Quality Assurance Bulletin

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Program Support Bureau

County of Los Angeles - Department of Mental Health
Marvin J. Southard, DSW , Director

CLINICAL AUDITS BY STATE DMH

Los Angeles County is more than half way between our triennial State DMH System Review. One section of that Review is an audit of adult records. In addition, the EPSDT audit for Los Angeles County has just been completed. While we have not yet received the report of the EPSDT audit, we informally know the audit findings and had a very informative Exit Conference. For these reasons, it seemed timely to distribute a QA Bulletin reminding managers of areas in which we need to ensure compliance to minimize audit exceptions. It is imperative that managers and QA staff review this information with clinicians.

<u>The Clinical Loop and Medical Necessity</u>

The Department has transformed the basic information required by Medi-Cal into a process which we have designated the "Clinical Loop" because those requirements converge to support both good clinical practice and Medical Necessity. The **three documentation elements of the Clinical Loop** are the:

1. **Assessment**
2. **Client Plan**
3. **Progress Notes**

Through these documents, the requirements of Medical Necessity are threaded:

- The first two **Medical Necessity requirements** of
  - **an included diagnosis** and
  - **impairments in life functioning**

are initially found in the first document of the Clinical Loop, the Assessment. Signs and symptoms which support an included diagnosis and impairments in life functioning are all recorded in the Assessment. Subsequent to the Assessment, these elements of Medical Necessity continue to be supported by Progress Notes and the Annual Assessment Update.

- The third Medical Necessity requirement of
  - **interventions** related to goals

are identified on the Client Plan and specifically reflected in Progress Note documentation.

Assessments

Assessment forms have been developed by the Department for use by directly-operated and contract providers in order to encompass all the required elements of an assessment. While discussions are currently under way with contractors regarding the incorporation of these forms into electronic record systems, when using paper copy of these assessments they are not to be altered in either content or format.

In order to meet all requirements set forth in the contract with State DMH and DMH Policy 104.9, the Assessment must be fully completed. If a particular section of the Assessment is not applicable to a client, "not applicable" should be noted on the Assessment. Leaving a section blank without such a notation is not appropriate.

Per the State Contract and Medi-Cal auditing protocols, all Assessments must contain information regarding allergies and adverse reactions or lack of allergies/sensitivities. This is an important clinical assessment practice that the Department includes in DMH Policy 104.9.

Neither the State nor the Department has limits on the duration of a specific assessment contact nor the number of assessment contacts that may be needed to complete an assessment. The Department's minimum requirement for an assessment update is annual (Annual Assessment Update, MH 637) but does not restrict this to once a year. Documenting information on an Assessment Addendum or performing a complete Assessment Update in addition to the Annual Assessment Update is encouraged any time the status of a client changes sufficiently in a clinician's opinion to warrant such an action. Any time any one of the Assessment forms is used, an Assessment claim can be submitted.

Client Plan

The Client Care Coordination Plan (CCCP – MH 636) is also a required form meaning that content and format may not be altered when used. All DMH directly-operated and contract Providers are required to have a CCCP in place for all clients within 60 days (for clients without an existing open episode anywhere in the system) or 30 days (for clients with current open episodes elsewhere in the system). The CCCP must be filled out completely, with goals/objectives and interventions in place to cover each service provided to a client.

The goals/objectives and interventions must be discussed with a client. Documentation of client participation in plan development must be explicit – typically the client's signature is obtained to show participation in the client planning process. The client can be of any age to sign for or express agreement/participation with the client plan. For children, the parent's/responsible adult's signature is desirable along with the client's signature, but getting documentation of participation and agreement by someone who is a party to the Plan is critical. Documentation of telephone discussion and agreement of a parent/responsible adult is acceptable. If none of these measures yield the required documentation within the required timeframes, documentation must detail the plan for discussion and reaching agreement. In addition, the client must be offered a copy of the CCCP. The revised CCCP has check boxes regarding whether the client accepted or declined this offer.

Progress Notes

All DMH directly-operated and contract providers are required to have a Progress Note in the client's clinical record for each service provided prior to claiming for that service. Service time, date, Procedure Code, and interventions must be included on each Progress Note. Additionally, Progress Notes must be signed by the author of the note along with his/her professional license or job title. In order to be Medi-Cal claimable, progress notes must be legible; notes that are not legible are not reimbursable by Medi-Cal.

Blended notes (two services combined into one note) are no longer an accepted practice. If, for example, a significant, documentable TCM service is provided in the same contact as an individual therapy, rehab, or collateral, two separate notes that meet all documentation requirements (date, time, code, intervention, signature) must be made.

Documentation not completed on the date of service – The Department standard for directly-operated programs is that a Progress Note must be written by the end of the next scheduled work day (Policy 104.8). When a note is written after the date of service, the note should begin with "Note written on xx/xx/xx." The Policy does not require that anything written after the date of service be labeled as a "late entry". The only situation in which the Department requires an entry be labeled as a "Late entry" in its paper record is if the Progress Note would **also** be "out-of-sequence" when written/filed. In this instance, for the paper records of directly-operated programs the date of service should be entered on the top portion of the Progress Note and the note should begin with a statement, "Out-of-sequence, note written on xx/xx/xx." The most important principle to remember regarding dates is that the date of service recorded in the clinical record on the Progress Note MUST match the date of service on the claim or the service will be disallowed when audited.

