and impairments)**

Medical Necessity

The term ***Medical Necessity*** encompasses a set of criteria that are used to determine whether Specialty Mental Health Services are **reasonable, necessary and/or appropriate.**

Medical Necessity is crucial to (1) substantiate the need for service and (2) ensure that any service rendered is reimbursable by Medi-Cal.

Medical Necessity

Per state regulation, ADMHS serves:

- Children with severe emotional disturbance (SED)
- Adults with severe & persistent mental illness (SPMI)

Medical Necessity criteria

- Covered diagnosis
- Functional Impairments
 - Social, occupational, housing, placement (jail, inpatient), activities of daily living, educational
- Interventions
 - Directly address diminishing the diagnostic symptom/impairments, maintaining functioning and diminishing risk for loss of functioning
- Condition would not be responsive to physical health care based treatment

Functional Impairment

- • Describe limitations in functioning related to the mental health condition which are apparent in the five domains: daily living activities, socialization, work/academics, attention/focus/concentration, and the consequences the client experiences when he/she relapses (mental health symptoms, not substance use).
- • Include the degree, scope, and chronicity of the impairments and individualize them contextually (giving examples). Avoid stating generalizations such as 'impaired daily living activities.'
- • Include the client's perspective regarding the impact of the impairments in his life, relationships, work, cognition, and how these are limiting for him/her.
-

Interventions

- Two intervention criteria:
 - The focus of the proposed/actual intervention must address the functional impairment identified as a result of the qualifying mental health diagnosis.
 - The expectation that the proposed/actual intervention will do, **at least one** of the following:
 - Significantly diminish the impairment
 - Prevent significant deterioration
 - Allow the child to progress developmentally as individually appropriate
 - For full scope beneficiaries under the age of 21 years, correct or ameliorate the condition

Basics of Assessment

Assessment

- What is the purpose?
 - Establish Medical Necessity
 - Begin therapeutic rapport
 - Identify strengths, needs, barriers
 - Understand how mental illness affects the various areas of a person's life
 - Collect information for planning treatment

Assessment

- Should clearly state symptoms and impairments
- Is the starting place for developing treatment goals
 - Must show rationale for treatment
 - Must include inherent personal strengths
 - Should demonstrate need and barriers
 - Should inform your goal setting and treatment plan development

Assessment Time Line

- Needs to be completed within 60 days
- Requires updating at a minimum annually
- Or whenever clinically indicated, such as following a significant life event that potentially changes the client's mental status, diagnosis or treatment direction, or any other major life stressor

Treatment Plan

Treatment Plan

The Treatment Plan should:

- Focus on what the client wants from treatment
- Incorporate symptoms, behaviors or impairments identified in the Assessment
- Individualize interventions to meet the needs of the client
- Act like a road map to assist in setting and staying on the course of treatment.

Treatment Plan Goals

- Must be SMART (Specific, Measurable, Attainable, Realistic and Time-Bound)
- Must be in support of long-term goal.
- Must be linked to Assessment
- Should be achievable
- Related to the beneficiary's mental health needs
- Related to the beneficiary's functional impairments as a result of the mental health diagnosis

Writing Goals for the Treatment Plan

Verb	What you are Measuring	Target Person	Client's Behaviors	Baseline measure	Goal Measure
To increase	# of minutes	client	Engages in pleasurable activities (social, physical, pleasant)	From 0 minutes a day	To 30 minutes a day
To increase	# of times	client	Uses active problem-solving skills	From 0 times per week	To 5 times per week
To increase	# of times	client	Uses relaxation skills	from 0 times per week	To 5 times per week

Interventions

- Interventions must always link back to an identified mental health need(s) of the client
- Specific and clearly defined
- Interventions must clearly show how what STAFF did will:
 - improve the client's functioning, and/or
 - diminish the client's mental health symptoms

NOTE

- Services rendered must link to the treatment plan (except for crisis, assessment and and plan development)
- Treatment Plans and Assessments **MUST** be updated yearly
- The Treatment Plan **MUST** be signed yearly (or documented appropriately as to why it has not been)

REMEMBER!

When a client is transferred, the treatment plan must be changed to include new services and the new provider/program.

Updating a Treatment Plan

- All treatment plans must be updated annually.
- The treatment plan anniversary is **one year from the first day of the month of admission.**
- Additionally, treatment plans must be updated whenever clinically indicated, such as following a significant life event that potentially changes the client's mental status, diagnosis or treatment direction, or any other major life stressor.

