LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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Provider Bulletin

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IN THIS ISSUE

NEW DOCUMENTATION REQUIREMENTS FOR SPECIALTY MENTAL HEALTH SERVICES EFFECTIVE JULY, 01 2022.

This Bulletin provides updated documentation requirements for all non-hospital Medi-Cal Specialty Mental Health Services (SMHS) based on Department of Health Care Services (DHCS) Information Notice No: 22-019, which will go into effect July 1, 2022. The below requirements apply to all Medi-Cal non-hospital services including residential and day programs as well as CalWORKs programs. Some specialized programs, including FSP and Wraparound, may be subject to additional documentation requirements. Services provided within STRTPs are subject to separate documentation requirements as noted in the Interim STRTP Regulations.

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS is streamlining clinical documentation requirements and the reasons for monetary disallowances have shifted from documentation technicalities to instances of fraud, waste and abuse (Reasons for Recoupment FY 2021/2022). Therefore, non-compliance with documentation requirements noted below, for example the absence of a care plan when one is required, will not have accompanying recoupment but may result in the need for a corrective action plan (CAP). In addition, greater flexibility has been extended to when services may be reimbursable such as services provided during the assessment process regardless of whether the criteria to access SMHS is ultimately met (see QA Bulletin 21-08).

DHCS and LACDMH will not require standardized forms for the Assessment, Problem List, Care Plan or Progress Note requirements identified below. For Directly-Operated (DO) providers using IBHIS, forms within IBHIS will be utilized by all practitioners to satisfy the below requirements and paper forms will also be developed. For contracted providers, including Legal Entity (LE) and Fee-For-Service (FFS) providers, the forms used by DO providers are not required but may be utilized if desired. Contracted providers are responsible for ensuring their documentation meets the below requirements.

Assessment Requirements

What Has to be Documented:

Assessments must contain the required seven (7) uniform Assessment domains as identified below, but there is no requirement for the domains to be laid out in this manner. For clients 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 but is not sufficient as the Assessment in-and-of itself.

Domain 1	Domain 5
• Presenting Problem(S) • Current Mental Status • History of Presenting Problem(s) • Client Identified Impairment(s)	• Social and Life Circumstances • Culture/Religion/Spirituality
Domain 2	**Domain 6**
• Trauma	• Strengths, Risk Behaviors & Safety Factors
Domain 3	**Domain 7**
• Behavioral Health History (including Substance Use History) • Comorbidity (i.e., substance use & mental health)	• Clinical Summary & Recommendations • Diagnostic Impression • Medical Necessity Determination/ Level of Care/ Access Criteria
Domain 4	
• Medical History • Current Medications • Comorbidity (i.e., medical & mental health)	

Detailed, itemized data elements for each domain are no longer required. Domains are now described in a more general manner. The result is that greater flexibility is afforded the assessing clinician to focus on areas of relevance.

Who Can Document:

The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting physical and mental health must be completed by a practitioner, operating within their scope of practice, who is licensed, registered/waivered, and/or under the direction of a licensed mental health professional (i.e., student professionals in these disciplines with co-signature).

Providers may designate certain other qualified practitioners to contribute to the Assessment, including gathering mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. For DO providers, this information is documented in a Progress Note and reviewed with the primary assessing clinician, who then enters the relevant information into the Assessment form.

Timeframe/Frequency of Documentation:

- Initial and subsequent Assessments should be completed within a reasonable period of time and in accordance with generally accepted standards of practice. There is no longer a requirement to complete the Assessment within 60 days from the start of the Assessment or before any treatment services; however, efforts should be made to complete the Assessment as quickly as possible in-order-to move the client into treatment, if indicated.

- Although not the standard course of action, under certain limited circumstances (e.g., the client is running out of medication) the Initial Medication Evaluation (IME) may serve as the Assessment if the MD/NP/DO is the most appropriate first contact for the client. Please note that in these instances the IME should focus on a broad evaluation of the client's needs similarly to the standard Assessment. A standard Assessment

is not required to be completed in addition to the IME unless there is clinical justification to further assess the client.

- The frequency of the Assessment is up to clinical discretion. Triannual Assessments are no longer required. There is no longer a requirement to complete an Assessment Addendum when there is additional information gathered, whether a change or addition, after the completion of the Assessment. Instead, refer to the new requirements involving the Problem List to identify the current presenting issues and needs of the client. If it is determined that another Assessment is needed, existing information should be reviewed and incorporated to minimize redundancy in questioning.