Multiple staff present during a meeting:

- For groups, it's clear that the interventions of each staff present must be documented.
- For family meeting and/or case conferences, such as occurs in programs like MAT and WrapAround, only the time a staff can document their unique participation may be claimed. In a 2 hour meeting with a family, one staff spends an hour coaching a client on their responses during the course of the meeting so documents his/her interventions and claims that hour as an individual with x collaterals; another staff facilitates the meeting/interactions some of which are related to the mental health issues of the client so claims an individual contact with x collaterals for the time spent related to mental health issues; a third staff spends 30 minutes coaching a collateral on his/her interactions with the client documenting that intervention and claiming collateral for 30 minutes.

Other Standard Documentation and/or Claiming Information

Marital Therapy – this is not in itself a reimbursable service, that is, there is not a code for Marital Therapy. If both partners are clients then interventions can be directed to both with notes in each chart related to his/her therapy issues. If only one partner is a client, the interactions and documentation must be viewed as a service to a client and a collateral. The claim would be for individual therapy or rehab with one collateral present.

Juvenile Halls – the Court Order adjudicating a youth to placement must occur prior to claiming services to Medi-Cal:

- If a youth is placed following adjudication and then arrested again, a new adjudication must occur prior to claiming Medi-Cal
- If a youth is placed following adjudication and returns to JH as a result of a failed placement, a new adjudication is not required.

Clerical activities and socialization activities - these are not activities reimbursed by Medi-Cal.

Safety is not a reimbursable reason for a second person participating in a field visit. If the time of both participants is to be claimed, the interventions of both staff must be clearly documented. Only that portion of the time where a service was provided should be claimed for each staff person.

General observation of or participation in an activity with a client (such as going to a movie or watching him/her in class) is not a MC reimbursable service; there must be a specific, documented purpose for the observation/activity which would ordinarily be claimed as an individual rehab service. Such services are almost always pre-planned with a specific purpose. Three examples of reimbursable services:

1) a child is disruptive in the classroom so a therapist schedules observation time in the classroom to better understand the classroom dynamics that are occurring and documents his/her assessment of the dynamics in the progress note that claims the observation time;
2) a child is disruptive in the classroom so a rehab specialist or therapist is present in the classroom monitoring behavior, prompting or providing frequent support to the child or teacher to the end of diminishing disruptive classroom behavior and the rehab specialist/therapist documents his/her specific interventions in the note;
3) a youth is doing poorly because he/she cannot maintain a focus on assignments and experiences frustration and low esteem so a rehab specialist/therapist is with the youth in the classroom to help the youth focus, deal with his/her frustration with the work, and resulting feelings of low esteem documenting specific interventions in his/her Progress Note.

Claimable activities do not include helping the youth with his/her homework or sitting in a classroom because the teacher would not allow the client to leave for a scheduled appointment.

<u>Other Exit Conference Documentation and/or Claiming Comments</u>

Please note that there is no written information from the State regarding the following discussions at the Exit Conference so contract programs must make their own decisions regarding whether or not they claim for these activities. Directly-operated programs should claim in accord with the following information.

Writing a letter or report should only be claimed to MC if the note and/or letter/report explicitly documents how this activity is a benefit to the beneficiary. A routine, non-specific letter/report on client attendance in therapy should not be claimed to MC. While the following comments are related to court letters/reports, the principles can be applied to all report/letter writing.

- If letters/reports will be on-going and are for the benefit of the client, there should be a long term goal on the CCCP such as, "Client wishes to remain at home and not return to JH." Short term goals can then be set to support behaviors that will achieve this long-term goal. Staff participation would be to periodically update the Court on client participation and progress in therapy and recommendations regarding continued placement at home.
- If a letter/report is claimed, the note should reference by date the letter/report and the letter/report should be in the correspondence section of the clinical record
- If a letter/report is claimed, the note should specifically document the benefit to the client such as, "Client requires letter/report of support for his/her continued living at home. Letter/report written to Court to explain client's current involvement and progress in treatment and explaining why home placement continues to be (or is not) in the best interest of the client. See letter/report dated xx/xx/xx."

The time claimed preparing a child or elder abuse report is currently being allowed if the claim is for the person who is the alleged victim of the abuse - the report is viewed as a benefit to the beneficiary. Time spent dealing with the mechanics of the report (faxing, etc) is not reimbursable; however, the time spent making the report over the telephone may be included in the report writing time. If a report is not made as a result of the telephone call, the time spent on the phone consulting may be claimed as a case consultation. For DMH programs, the actual abuse report is NOT filed in the clinical record. A copy of the report should be stored in a notebook/file folder in a secure place available if needed for an audit. Those DMH clinics with high density filing systems have a lockable shelf in which these reports can be filed. Key access is only available to specific management staff. The Program Manager in other clinics must secure the reports in his/her office. The content of the chart note can simply read, "A suspected Child (or Elder) Abuse report was prepared."

Letters to clients terminating services are not reimbursable; however, letters to clients stating the need to continue with services, if clinical in nature, may be reimbursable. Discharge summaries, similarly, can be reimbursable when written by the service provider if they are clinical in nature. Discharge Summaries that simply summarize numbers of visits and state a diagnosis are not reimbursable by MC. A reimbursable Discharge Summary must comment on things like: diagnosis – rationale for changing or not changing the diagnosis related to signs and symptoms; effective and/or ineffective interventions; client and significant other participation and responsiveness; progress and recommendations for future services if needed.

c: Executive Management Team
District Chiefs
Program Heads
TJ Hill, ACHSA
Department QA staff
Judy Miller, Compliance Program Office
Nancy Butram, Revenue Management
Donna Warren-Kruer, Managed Care