County of Marin

Behavioral Health and Recovery Services

Documentation Manual for Fee for Service Providers

FY 16-17

May 2017 revision

County of Marin
www.co.marin.ca.us

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

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Introduction

Marin County Behavioral Health and Recovery Services (BHRS) is a county mental health organization (also referred to as a Mental Health Plan) that provides services to the community and then seeks reimbursement from state and federal funding sources. There are many rules associated with billing the state and federal government. In general, good ethical standards meet nearly all of the requirements. At times, there is a need to provide some guidance and clarity so staff can efficiently and effectively document for the services they provide. Although some clients receive services that are funded through grants, as a policy we do not reduce or alter documentation standards because of the client's funding source.

Marin County has adopted a Compliance Program based on guidance and standards established by the Office of Inspector General, U.S. Department of Health and Human Services. The intent of the compliance plan is to prevent fraud and abuse at all levels. The compliance plan particularly supports the integrity of all health data submissions, as evidenced by accuracy, reliability, validity, and timeliness. The plan applies to staff, volunteers, trainees, and contractors working in county owned or operated sites. As part of this plan we must work to ensure that all services submitted for reimbursement are based on accurate, complete, and timely documentation (for Reasons for Recoupment from DHCS, see Appendix D). It is the responsibility of every provider to submit a complete and accurate record of the services they provide and to document services in compliance with all applicable laws and regulations.

This guide reflects the current requirements for direct services reimbursed by Medi-Cal Specialty Mental Health Services (Division 1, Title 9, California Code of Regulations (CCR)) and serves as the basis for all documentation and claiming in the County of Marin, regardless of payer source. All staff, whether directly operated by the County or Contracted Network "Providers" are expected to abide by the information found in this guide.

Quality Improvement may issue updates and/or clarifications to information found in this manual via Provider meetings, emails, or acceptable modes of communication. The updates and/or clarifications are considered to be official BHRS requirements and will be incorporated into this guide as appropriate.

Why We Document

- Legal and Revenue purposes: Charts are legal records and assist in protecting legal interests of client, and provider.
- Client picture and history: Charts provide documented evidence of the client's current situations, progress and obstacles toward achieving goals.
- Communication and collaboration with other service providers and improved quality of care: Coordinate and provide continuity of care.

Remember: Clients have the right to access their medical records.

Medical Necessity and Functional Impairments

Medical necessity is established through the assessment process. Diagnosis and impairments further strengthen and reaffirm the need for mental health services that support the client/family's road to recovery. Although we establish medical necessity at assessment, **it does not end here**. Medical necessity permeates every service that is offered and delivered to the client/family; therefore, it requires ongoing re-assessment throughout the client/family's course of treatment provided through Marin County of Marin Mental Health and Substance Use Services.

To be eligible for Medi-Cal reimbursement for Outpatient/Specialty Mental Health Services, a service must ***meet all 3 criteria for medical necessity***

- Diagnostic Criteria
- Impairment Criteria
- Intervention Related Criteria

Diagnostic Criteria:

An included diagnosis (see Appendix A for DHCS approved diagnoses)

Impairment Criteria:

An impairment as a result of a mental disorder

A functional impairment is a dysfunction in social, developmental and/or occupational spheres of life.

- Occupational/Educational
- ADLs (Activities Of Daily Living)
- Family And Social Relationships
- Housing
- Health
- Symptoms
- History Of Psychiatric Hospitalizations
- Probability Of Deterioration In An Area Of Life Functioning

Determining the level of severity is a clinical judgment.