- If a diagnosis requires updating post-Assessment, information supporting the new diagnosis may be documented in a progress note. An Assessment Addendum supporting the change in diagnosis is no longer required. For DO providers, it is recommended that the progress note supporting the change in diagnosis is referenced in the comments field of the Diagnosis Form.

- If a provider is accepting a client referred or transferred from another provider, the accepting provider may choose to do an Assessment or use the Assessment from the referring provider based on clinical judgment. Similarly, if a client is coming back into treatment the provider may choose to do an Assessment based on clinical judgment, taking into account factors including the period of time elapsed since the client was last seen, the age of the client, and whether the client's current symptoms are consistent with the prior diagnosis. If it is determined that another Assessment is needed, existing information should be reviewed and incorporated to minimize redundancy in questioning.

Forms:

For DO providers, the current Infancy, Childhood & Relationship Enrichment (ICARE) Assessment, Child/Adolescent Full Assessment, Adult Full Assessment and Immediate/Same Day Assessment meet the above requirements for an Assessment and can continue to be used after July 1, 2022. The Child/Adolescent Assessment Addendum and Re-Assessment and the Adult Assessment Addendum and Re-Assessment are no longer required. The Re-Assessment forms may continue to be used for returning clients when clinically appropriate. In an effort to streamline Assessment documentation, remove redundancies and make the forms more user-friendly, the Assessment forms will be modified in the future, including removing the Addendum and Re-Assessment forms.

Note: As of the date of this Bulletin, an Annual Assessment requirement for TCM services remains in effect per State Plan Amendment 12-025. Therefore, LACDMH will continue to require the Needs Evaluation Tool (NET) and CANS to fulfill the State requirement. Should the State requirement change, LACDMH will revisit the need for the NET.

Problem List

What Has to be Documented:

The Problem List must contain:

- Symptoms, conditions, diagnoses, and/or risk factors identified through the Assessment, diagnostic evaluation, crisis encounters, or other types of service encounters:
  - Diagnoses identified by a practitioner acting within their scope of practice, if any.
  - Problems identified by a practitioner acting within their scope of practice, if any.
  - Problems or illnesses identified by the client 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.

While a code set for the Problem List is not required, a standard-based coding system such as the CORE Problem List subset of SNOMED CT is highly recommended for future interoperability and coordination of care requirements. Licensing is required to use the CORE SNOMED CT codes. For DO providers, the Problem List in IBHIS utilizes the CORE SNOMED CT codes.

DMH recognizes that “Problem List” is not a strength-based term; however, since it is a widely recognized term-of-art, it will be retained in-order-to remain consistent with physical health care system language for care coordination and integration. This does not mean that providers should only focus on the client’s problems. A client’s strengths are identified in the Assessment, CANS, NET, and progress notes and should continue to be capitalized upon throughout treatment.

Who can document:

Any practitioner on the treatment team can add problems to the Problem List as it is a reporting form, not a diagnosing form.

Timeframe/Frequency of Documentation:
Providers shall update the Problem List on an ongoing basis to reflect the current presentation of the client, adding or removing problems when there is a relevant change to a client’s condition and as new problems are identified.

Forms:

For DO providers, the Problem List within IBHIS should continue to be used. On July 1, 2022, the progress note forms in IBHIS will be updated to more easily view the current active problems and quickly update the Problem List if applicable. Please watch for an IBHIS Notification Bulletin that will be issued prior to July 1, 2022.

Treatment and Care Planning Requirements

What Has to be Documented:

Care planning with clients is a standard of practice which helps to organize and guide treatment. Care Plans assist in ensuring clients continue to move forward on a path to recovery. For specific services (i.e., Targeted Case Management (TCM), Intensive Care Coordination (ICC), Therapeutic Behavioral Services (TBS), and Intensive Home Based Services (IHBS)), DHCS and the Centers for Medicare and Medicaid Services (CMS) continue to require the development and periodic revision of a Care Plan. The Care Plan may be documented in the Progress Note within the Next Steps section (See Organizational Providers Manual for additional information). Please refer to the next section on Progress Notes for additional information on Care Plan requirements. The formal Client Treatment Plan, with its numerous required data elements (e.g., specific observable and/or specific quantifiable goals/treatment objectives), is no longer required for any service or program other than services rendered within STRTPs (see link to Interim STRTP regulations provided above).