Progress Notes

Progress Notes

Quality of Writing

- Paint a clear, concise and cohesive picture of what happened during the service provided.
- Reader-centered with the understanding that both clients and other staff have access to these records.
- Written in objective language anyone can understand. **DO NOT** include personal statements, thoughts or feelings about the client, or co workers, or personal frustrations regarding the program you work for.
- Only include information relevant to the service provided.

How do I write a progress note?

- Goal or reason for service:
 - Tied to a treatment plan goal to address the client's functional impairment and qualifying diagnosis
 - Meet with client for individual therapy session to address client's goal of reducing depressed mood to no more than 4 times a week to support client in obtaining employment.
 - Follow up with client on their ability to contact Recreational Learning Center in order to increase socialization skills and obtain community supports.

How do I write a progress note?

- Interventions:
 - All interventions must always link back to an identified mental health need(s) of the client
 - The intervention documented should be about the purpose of the activity, not the activity itself.
 - What did you do to support the client in working towards the identified goal or reason for service.
 - Avoid clinical jargon
 - Use language that is behaviorally specific
 - illustrate something that you did on behalf of the clients mental health goals and functional impairment
 - What was their response to what you did?
 - If you don't mention them its like they were not even present.

How do I write a progress note?

- Additional narrative:
 - Any additional follow up
 - Next appointment date
 - Related information not needed in the interventions section

Progress Notes

1. Is it clear that I took some action that will help my client?
2. Will the action work toward improving or maintaining my client's mental health?
3. Did the service I provided relate directly back to the identified mental health needs / diagnosis of my client?

If the answer is yes to all three questions, you have a complete and accurate note

Progress Note

- Write a progress note for every service whether or not it is billable – especially when a client misses or cancels.

This information is very important. Remember: the client's progress notes need to give other people all the relevant information about a client and their treatment.

Note on non-billable documentation

- When a clerical activity is performed in conjunction with a billable service, it is not necessary to write a separate progress note. Document the clerical activity along with the billable service, but clearly indicate that the clerical activity was not billed.
- For example, “Met with client and discussed housing options. Faxed form to TMHA (not billed)”.

Non-billable documentation

➤ Transporting clients	➤ Adult client in jail
➤ Leaving/listening to voicemail messages	➤ Youth or Transition-Aged Youth in Juvenile Hall or Facility (unless they are adjudicated for placement; court order must be in chart)
➤ Sending/receiving faxes or emails	➤ Providing assistance and/or services to a client's significant other(s) that are not related or directly benefit the client
➤ Scheduling appointments or appointment reminders	➤ Appointment cancellations (by either the provider/clinician or the client)
➤ Missed appointment (No-show/client not a home)	➤ Ongoing Rep-Payee/Subpayee functions such as requesting checks
➤ Interpretation/translation support, unless provided along with a billable service	<ul style="list-style-type: none"> ➤ Writing a letter excusing a client from jury duty/testifying ➤ Court appearances and court related services
➤ Client currently placed at an IMD, psychiatric skilled nursing facility, or psychiatric hospital, with the exception of Targeted Case Management (TCM) services for purposes of placement or discharge planning	➤ Clerical activities associated with closing a chart

Non billable services

- Reviewing charts or other paper work
- Transportation
- Filling out SSI forms
- Grocery store trips (when medical necessity is not documented)
- No shows
- Supervision

Progress Note

- **Notes must justify the amount of time claimed**

“Referred to Housing Authority” doesn’t justify 45 minutes. Write down the **details!**

Notes:

You know why some services take a long time – The auditors probably don’t. So explain.

When anyone reads your service they should be able to say “Sure I can see why this dedicated worker spent _____ minutes on this service.”

Progress Note

You cannot reuse the same note.
You can follow a basic outline and use basic language –but **identical** notes never pass an audit – **details** need to be different

Remember: notes should state details, not vague generalities.