Medical Necessity continued page 6

Intervention Criteria:

The focus of intervention addresses mental health condition(s). (The condition would not be responsive to physical health care based treatment)

The expectation that proposed interventions will:

- Significantly diminish the impairment
- Prevent significant deterioration in important area of life functioning
- Allow child to progress developmentally as individually appropriate

ALL SERVICES AND INTERVENTIONS FOR WHICH MEDI-CAL REIMBURSEMENTS ARE REQUESTED MUST ACCOMPLISH ONE OF THE FOLLOWING:

- Diminish impairment
- Prevent significant deterioration
- Allow a child to progress developmentally as individually appropriate

Connection Between the Assessment, Case Formulation, Client Plan and Progress Notes

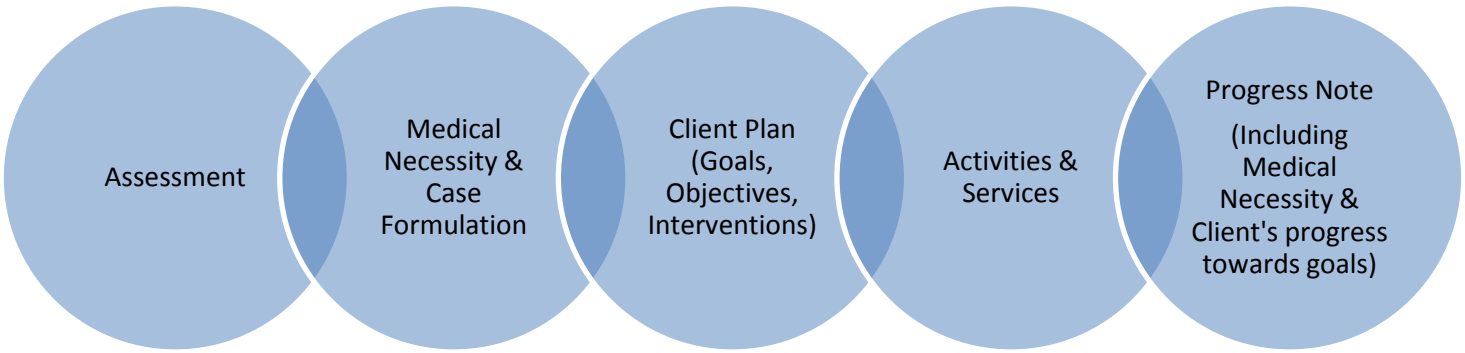
Definitions:

Assessment: A service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis and the use of use of testing procedures

Case Formulation: Describes the person's presenting problems, describes factors that may be contributing to the person's problems (both if they were present at the beginning of the problem and/or if they contribute to the person maintaining their current level of functioning), describes the clients strengths. Case formulations should also describe the disposition with frequency (e.g. weekly therapy to assist with symptom management)

Client Plan: A client plan is an agreement between the treating staff and the client regarding the client's goals, objectives to reach in order to meet the goal and the interventions that the staff will use to assist the client in meeting his/her objectives (and ultimately the goal).

Progress Notes: A part of the medical record in which the staff describes interactions with clients, ***medical necessity at the time of service***, progress towards goals, and any services done on the client's behalf. Services done to assist client in coordinating treatment need to include why the client needs assistance (must include medical necessity). BHRS and Network Providers are required to write progress notes using SIRP format.



COUNTY OF MARIN

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

How to Strengthen Your Assessments

- Describe the client's strengths and weaknesses in behaviorally specific language.
- Perform a thorough assessment including these elements:
    - Reason for Assessment
    - History of the Present Illness or Difficulty
    - Mental Health History
    - Substance Use History
    - Medical History
    - Work History
    - Family History
    - Review of Physical Systems
    - Mental Status Examination
    - DSM-5 Diagnosis
- Before making a diagnosis, make sure the diagnosis is supported by behaviors, symptoms, and functional impairments documented in the assessment. DHCS is clear that if the assessment does not support the diagnosis, the entire treatment episode is subject to disallowance.
- If your assessment consists of several interviews with the client, think twice before assigning an "Unspecified" diagnosis. Although there are cases in which the behaviors and symptoms presented by the client do not fit one of the specific DSM diagnoses, assigning an "Unspecified diagnosis should be done sparingly and not just because the person performing the assessment neglected to obtain the information, which would have made further diagnostic specificity possible.

Remember: There is a relationship between the diagnosis and the treatment

The relationship between diagnosis and (1) type of treatment, (2) manner of approach, (3) choice of specific therapeutic techniques, (4) treatment frequency, and (5) length of treatment is equally important in the case of psychological treatments.

