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BHS Policies and Procedures

	City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES	1380 Howard Street, 5th Floor San Francisco, CA 94103 (415) 255-3400 FAX (415) 255-3567

Policy and Procedure Title: **Medi-Cal Documentation Requirements**

Issued By: DocuSigned by: Maximilian Rocha EB51A346C32641B... Maximilian Rocha, LCSW Director of Systems of Care Date: September 28, 2022	Manual Number: 3.10-14 Reference: Behavioral Health Information Notice (BHIN) 22-019

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse clients. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our clients' needs and lived experiences.

Background:

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to reform behavioral health documentation requirements to improve the 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.

To achieve this aim, DHCS is streamlining and standardizing clinical documentation requirements across Medi-Cal SMHS and DMC-ODS services. These guidelines do not apply to non-specialty behavioral health services in Fee for Service and Medi-Cal managed care. These updated documentation requirements better align with Centers for Medicare and Medicaid Services' national coding standards and physical health care documentation practices.

Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021) Assembly Bill (AB) 133 implements various components of the CalAIM initiative, including those components in W&I sections 14184.100, et seq. DHCS has set standards through Behavioral Health Information Notice (BHIN) 22-019, until DHCS promulgates or amends regulations by July 1, 2024. (W&I, § 14184.402, subds. (h)(3) and (i)(1).)

Effective July 1, 2022, the chart documentation requirements for all outpatient SMHS and outpatient DMC-ODS services are as established below. In case of a conflict in guidelines providers should reference

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the most recently published document related to that specific element.

Regulation under BHIN 22-019 supersedes state regulations as noted in Attachment 2, BHIN 21-046 (related to client plan and signature requirements), MHSUDS IN 17-040 in full, and BHINs or other guidance in existence as of the date of publishing this BHIN regarding documentation requirements for SMHS and DMC-ODS services except as outlined in Attachment 1. To the extent that there is conflict between the MHP contract, or the DMC-ODS Intergovernmental Agreement terms and BHIN 22-019, the policy contained within 22-019 supersedes the contract terms.

Purpose:
To streamline clinical documentation requirements for all Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

Scope:
This policy applies to Medi-Cal network providers offering Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

Policy:
Effective July 1, 2022, the chart documentation requirements for all SMHS and DMC-ODS services are as established in the procedure below. Deviations from compliance with documentation standards outlined below will require corrective action plans. Recoupment shall be focused on fraud, waste, and abuse.1

DHCS removed client plan requirements from SMHS and DMC-ODS, with the exception of continued requirements specifically noted in Attachment 1 and replaced them with updated behavioral health documentation requirements, including problem list and progress notes requirements.

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.

San Francisco Specific Documentation Policy Guidance
To review local Medi-Cal documentation standards “At-A-Glance” see 3.10-14 policy attachments 3 through 6. Policy guidance can be found on the BHS Policy and Procedure webpage under “CalAIM” (https://www.sfdph.org/dph/comupg/oservices/mentalhlth/cbhs/cbhsmnupolyproc.asp).

Procedure:

I. Standardized Assessment Requirements

A. SMHS

a) The SF MHP requires providers to use the uniform assessment domains as identified below. For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool will be utilized to help inform the assessment domain requirements.

[1] Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for “fraud,” “waste,” and “abuse” can also be found in the Medicare Managed Care Manual.

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b) Providers serving adults shall complete the initial assessment in 60 days from the episode opening and every three years for subsequent SMHS assessments. Completion of the ANSA shall coincide with the initial assessment, any time there is a significant change in a client's life, every three years, and at discharge. If providers cannot complete initial assessments within 60 days, efforts to complete it within a clinically reasonably timeframe should be documented and in accordance with generally accepted standards of practice.
c) Providers serving youth shall complete the initial CANS assessment 60 days from the episode opening. CANS ratings and PSC are due every six months. If providers cannot complete initial assessments within 60 days, efforts to complete it within a clinically reasonably timeframe should be documented and in accordance with generally accepted standards of practice. Assessment updates should be done any time there is a significant change in a client's life.
d) 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.[2]
e) The assessment shall include a typed or legibly printed name and signature of the service provider and date of signature.
f) 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.
g) 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.
h) The 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.

B. DMC-ODS

a) DMC-ODS providers shall 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 and 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

[2] For more detailed information on BHS access criteria and medical necessity refer to policy 3.04-10.