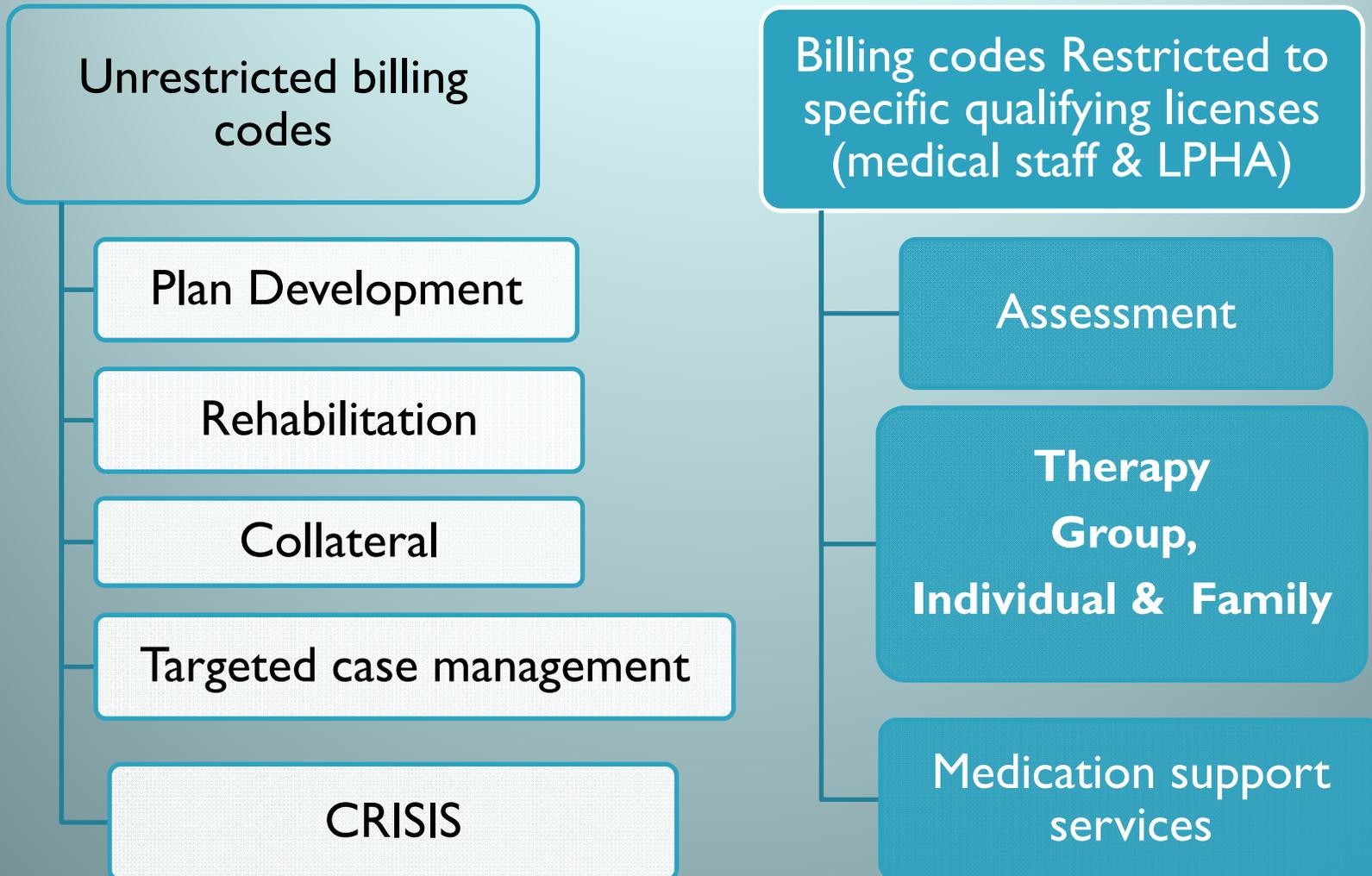
TRAVEL TIME GUIDELINES

	ALLOWED
From staff's assigned clinic site to ...	Client's home, or any setting in which the client is seen (other than the staff's office). Can include return time to the clinic.
From staff's assigned clinic site to ...	Inter-agency meetings, such as those for an IEP, DSS, and Probation, during which a MHS is provided. Return time to the clinic can be included in travel time.
From staff's assigned clinic site to ...	Out-of-county group home to provide MHS to one or more county youth. Time to return to clinic can be included in travel time.
From staff's assigned clinic site to ...	Out-of-county Board and Care to provide MHS to one or more county clients. Time to return to clinic can be included in travel time.
From staff's assigned clinic site to ...	Client A's location. If staff visit client A more than once in a day, travel time can be billed for these visits if each visit originated from staff's assigned clinic site.
From Client A's location to ...	Client B and Client C on the same day. Travel time is only allowed for time between Client A's and Client B's location, between B and C, etc. Include return time to the clinic on last client visit of the day. Don't include the return time to the clinic if staff returns home from the last client visit.
From Mobile Crisis Service's initial dispatch point to ...	Client location.
From Mobile Crisis Service's client contact point to ...	A location necessary in the process of resolving the crisis, such as the PHF, emergency room, mental health clinic, alternative secure housing, etc.