Client Plans

Client Plans should contain the client's goals, the objectives the client will reach in order to achieve the goal and the intervention staff will take to assist the client in meeting the objectives and achieving the goal.

Goals:

A Goal represents client's/family's long-term dreams or desires - "the big picture."

Goals are meaningful when the client is involved in the development of the plan.

Objectives:

Objectives are the practical steps to move toward the Goal and drive the interventions/ services.

Client Plan Objectives need to be **specific**, **measurable**, and **observable**.

3 Ways to Measure Goals:

1. COUNTING (at least 1 trigger)
2. PERCENTAGE (use coping strategies 75% of the time)
3. SCALING (rate self at no more than a 5 on a scale of 1-10 for anxiety with 10 being very anxious and 0 being not anxious at all)

Example: Client will learn to identify at least two triggers that precede an aggressive incident. Client will learn three tools to decrease agitation from a baseline of one as measured by client report and collaboration with staff at client's housing.

Interventions:

Interventions are the actions by the staff that assist the client in accomplishing the objectives. Interventions need to include the frequency and duration of the intervention.

Example: Staff will use psychoeducation to assist client with learning two strategies to effectively manage auditory hallucinations. Staff will offer client feedback for recognizing at least two triggers that precede an aggressive incident during weekly meetings with client for the next 6 months.

Note: Interventions or services that address impairments resulting from non-covered diagnoses are not reimbursable.

How to Strengthen Your Client Plans

Be clear about WHAT you are treating

Describe the behaviors, symptoms, and functional impairments that are the direct result of the included diagnosis or diagnoses in behaviorally specific terms.

Describe the behaviors, symptoms and functional impairments that are the goals of your interventions in specific language and quantify them whenever possible (e.g. by using self-reports of severity using a simple 1 to 10 scales with defined anchor points).

Be clear about HOW you are treating what you are treating

Identify the proposed type(s) of interventions and modalities you will be using, including detailed descriptions of the interventions. Avoid general terms such as “therapy” and instead describe what the interventions will actually involve. (e.g., identify self-defeating strategies and this basis by exploring and analyzing the client’s typical self-statements and use cognitive restructuring to modify these beliefs.)

All interventions should include frequencies and durations. How frequently and for how long do you plan to continue intervening in this particular way before re-evaluating and modifying your interventions?

Remember:

- Documented interventions must have as their focus the condition/impairments resulting directly from the included diagnosis(es) in order to establish medical necessity.
- Documented interventions must have reasonable expectation of significantly diminishing impairments, preventing significant deterioration, or allowing a child to progress developmentally as appropriate.

Progress Notes

BHRS and Network Providers are required to write notes in the SIRP format.

Situation: *Sets the stage. Gives reader an idea of why the service is occurring, what symptoms or behaviors are the focus of the service.*

- Use descriptive sentences
- State the purpose of the contact
- Include statements about client's appearance, mood, behaviors, symptoms, functioning.

Intervention: Identifies what you did during the interaction with or for the client to address the situation. Use verbs to describe your actions: (see Appendix B for more suggestions)

- Identified skills used to cope/adapt/respond/problem solve.
- Reinforced new behaviors, strengths (name)
- Taught/modeled/practiced skill (specify)
- Redirected

Response: Response from the client following your intervention. Describe verbal and non-verbal response from client.

- Client sat back in her chair, breathed deeply and appeared less anxious
- Client stated she would contact her primary doctor
- Client agreed to practice skill/behavior on his own

Plan: Indicate what next steps will be. "P" relates to the objectives on the Client Plan. Specifies action items as a result of the contact and service provided. For example:

- Contacts to be made on behalf of the client
- Skills client will be learning
- Follow up on homework assignments

For Sample Phrasing of Interventions and Client Response, see Appendix B.

How to Strengthen Your Progress Notes

- Remember that in order to be reimbursable; the progress note for each service must include documentation of an intervention that meets the intervention criteria identified in the client plan.

