Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Information Management Clinical Records Documentation 05.01.15 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	9/26/2022

SUBJECT:	DMC-ODS Documentation of Services and Assessment Standards

PURPOSE:

To describe the County of Orange Drug Medi-Cal Organized Delivery System (DMC-ODS) documentation requirements and assessment standards for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate and effective beneficiary care; address equity and disparities; and ensure quality and program integrity.

POLICY:

Orange County Health Care Agency (OCHCA) Mental Health and Recovery Services (MHRS) adheres to California state regulations and guidelines regarding clinical documentation requirements and assessment standards for DMC-ODS services in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

This Policy and Procedure (P&P) outlines minimum requirements for clinical documentation of services provided to beneficiaries within MHRS. Many specialized programs may have additional or more stringent requirements due to regulations or requirements of funding sources. These additional requirements shall be specified in program P&Ps.

SCOPE:

The provisions of this policy are applicable to all MHRS County and County contracted staff providing DMC-ODS and applicable SUD services.

REFERENCES:

Behavioral Health Information Notice No: 22-019 Documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services

Behavioral Health Information Notice No: 21-075 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026

Welfare and Institutions Code (WIC) §§14184.100, et seq.

Title IX Rehabilitative and Developmental Services

Agreement between Department of Health Care Services and Orange County Behavioral Health Services

PROCEDURE:

I. Standardized Assessment

A. Providers will use the American Society of Addiction Medicine (ASAM) criteria assessment for DMC-ODS beneficiaries.

B. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.

C. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

D. Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment.

E. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over.

F. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes.

G. Assessments in Residential levels of care shall be completed as part of the initial admission process and shall be updated at 30 days intervals, if necessary to substantiate continued medical necessity for residential treatment.

H. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. However, assessment services shall be provided for the purpose of stabilization of symptoms, managing withdrawal and transitioning to other appropriate levels of care.

II. DMC-ODS Problem List

A. The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.

B. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

C. A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.

D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.

E. The problem list shall include, but is not limited to, the following:

1. Diagnoses identified by a provider acting within their scope of practice, if any.

    a) Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.

2. Problems identified by a provider acting within their scope of practice, if any.

3. Problems or illnesses identified by the beneficiary and/or significant support person, if any, including the need for the beneficiary to obtain a physical examination if indicated.

4. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

F. Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition. Problems should not be removed from the list unless they are actually resolved.

G. The initial Problem List should be completed by the conclusion of the assessment. Providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

III. DMC-ODS Progress Notes

A. Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

B. Providers shall create progress notes for the provision of all DMC-ODS services.

C. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

D. At a minimum, progress notes shall include:

1. The type of service rendered.

2. A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

3. The date that the service was provided to the beneficiary.

4. Duration of the service, including travel and documentation time.

5. Location of the beneficiary at the time of receiving the service.

6. A typed or legibly printed name, signature of the service provider and date of signature.

7. International Statistical Classification of Diseases and Related Health Problems (ICD) 10 code.

8. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

9. Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

E. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential treatment services.

F. Group services progress notes

1. A list of participants is required to be documented and maintained by the plan or provider.

2. Should more than one provider render a group service, each rendering provider shall complete a separate progress note for the group session and sign it.

3. All other progress notes requirements listed above shall also be met.

IV. Treatment Planning

A. Treatment plan requirements have been removed from the DMC-ODS, with the exception of specialized programs that must also follow federal law or other requirements, such as Narcotic Treatment Programs (NTP).

1. Peer support services must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

V. Telehealth Consent

A. The provider must document in the beneficiary's record, at least once prior to initiating services through telehealth, that the following information was provided to the beneficiary and that the beneficiary's verbal or written acknowledgment of the information was received.

1. An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in person, face-to-face visit.

2. An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future.

3. An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and

4. The potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

VI. Services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.