NOT ALLOWED

From location A to ...	Location B for any non-billable service (e.g. staff arrives to the client's home but he/she is not there.)
From staff's <u>home</u> to ...	Assigned clinic site or a secondary/satellite office (e.g. schools, a class room service site, an office co-located with DSS or Probation, etc.)
From staff's <u>home</u> to ...	Out-of-County group home to provide MHS to one or more county clients.
From staff's assigned clinic site to ...	An IMD to provide MHS to one or more county beneficiaries.
Transporting a client from point A to point B	Transporting clients from their home and driving them to clinic is not a billable activity unless a service is provided.
From any work site to staff's home...non-billable	

Services reimbursed by Medi-Cal:



Medication Support Progress Note

Definition of Medication Support

Services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include, but are not limited to, evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instructions in the use, risk, and benefits of and alternatives for medication.
(Title 9, 1810.225)

Who is authorized to provide Medication Support?

Physicians (MD or DO), registered nurses (RN), certified nurse specialist (CNS), licensed vocational nurses (LVN), licensed psychiatric technicians (LPTs), physician assistants (PA), nurse practitioners (NP), and pharmacists may provide these services.

What are the most common types of Medication Support services?

Services may include providing detailed explanations and information on:

- How medications work
- Different types of medications available and why they are used
- Anticipated outcomes of taking a medication
- The importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate)
- How the use of the medication may improve the effectiveness of other services a beneficiary is receiving (e.g., group or individual therapy)
- Possible side effects of medications and how to manage them
- Medication interactions or possible complications related to using medications with alcohol or other medications or substances
- The impact of choosing to not take medications

Medical Notes

To provide services related to a medical issue:

- Must connect it back to the mental health symptoms.
- Are mental health symptoms preventing the client from attending to their medical problems?
- Is the medical condition increasing or exacerbating the mental health symptoms? And/or vice-versa?

Med support DANGER ZONES

- Getting a chart prepared for an MD is not med support
- Time spent on issues or medications for hypertension, diabetes, liver disease, or infections are likely Non-Bill.
- If you do an intervention state clearly what you did for each visit, not “as needed”
- Include client needs for level of support with medications (med boxes, access to meds)
- Faxing is not med support

How much time can be allotted (i.e. claimed) for Medication Support?

- The maximum number of hours claimable for Medication Support services in a 24-hour period is 4 hours per client.

Crisis Intervention

is an **immediate, unplanned, emergency response service** enabling an individual to cope with the crisis while maintaining her/his status as a functioning community member to the greatest extent possible. Crisis Intervention services are limited to stabilization of the presenting emergency.

Crisis Intervention

- A client can be upset, crying, screaming, angry, sad, anxious, or mute – something that most normal people would consider a “crisis” – but that’s not what “Crisis” means to Medi-Cal.
- It’s a very good idea to **start** the note by saying that you’re **responding** to a situation that appears to be a **potential 5150**, or to a client who appears to be, or you were told was, **suicidal or gravely disabled**. (it was still a Crisis Intervention if you determine not to hospitalize)
- Remember: it’s the **details** that make the note billable.
- You can bill up to 8 hours of crisis intervention in a 24 hour period.

At a minimum, all Crisis Intervention progress notes will capture the following:

1. Presenting Problem
2. Precipitation Events
3. Risk Assessment
4. Objectivity (Non-judgmental language)
5. Clinical Intervention
6. Client's Response
7. Follow up

Crisis intervention example

- Goal: Therapist received call from Lakeview Junior High requesting 5585 assessment for client presenting with suicidal ideation on this day. Therapist to assess for current risk to determine appropriate level of care. Phone and documentation time included in total billing time.

Crisis intervention example continued

- Intervention: Therapist gathered information from school counselor regarding precipitating events and spoke with client to begin risk assessment. Client reported cutting on this day due to stressors surrounding relationship with boyfriend and stated “I just want to end it all”. Client denied any history of suicidal ideation and expressed remorse for cutting incident. Client denied needing medical attention for cuts “I didn’t draw blood” and denied current thoughts of suicide or self harm. T spoke with client regarding her ability to contract for safety and discussed use of coping skills. Therapist supported client in developing plan to have mother meet at school with counselor to address current needs. Client agreed to plan and stated she is “feeling a lot better now”. Therapist provided client with crisis hotline and encouraged use, as needed.