- Progress notes that describe sessions involving nothing more than a report of what the client said are not reimbursable. Passive listening without intervening in some way does not move the client closer to his/her goals. This is one of the most frequently encountered problems in progress notes, especially those written by novice therapists and case managers.

- When looking back on a session, if you find that you did not intervene in some way that was consistent with the Client Plan, you should consider not billing for the time.

- Remember that so-called "therapeutic non-specifics" (e.g., empathic listening, "being open to what the clients says") are not really interventions—at least in the sense which would make them Medi-Cal reimbursable.

- When you write your progress notes, ask yourself whether the session moved the client closer to achieving the goals that are on his/her Client Plan. If your answer is "no," you need to determine why this was the case and formulate a plan for avoiding this during future sessions. This plan should be made part of the progress note for this session.

How to Strengthen Your Overall Treatment Strategy

In addition to evaluating the effectiveness of your interventions on a regular basis (and documenting these evaluations in the progress notes and in revisions of the Client Plan), **you should periodically review the appropriateness of your treatment strategy as a whole.**

This would include an evaluation of

- The appropriateness of the array of services being provided.
- The frequency with which the services are provided
- The intensity with which the services are provided (i.e. session length)

It is especially important that service providers be able to determine when a client is receiving too few services, too many services, inadequate service, excessive service, or duplicate services by multiple providers.

When documentation is reviewed for medical necessity, there is a strong correlation between the percentage of services that are disallowed due to documentation that does not meet medical necessity criteria for Specialty Mental Health Services and the number of hours being claimed per day or per week for that beneficiary. There is no prohibition against providing intensive services, but the documentation for intensive services must meet medical necessity criteria.

Reauthorizations

The following are requirements for Reauthorizations:

Documentation:

- Reauthorization Requests must have all components to meet Medical Necessity.
- Review Diagnosis and update as necessary
- Symptoms and Functional Impairments that demonstrated that the client is Seriously Mentally Ill. If the client's functional impairments are mild to moderate, this client will be referred UNLESS the clinician clearly documents that services are needed to maintain current level of functioning.
- Treatment Goals that are ***Specific, Measurable, and Observable.***
- Interventions MUST be what staff will do to help decrease client's mental health symptoms and address functional impairments.
- Clinical formulation is where you bring it together to justify why the client needs services.

Reauthorizations MUST include the most recent assessment and treatment plan. Client plan MUST be signed by the client, the clinician, and the supervisor (if applicable)

Procedure:

- Reauthorizations need to be submitted a minimum of 10 working days prior to the expiration of authorized services to ensure no interruption of services.
- **Please include start date of the reauthorization on the form**.

For Reauthorization and Change of Service Modality Request form, see Appendix C.

Appendix A.

SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES
ICD-10 COVERED DIAGNOSIS TABLE

Diagnosis Code	Description
F20.0	**Paranoid schizophrenia ***
F20.1	Disorganized schizophrenia *
F20.2	Catatonic schizophrenia *
F20.3	Undifferentiated schizophrenia *
F20.5	Residual schizophrenia *
F20.81	Schizophreniform disorder
F20.89	Other Schizophrenia *
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder *
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders *
F25.9	Schizoaffective disorder, unspecified *
F28	Oth psych disorder not due to a sub or known physiol cond
F29	Unsp psychosis not due to a substance or known physiol cond
F30.10	Manic episode without psychotic symptoms, unspecified *
F30.11	Manic episode without psychotic symptoms, mild *
F30.12	Manic episode without psychotic symptoms, moderate *
F30.13	Manic episode, severe, without psychotic symptoms *
F30.2	Manic episode, severe with psychotic symptoms *
F30.3	Manic episode in partial remission *
F30.4	Manic episode in full remission *
F30.8	Other manic episodes *
F30.9	Manic episode, unspecified *
F31.0	Bipolar I Disorder, Single Manic Episode without Psychotic Features, Unspecified
F31.10	Bipolar disord, crnt episode manic w/o psych features, unsp *
F31.11	Bipolar disord, crnt episode manic w/o psych features, mild
F31.12	Bipolar disord, crnt episode manic w/o psych features, mod
F31.13	Bipolar disord, crnt epsd manic w/o psych features, severe
F31.2	Bipolar disord, crnt episode manic severe w psych features
F31.30	Bipolar disord, crnt epsd depress, mild or mod severt, unsp *
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disord, crnt epsd depress, sev, w/o psych features
F31.5	Bipolar disord, crnt epsd depress, severe, w psych features