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

II. SMHS Assessment Domain Requirements

A. The SMHS assessment shall include the following seven required domains. Providers shall document the domains in the SMHS assessment and keep the assessment in the beneficiary's medical record. SMHS providers shall complete the assessment within 60 days of episode opening. If providers cannot complete initial assessments within 60 days, efforts to complete it within a clinically reasonably timeframe should be documented and in accordance with generally accepted standards of practice. Assessment updates should be done any time there is a significant change in a client's life.

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

Domain 2:
- Trauma

Domain 3:
- Behavioral Health History
- Comorbidity

Domain 4:
- Medical History
- Current Medications
- Comorbidity with Behavioral Health

Domain 5:
- Social and Life Circumstances
- Culture/Religion/Spirituality

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

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

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III. SMHS, DMC, and 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:
   - Diagnoses identified by a provider acting within their scope of practice, if any.
     - o Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
   - Problems identified by a provider acting within their scope of practice, if any.
   - Problems or illnesses identified by the beneficiary and/or significant support person, if any.
   - 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. DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

IV. SMHS, DMC and DMC-ODS Progress Notes

A. Providers shall create progress notes for the provision of all SMHS and DMC-ODS services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
B. Progress notes shall include:
   - The type of service rendered.
   - 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).
   - The date that the service was provided to the beneficiary.
   - Duration of the service, including travel and documentation time.
   - Location of the beneficiary at the time of receiving the service.
   - A typed or legibly printed name and signature of the service provider and date of signature.
   - ICD 10 code.[3]
   - Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code as consistent with current guidance. (this is done on the backend)

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[3] For valid Medi-Cal claims, appropriate ICD-10 and HCPCS/CPT codes must appear in the clinical record, associated with each encounter and consistent with the description in the progress note. For further guidance on coding during the assessment process, refer to the FAQ Medical Necessity Questions Related to CalAIM

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- 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.

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

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). Weekly summaries will no longer be required for day rehabilitation and day treatment intensive.

E. When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, 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. All other progress note requirements listed above shall also be met.

V. Treatment and Care Planning Requirements

DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC-ODS, with the exception of the continued requirements specifically noted in Attachment 1. Several of these care plan requirements remain in effect due to applicable federal regulations or guidance.

A. Targeted Case Management (TCM)

Targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. [4]

The TCM care plan:

- 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;
- 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;
- Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

These required elements must be provided in a narrative format in the beneficiary’s progress notes.

B. Peer Support Services

[4] See the California State Plan, Sec. 3, Att. 3.1-A, Supp. 1, pp. 8-17; 42 C.F.R. § 440.169(d)(2) and 42 C.F.R. § 441.18 for more specific guidance.

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Peer support services must be based on an approved plan of care.[5] 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.

C. Additional Treatment and Care Plan Requirements
Requirements for treatment and care planning for additional service types are found in Attachment 1.

VI. Telehealth Consent

If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: 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; 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; 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 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. The provider must document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received in a progress note.

Monitoring
BHS oversight will include verifying that provider documentation complies with the requirements in this policy, that services provided to Medi-Cal beneficiaries are medically necessary, and that documentation complies with the applicable state and Federal laws, regulations, the MHP contract, and the DMC-ODS Intergovernmental Agreement.

Definitions:
Drug Medi-Cal (DMC): Drug Medi-Cal is a treatment funding source for eligible Medi-Cal members. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment.

Drug Medi-Cal Organized Delivery System (DMC-ODS): The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115

[5] State Medicaid Director Letter #07-011; California State Plan, Supp. 3 to Att. 3.1-A, pp. 4, 5, 6h, 6i (Substance use disorder); p. 2m.1 (SMHS).

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demonstration. DHCS received approval from CMS on December 29, 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).

Fee-For-Service (FFS) Medi-Cal Delivery System: Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal beneficiaries. FFS providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.

Managed Care Plan (MCP): MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services (NSMHS) to children under the age of 21. MCPs refer to and coordinate with county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

Non-Specialty Mental Health Services (NSMHS): NSMHS are delivered via MCP and FFS delivery systems and are provided to recipients 21 years and over with mild-to- moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.

Specialty Mental Health Services (SMHS): SMHS include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.

Contact Person:
Director of Quality Management

Attachment(s):
Attachment 1: Requirements That Remain in Effect
Attachment 2: Superseded Regulations
Attachment 3: AOA Updates At-A-Glance
Attachment 4: CYF Updates At-A-Glance
Attachment 5: SUD Updates At-A-Glance
Attachment 6: CYF SUD Updates At-A-Glance
Attachment 7: FAQ CalAIM Documentation Requirements

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