Crisis intervention continued

- Additional narrative: Crisis hotline to remain available 24/7. Therapist to follow up with client to ensure stabilization.

Rehabilitation

- services concentrate on **active skill-building** and **teaching** and may be provided by unlicensed, unregistered mental health workers, such as a Case Worker. Rehabilitation **does not** include psychosocial or psychotherapeutic interventions.

REHABILITATION

The key to Rehab is **SKILLS**

- The purpose of Rehab is to improve, maintain, restore, develop, increase, teach, etc. **useful life skills**.
- Say what you taught, and how it supports Client's goals, or how it helps diminish symptoms or impairments.
- Anybody should be able to say "I see how these skills would help"

(remember this is NOT therapy, it is skill building)

Rehabilitation

- Assistance in improving, maintaining or restoring a beneficiary's or group of beneficiaries:
 - Functional skills
 - Daily living skills
 - Social and leisure skills
 - Grooming and personal hygiene skills
 - Meal preparation skills
 - Support resources
 - Medication education-within the scope of your practice

Cautions for staff other than LPHA

- Avoid the terms:
 1. “Processed” client feelings
 2. “Normalized” clients feelings
 3. “Helped clarify” thoughts and feelings

Those phrases give impression of therapy work to a reader.

Rehabilitation example

- *Client (clt) present for scheduled visit to address goal of money management skill-building to reduce ongoing activities of daily living (ADL) impairment of running out of money to buy food at end of month. Face to face and documentation time included in billing. Reviewed the material from chapter three of “Managing Mental Illness” with client. Helped develop a list of expenses and income. Helped identify necessary vs. discretionary purchases. Highlighted practical choices based on client’s overall goal. Client was collaborative and able to identify areas where he can reduce discretionary purchases without negatively impacting his quality of life. Client reports he is aware that he has very little “fun” money but going hungry isn’t a better alternative for him. Case worker will follow up with client next week (9/9/2014) to discuss client’s progress with money management goals and to discuss how to maximize food purchases on a limited budget.*

-

Therapy

- services include interactive psychosocial or psychotherapeutic processes between a person or group and a mental health professional qualified and/or licensed to provide psychotherapy treatment. The focus of therapy is the **exploration of thoughts, feelings and behavior** for the purpose of problem solving or improving functioning.

Therapy:

- The application of cognitive, affective, verbal or nonverbal therapeutic strategies by a LPHA
- Focused on assisting a beneficiary in acquiring greater personal, interpersonal and community functioning
- Helps modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective.
- Describe use of evidenced-based therapeutic interventions and methods. (CBT, DBT, etc.)

Plan Development

- “Plan development means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress” (Title 9, 1810.232)

Examples of Plan Development

- ▶ Writing the treatment plan
- ▶ Reviewing previous plans with the client in order to develop the treatment plan
- ▶ Treatment meeting to discuss the client's progress of treatment plan goals
- ▶ Consultation with another professional for advice and/or opinion that **results in changes** to the treatment plan
- ▶ Meeting with client to discuss the treatment plan and obtain client/caregiver signature as evidence of participation

Plan development

- *Goal: To review progress toward goals and objectives of previous year's Treatment Plan and create individualized Treatment Plan with client. Interventions: Therapist reviewed client's progress toward his treatment goals and objectives. Therapist explored with client the areas of functioning he would like to improve. Therapist assisted client in identifying his strengths. Therapist developed treatment goals and objectives with client. Client was able to acknowledge the progress he has made toward his treatment goals and objectives in the last year. Client identified 2 areas of functioning that he would like to improve. Client was able to identify several strengths that he can utilize to meet his goals. Client actively participated in the development of his treatment goals and objectives. Client agrees with the current treatment plan.*

Collateral

- Different to how we define collateral in plain English
- *“Collateral services are activities provided to significant support person(s) in a client’s life for purpose of meeting the needs of the client in achieving the goals of the client’s care plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better use of Specialty Mental Health Services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The client may or may not be present for this service activity.” (Title 9, 1810.206)*

Who is a support person?

- A significant support person in the client's life
- Support person **CANNOT BE** someone who provides services for within ADMHS, a community based organization, or other agency billing Medi-Cal for services
- Teachers, probation officers, and other agency personnel (usually a paid professional) do not fall under the “significant support person” definition. These contacts should be documented as Targeted Case Management services.