Diagnosis Code	Description
F31.60	Bipolar disorder, current episode mixed, unspecified *
F31.61	Bipolar disorder, current episode mixed, mild*
F31.62	Bipolar disorder, current episode mixed, moderate *
F31.63	Bipolar disord, crnt epsd mixed, severe, w/o psych features *
F31.64	Bipolar disord, crnt episode mixed, severe, w psych features *
F31.70	Bipolar disord, currently in remis, most recent episode unsp *
F31.71	Bipolar disord, in partial remis, most recent epsd hypomanic *
F31.72	Bipolar disord, in full remis, most recent episode hypomanic *
F31.73	Bipolar disord, in partial remis, most recent episode manic
F31.74	Bipolar disorder, in full remis, most recent episode manic
F31.75	Bipolar disord, in partial remis, most recent epsd depress
F31.76	Bipolar disorder, in full remis, most recent episode depress
F31.77	Bipolar disord, in partial remis, most recent episode mixed *
F31.78	Bipolar disorder, in full remis, most recent episode mixed *
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressv disord, single epsd, sev w/o psych features
F32.3	Major depressv disord, single epsd, severe with psych features
F32.4	Major depressv disorder, single episode, in partial remis
F32.5	Major depressive disorder, single episode, infull remission
F32.89	Other Specified Depressive Episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressv disorder, recurrent severe without psych features
F33.3	Major depressv disorder, recurrent, severe with psych symptoms
F33.40	Major depressive disorder, recurrent, in remission, unsp *
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders *
F33.9	Major depressive disorder, recurrent, unspecified
F34.0	Cyclothymic disorder
F34.1	Dysthymic disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder *
F34.9	Persistent mood [affective] disorder, unspecified *
F39	Unspecified mood [affective] disorder *
F39	Unspecified Mood Disorder *
F40.00	Agoraphobia, unspecified
F40.01	Agoraphobia with panic disorder *
F40.02	Agoraphobia without panic disorder *

Diagnosis Code	Description
F40.10	Social phobia, unspecified
F40.11	Social phobia, generalized *
F40.210	Arachnophobia *
F40.218	Other animal type phobia
F40.220	Fear of thunderstorms *
F40.228	Other natural environment type phobia
F40.230	Fear of blood
F40.231	Fear of injections and transfusions
F40.232	Fear of other medical care
F40.233	Fear of injury
F40.240	Claustrophobia *
F40.241	Acrophobia *
F40.242	Fear of bridges *
F40.243	Fear of flying *
F40.248	Other situational type phobia
F40.290	Androphobia *
F40.291	Gynephobia *
F40.298	Other specified phobia
F40.8	Other phobic anxiety disorders *
F41.0	Panic disorder without agoraphobia
F41.1	Generalized anxiety disorder
F41.3	Other mixed anxiety disorders *
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-compulsive Disorder, Unspecified
F43.0	Acute stress reaction
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute *
F43.12	Post-traumatic stress disorder, chronic *
F43.20	Adjustment disorder, unspecified
F43.21	Adjustment disorder with depressed mood
F43.22	Adjustment disorder with anxiety
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F43.24	Adjustment disorder with disturbance of conduct
F43.25	Adjustment disorder w mixed disturb of emotions and conduct
F43.29	Adjustment Disorder with Other Symptoms *
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.4	Conversion disorder with motor symptom or deficit
F44.5	Conversion disorder with seizures or convulsions