Forms:

As of July 1, 2022, the Client Treatment Plan will be obsolete. For DO providers, the DMH Client Treatment Plan form within IBHIS will be read-only and the treatment plan sections of the Medication Consent and Treatment Plan forms will be removed. Please watch for an IBHIS Notification Bulletin that will be issued prior to July 1, 2022.

Progress Notes

What Has to be Documented:

Progress Notes shall support the need for the service (i.e., Medical Necessity) and include:

- ✓ Sufficient detail to support the service code selected for the service type indicated by the service code description;
- ✓ A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors);
- ✓ The type of service rendered;
- ✓ The date that the service was provided to the client;
- ✓ Duration of the service, including travel and documentation time;
- ✓ Location of the client at the time of receiving the service;
- ✓ Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code;
- ✓ ICD 10 code (the ICD 10 code is not required to be on the progress note but must appear in the clinical record, associated with each encounter and consistent with the description in the progress note);
- ✓ Next steps including, but not limited to, planned action steps by the practitioner or by the client, collaboration with the client, collaboration with other provider(s) and any update to the Problem List as appropriate;
- ✓ A typed or legibly printed name, signature of the service practitioner and date of signature.

When a group service is rendered, a list of participants is required to be documented and maintained by the practitioner. Should more than one practitioner render a group service, one progress note may be completed and signed by one practitioner. While one progress note with one practitioner signature is acceptable where multiple practitioners are involved, the progress note shall clearly document the specific amount of time and

involvement of each practitioner, including documentation time. Please note that this rule also applies to those situations in which multiple practitioners serve an individual client.

With the exception of services in an STRTP, the next steps within the Progress Note may serve as the Care Plan for services that continue to require a documented Care Plan. Practitioners should be careful to ensure that the next steps lay out the planned interventions to assist the client and that the client participates in identifying the next steps. The next steps should not simply be a statement of the next appointment date.

Progress Notes for treatment services are no longer required to link back to the Client Treatment Plan and Assessment (previously referred-to as the "Clinical Loop"). The focus of the note is on describing what was done to address the client's needs and the planned next steps in the treatment of the client. Practitioners should continue to document relevant information that is pertinent to the client's treatment for the purposes of care coordination and good clinical documentation.

Timeframe/Frequency of Documentation:

Providers shall complete Progress Notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours. This is a change to the current policy, which requires all clinical documentation to be finalized by the end of the next scheduled workday following the date of service. For DO providers, supervisors should continue to review documentation by the end of their next scheduled workday when a co-signature is required.

For Mode 15 services (e.g., Mental Health Services (MHS) and TCM) Progress Notes shall continue to be completed for each service provided. For services billed on a daily basis including Therapeutic Foster Care, Day Treatment Intensive, Day Rehabilitation, and Crisis Residential, a Progress Note shall be completed for each day of service. Weekly summaries will no longer be required for Day Rehabilitation and Day Treatment Intensive services.

Forms:

For DO providers, the Individual & Group Progress Note forms in IBHIS will be modified to account for the Problem List and to remove unnecessary fields on July 1, 2022. Please watch for an IBHIS Notification Bulletin that will be issued prior to July 1, 2022. In an effort to streamline documentation, remove redundancies and make the forms more user-friendly, the Progress Note forms, including the Crisis Evaluation Progress Note, will have additional modifications in the future.

Implementation:
There are no specific deadlines currently required for form modifications for contracted providers. However, in-order-to reduce documentation burden on practitioners, contracted providers should demonstrate a good-faith effort to implement the changes described in this Bulletin as quickly as possible commencing July 1, 2022, including ending requirements that have become obsolete (e.g., Triannual Assessments and formal Client Treatment Plans) and beginning new timeframe/frequency of documentation practices. For DO providers using IBHIS, the implementation timeline for form modifications will be as described in this Bulletin.

The Organizational Provider's Manual and related DMH Policies will be updated to account for the documentation requirement changes described in this Bulletin. In addition, a short training video covering the new documentation requirements will be available on the QA Unit's website under "Training."

If DO or contracted providers have any questions related to this Bulletin, please contact the QA Unit at QualityAssurance@dmh.lacounty.gov.

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