Collateral Services:

- are available to the parents, spouses, caregivers, friends, and any other non-paid, non-professional significant support person(s) of a client directly receiving support for mental health needs.
- help the significant support person to understand and accept the client's condition and involve them in treatment service planning and in the implementation of the treatment plan.
- are usually centered on providing **education, training, and consultation** for the express purpose of benefiting the client.

Collateral example

- Goal: Therapist to speak with client's mother regarding client's recent escalation of depressed mood to support client in maintaining her current home placement and avoiding a higher level of care. Phone and documentation time included in total billing time.
- Interventions: Therapist placed call to client's mother and gathered information regarding client's presentation on this day. Mother reported that client continues to be non-compliant and has "been hiding in her room all week long". Therapist provided mother with information regarding how supporting client in maintaining use of coping skills on a daily basis will support client in avoiding continued de-compensation. Therapist coached mother on how to reinforce use by giving client choice of which coping skill to use and practicing skill with client. Therapist spoke with mother regarding importance of approaching client with positive reinforcement to increase client's participation in the home environment. Mother agreed to do so and informed therapist she would allow client to pick coping skill and then provide client with reward once skill was practiced along with mother. Therapist agreed with mother's plan and encouraged mother to contact crisis line if mother has any concerns regarding client's immediate safety. Mother agreed to do so.

Collateral example continued

- Additional Narrative: Therapist to follow up with client during individual therapy session on 7/21/15.

Targeted Case Management

“Assisting a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of client’s progress; placement services; and plan development.” (Title 9, 1810.249)

Targeted Case Management

- TCM includes assessing needs, providing linkage, and monitoring.
- Is associated with a treatment plan goal
- Clearly shows evidence that mental health symptoms prevent a person from doing activity without support

Targeted Case Management

Helping a client **access** needed services – not providing the service.

TCM includes:

- ▶ Establishing and making referrals
- ▶ Monitoring the client's access to services
- ▶ Monitoring the client's progress once access to services has been established
- ▶ Locating and securing an appropriate living arrangement, including linkage to resources (e.g. Board and Care, Section 8 Housing, or transitional living)
- ▶ Arranging and conducting pre-placement visits, including negotiating housing or placement contracts
- ▶ Completing a transfer note summary (if client changes a service provider)

Group Progress Notes

Group progress notes capture interventions provided to several clients during a single session or activity. This note is similar to a standard progress note with a few key exceptions.

- **Group Name and Topic/Title:** Give the group a name that will be used to consistently to identify that group of participants, such as “Jane’s Group” or “Carmen’s House”. Additionally, choose a title that reflects the topic or purpose of the group, such as “Managing Money Wisely” or “Solving Conflicts Peacefully”.
- **Group Members:** Select all standing members of the group. After creating the initial progress note, this section will automatically populate with the group member’s information. Check the “Present” box to indicate if the member was present at that group session. In the “*Additional participants in group*” box, enter the number of clients that are not standing members but participated during that group session.
- **Goal of Reason for Service:** Provide further details on the goals behind that particular group session. For example, a group on “Managing Money Wisely” may have a group goal “to provide participants with the opportunity to learn budgeting skills to help them maintain housing.”
- **Interventions:** With as much details as possible, explain the skill-building interventions applied to the entire group (i.e. what did staff do/teach?). For example, “Taught the group to develop a budget by listing expenses...practiced balancing a checkbook...”.
- **Individual Response/Reactions:** At the end of the group note, the clinician is routed back to the home page to complete **individualized** progress notes. Document each client’s behavior, participation and intervention information.

Group Notes

Group rehab – may be conducted by licensed and unlicensed staff. It is focused on improving, maintaining or restoring of functioning skills.

Group therapy- only licensed, waived or registered mental health professionals may conduct group therapy within the scope of their professional license

Both Group Psychotherapy and Group Rehabilitation must be structured so that clients focus on specific goals/objectives that meet medical necessity and each client receives individualized feedback from the group leader(s).

Group Notes

- **Note:** The number of all clients (Medi-Cal or OHC) is used in the calculation.
- **Note:** If more than one (1) staff is claiming services, there must be documentation of each staff's contribution to the group.
- Think about the clinical loop and care plan
- Group note must show individual CLIENT PLAN goals are related to what is documented
- Every group must clearly show a connection between each client's *goals and the activities in the group.*

Notes: look at CLIENT PLAN goals to make sure there's a match between what your doing and individual clients own goals

Final Instructions for Documentation Training

- Please fill out evaluation form before leaving.
- For any questions contact:
- ssoderman@co.santa-barbara.ca.us