Diagnosis Code	Description
F44.6	Conversion disorder with sensory symptom or deficit
F44.7	Conversion disorder with mixed symptom presentation
F44.81	Dissociative identity disorder
F44.9	Dissociative and conversion disorder, unspecified
F45.0	Somatization disorder *
F45.1	Undifferentiated somatoform disorder
F45.22	Body dysmorphic disorder
F45.41	Pain disorder exclusively related to psychological factors *
F45.42	Pain disorder with related psychological factors *
F45.8	Other somatoform disorders
F45.8	Other somatoform disorders
F48.1	Depersonalization-derealization syndrome
F50.00	Anorexia nervosa, unspecified *
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.81	Binge Eating Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating disorder, unspecified
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.9	Personality disorder, unspecified
F63.0	Pathological gambling
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania
F63.81	Intermittent explosive disorder
F63.9	Impulse disorder, unspecified *
F64.1	Dual Role Transvestism *
F64.2	Gender identity disorder of childhood
F64.9	Gender identity disorder, unspecified
F65.0	Fetishism
F65.1	Transvestic fetishism
F65.2	Exhibitionism
F65.3	Voyeurism
F65.4	Pedophilia
F65.50	Sadomasochism, unspecified *
F65.51	Sexual masochism

Diagnosis Code	Description
F65.52	Sexual sadism
F65.81	Frotteurism
F65.9	Paraphilia, unspecified
F68.10	Factitious disorder, unspecified
F68.11	Factitious disorder with predominantly psychological signs and symptoms *
F68.12	Factitious disorder with predominantly physical signs and symptoms *
F68.13	Factitious disorder with combined psychological and physical signs and symptoms *
F80.82	Social (Pragmatic) Communication Disorder *
F80.9	Developmental Disorder of Speech and Language, Unspecified
F84.2	Rett's syndrome *
F84.3	Other childhood disintegrative disorder *
F84.5	Asperger's syndrome *
F84.8	Other pervasive developmental disorders *
F84.9	Pervasive developmental disorder, unspecified *
F90.0	Attention-deficit/hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit/hyperactivity disorder, Predominantly Hyperactive Type
F90.2	Attention-deficit/hyperactivity disorder, combined type
F90.8	Attention Deficit/Hyperactivity Disorder, Other Type
F90.9	Attention-deficit/hyperactivity disorder, Unspecified Type
F91.1	Conduct disorder, childhood-onset type
F91.2	Conduct disorder, adolescent-onset type
F91.3	Oppositional defiant disorder
F91.8	Other Conduct Disorder
F91.9	Conduct disorder, unspecified
F93.0	Separation anxiety disorder of childhood
F93.8	Other childhood emotional disorders *
F93.9	Childhood emotional disorder, unspecified *
F94.0	Selective mutism
F94.1	Reactive attachment disorder of childhood

* Diagnoses not found in DSM-5 - carried over from DSM-IV

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Appendix B:

Sample Phrases for Interventions

Appendix B:
Sample Phrases for Interventions

Clinicians' Interventions

Acknowledged	Discussed	Inquired	Questioned
Addressed	Empathized	Interpreted	Reality-tested
Advocated	Encouraged	Interrupted	Recommended
Analyzed	Engaged	Joined	Reflected
Assisted	Established	Labeled	Reframed
Assured	Examined	Listened	Role-modeled
Called	Expanded	Made eye contact	Role-played
Challenged	Explained	Mirrored	Set limits
Clarified	Explored	Modeled	Shifted
Confronted	Facilitated	Monitored	Supported
Constructed	Figured Out	Noted	Urged
Consulted	Focused	Observed	Validated
Created	Guided	Offered feedback	Wondered
Defined	Helped	Played	Etc.
Demonstrated	Identified	Processed	
Developed	Informed	Provided	

Clients' Responses

- Agreed
- Affirmed
- Attempted
- Became (anxious, sad etc.)
- Calmed
- Complained
- Contradicted
- Cried
- Denied
- Disagreed
- Dissociated
- Explained
- Expressed
- Fell Asleep
- Frowned
- Looked (away, towards the ground, etc.)
- Made eye contact
- Nodded
- Played
- Quieted
- Relaxed
- Remained
- Said
- Shouted
- Smiled
- Yawned

Examples of Phrasing

I listened empathically as he…	We reframed…	I validated…	I clarified…
She used sessions as a reality check….	I challenged her perception….	Together we reviewed….	I reinforced his decision to….
I offered optional parenting interventions	I inquired	We constructed a (time line, genogram, set of goals, etc.)	I helped her identify….
I observed silently as she….	I wondered aloud….		

