Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Information Management Clinical Records Documentation 05.01.03 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	1/30/2023

SUBJECT:	Documentation of Services and Assessment Standards

PURPOSE:

To describe the County of Orange Mental Health Plan (hereby referred to as Orange MHP) 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 Specialty Mental Health Services (SMHS) in accordance with the 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 SMHS throughout the Orange MHP.

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

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. Orange MHP shall require providers to use uniform assessment domains as identified below. For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

B. The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to the providers clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

C. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether non-specialty mental health services (NSMHS) or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.

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

E. 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.

F. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.

G. Orange MHP may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (Cal.Code Regs., tit. 9, § 1840.344; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3, pp. 2m-p; California State Plan Section 3, Att.3.1-B, Supp. 2, pp. 15-17)

II. SMHS Assessment Domain Requirements

A. Providers shall document the seven domains in the SMHS assessment and keep the assessment in the beneficiary's electronic health record or medical record.

1. Domain 1: Presenting Problem(s); Current Mental Status; History of Presenting Problem(s); Beneficiary-Identified Impairment(s)

2. Domain 2: Trauma

3. Domain 3: Behavioral Health History; Comorbidity

4. Domain 4: Medical History; Current Medications; Comorbidity with Behavioral Health

5. Domain 5: Social and Life Circumstances; Culture/Religion/Spirituality

6. Domain 6: Strengths, Risk Behaviors, and Safety Factors

7. Domain 7: Clinical Summary and Recommendations, Diagnostic Impression; Medical Necessity Determination/Level of Care/Access Criteria

III. SMHS 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 Diagnostic and Statistical Manual (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.

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.

G. Providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

IV. SMHS Progress Notes

A. Providers shall create and complete progress notes for the provision of all SMHS services within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

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

C. 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 Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), or current version, diagnosis 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.

D. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation).

E. Group services progress notes

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

2. Should multiple providers render a group service, each provider shall complete a separate group progress note. The progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time.

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

V. Treatment and Care Planning

A. Care plans and their respective timelines vary and continue to be required for the following services: Targeted Case Management (TCM), Therapeutic Behavioral Services (TBS), Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Pathways to Well Being (PWB), Intensive Services (IS), Peer Support Services, Short-Term Residential Therapeutic Programs (STRTP) services and for dual eligible beneficiaries.

B. Targeted Case Management (TCM)

.1. TCM services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment.

2. The TCM Care Plan required elements shall be provided in a narrative format in the beneficiary's progress notes:

a) Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary.

b) Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals.

c) Identifies a course of action to respond to the assessed needs of the beneficiary; and

d) Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

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.