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Appendix C:

MMHP Child/Adult Medi-Cal
Reauthorization and Change of Service Modality Request Form

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BHRS CHILD/ADULT MEDI-CAL REAUTHORIZATION AND CHANGE OF SERVICE MODALITY REQUEST FORM

Fax To: 415 473-2353

Reauthorization request must be received 10 business days before expiration of prior authorization

Date:		Clinician:		
Provider/Agency:		Telephone:		Ext.
		Supervisor:		

Client Data:

Client Name:		Date of Birth:	
SS#:		or Medi-Cal#:	

Diagnosis:

Diagnoses: DSM5 code and written description		
	DSM 5 code	**Description**
Primary Dx		
Secondary Dx		
Tertiary Dx		
Substance Abuse/Dependence: Yes ☐ No ☐		

Diagnosis has been changed from the initial Access Team Referral (if applicable): Yes ☐ No ☐

Date of initial Access Team (or MMHP) referral _____

Treatment Info:

Requested Start Date of the reauthorization	
Date of most recent assessment	
Date of most recent treatment plan (signed by the client)	
# of sessions requesting	
Type of treatment modality (i.e.: family, PCIT, PPP, trauma, group, individual)	

1. Current Mental Health symptoms and rationale for requesting additional sessions/change of modality:

2. Progress toward meeting objectives from previous treatment plan:

3. Impairment in functioning (Include all that apply. ***Provide an explanation in box below.)***

☐ Occupational/Educational ☐ ADLs Activities of Daily Living ☐ Family and Social Relationships

☐ Housing ☐ Health ☐ Severity of Symptoms

☐ History of Psychiatric Hospitalizations ☐ Probability of Deterioration in an Area of Life Functioning

4. Psychiatric medications and Medical/ Health Issues, if any:

Remember: You must submit an assessment with a client plan to obtain approval for reauthorization.

- **The client plan MUST include objectives which are specific, measurable, and observable.**
- **The interventions on the client plan MUST include frequency and duration.**
- **The client plan must be SIGNED by the client.**
- **Supervisor Signature is required for all intern staff.**

Clinician	Supervisor
Date	Date

Appendix D:

Reasons for Recoupment from DHCS

www.dhcs.ca.gov

REASONS FOR RECOUPMENT
FOR FY 2016-2017

NON-HOSPITAL SERVICES

MEDICAL NECESSITY

1. Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R); CCR, title 9, chapter 11, section 1810.345(a); CCR, title 9, chapter 11, section 1840.112(b)(1)(4)

2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

a) A significant impairment in an important area of life functioning;
b) A probability of significant deterioration in an important area of life functioning;
c) A probability the child will not progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, title 9, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

3. Documentation in the medical record does not establish that the focus of the proposed intervention is to address the condition identified in CCR, title 9, chapter 11, section 1830.205(b)(2)(A),(B),(C)-(see below):

a) A significant impairment in an important area of life functioning;
b) A probability of significant deterioration in an important area of life functioning;
c) A probability the child will not progress developmentally as individually appropriate; and
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

4. Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:

a) Significantly diminish the impairment;
b) Prevent significant deterioration in an important area of life functioning;
c) Allow the child to progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

CLIENT PLAN

5. Initial client plan was not completed within the time period specified in the Mental Health Plan (MHP's) documentation guidelines, or lacking MHP guidelines, within 60 days of the intake unless there is documentation supporting the need for more time.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract

6. The client plan was not completed, at least, on an annual basis or as specified in the MHP's documentation guidelines.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract

7. No documentation of beneficiary or legal guardian participation in the plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the MHP Contract with the Department.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract

8. For beneficiaries receiving Therapeutic Behavioral Services (TBS), no documentation of a plan for TBS.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, DMH Letter No. 99-03, Pages 6-7

PROGRESS NOTES

9. No progress note was found for service claimed.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51458.1(a)(3); MHP Contract

10. The time claimed was greater than the time documented.

CCR, title 9, chapter 11, section 1810.440(c); CCR*, title 9, chapter 11, sections 1840.316 - 1840.322; CCR, title 22, chapter 3, section 51458.1(a)(3)(4)(5); CCR, title 22, chapter 3, section 51470(a); MHP* Contract

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation. (e.g. Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11.)

CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, part 435, *sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d*

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).

CFR, title 42, sections 435.1008 – 435.1009; CCR, title 22, section 50273(a)(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

a) Academic educational service;
b) Vocational service that has work or work training as its actual purpose;
c) Recreation; or
d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.

CCR, title 9, chapter 11, section 1840.312(a-d); CCR, title 9, chapter 11, section 1810.247; CCR, title 22, chapter 3, section 51458.1(a)(5)(7)

14. The claim for a group activity was not properly apportioned to all clients present.

CCR, title 9, chapter 11, section 1840.314(c); CCR, title 9, chapter 11, section 1840.316(b)(2)

15. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

MHP Contract

16. The progress note indicates the service provided was solely transportation.

CCR, title 9, chapter 11, section 1810.355(a)(2), CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); DMH Letter No. 02-07

17. The progress note indicates the service provided was solely clerical.

HOSPITAL SERVICES

CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

19a.No service was provided.

CCR, title 9, chapter 11, section 1840.112(b)(3); DMH Letter No. 02-07; CCR, title 22, chapter 3, section 51470(a)

19b.The service was claimed for a provider on the Office of Inspector General List of Excluded Individuals and Entities.

CFR, title 42, section 438.610; Social Security Act, sections 1128 and 1156; USC, title 42, chapter 7, subchapter XI, part A, sections 1320a-5 and 1320a-7

19c.The service was claimed for a provider on the Medi-Cal suspended and ineligible provider list

CCR, title 9, chapter 11, section 1840.314(a); Welfare and Institutions Code, Sections 14043.6, 14043.61 and 14123;

19d.The service was not provided within the scope of practice of the person delivering the service.

CCR, title 9, chapter 11, section 1840.314(d)

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

a) For the convenience of the family, caregivers, physician, or teacher;
b) To provide supervision or to ensure compliance with terms and conditions of probation;
c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch; or
d) To address conditions that are not a part of the child's/youth's mental health condition.

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21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

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MEDICAL NECESSITY

22. Admission

a) Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).
b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.
c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:

☐ Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction;
☐ Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;
☐ Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health;
☐ Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function; or
☐ Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized.

CCR, title 9, chapter 11, section 1820.205(a)

23. Continued Stay Services

a) Documentation in the medical record does not establish the continued presence of a diagnosis contained in Section 1820.205(a)(1)(A-R).
b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.
c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:

☐ Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction;
☐ Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter;

☐ Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health;
☐ Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function;
☐ Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized;
☐ Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization;
☐ Presence of new indications that meet medical necessity criteria specified in 22.a. above; or
☐ Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital.

CCR, title 9, chapter 11, section 1820.205

ADMINISTRATIVE DAY REQUIREMENTS

24. Documentation in the medical record does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

25. Documentation provided by the MHP does not establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:

a) The MHP or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be fewer than one (1) contact per week; and
b) The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

i. The status of the placement option;
ii. The date of the contact; and
iii. Signature of the person making the contact.

*CCR, title 9, chapter 11, section 1820.230(d)(*2)

CLIENT PLAN

26. The medical record does not contain a client plan.
CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

27. The client plan was not signed by a physician.
CFR, title 42, section 456.180: CCR, title 9, chapter 11, section 1820.210

OTHER

28. A hospital day was claimed and paid (1) on which the beneficiary was not a patient in the hospital or (2) for the day of discharge, neither of which is reimbursable.
CCR, title 9, chapter 11, section 1840.320(b)(1)(3)