New Employee Documentation Training: CSU

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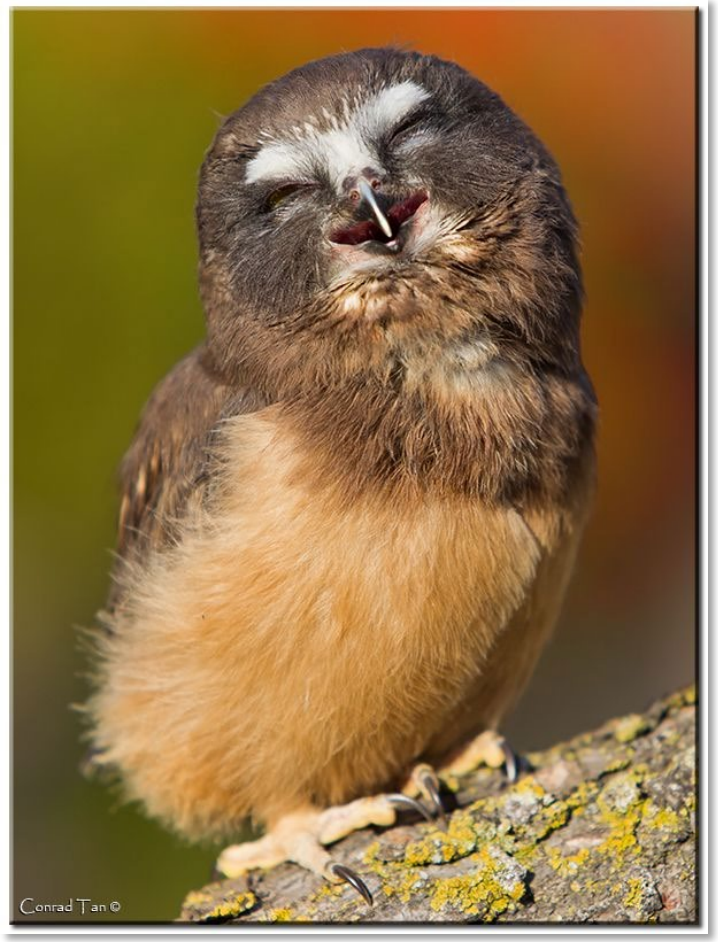
What do we do?

How would you describe the work we do?

How would Medi-Cal describe the work we do?

Specialty Mental Health Services (SMHS)

- Legally required benefit for clients with Medi-Cal in California
- Each county has a contract with the California Department of Health Care Services (DHCS or “the State”) to provide these services



Medical Necessity

Who qualifies for our services?

- Legally defined in California Code of Regulations Title 9: §1830.205 and 1830.210
- Must meet three criteria
- Qualifying means that the client has “met medical necessity” for specialty mental health services
  - Does not automatically mean that all services are medically necessary for that client!
  - Must be continually established throughout treatment

Medical Necessity Criteria for SMHS

1. The client has a qualifying diagnosis
    - See MHP-16 attachment “SCBH DSM-5 Included Diagnosis Table”
2. The symptoms of the client’s qualifying diagnosis are causing significant impairments in the client’s daily life, or would do so without the current treatment
    - Life Domain Functioning
    - Risk Behaviors
    - 5150 Involuntary Psychiatric Hold Criteria
3. Mental-health treatment is expected to help

Where is medical necessity documented?

For meeting medical necessity criteria for Specialty Mental Health Services overall, including Crisis Stabilization Services, documented in the assessment

- Belongs in the "Clinical Impressions & Rationale for Disposition" section
- Should "connect the dots" and make it very clear whether the client meets criteria; don't expect auditors to fill in the blanks.
- Example:

  Rebekah has a diagnosis of Major Depressive Disorder, Recurrent, Severe. **COVERED DIAGNOSIS**

  Her symptoms are causing significant risk factors of suicidal ideation and behavior. **RISK/FUNCTIONAL IMPAIRMENTS CAUSED BY SYMPTOMS**

  Rebekah's current risk status requires crisis-level mental health intervention. **TREATMENT WILL HELP**

  She therefore meets medical necessity criteria for Crisis Stabilization. **THEREFORE: SHE MEETS CRITERIA**

What if they don’t meet criteria? Explain why!

Tyler has a primary diagnosis of Amphetamine-Type Substance Use Disorder, Moderate, which is not a covered primary diagnosis for Specialty Mental Health Services. Tyler therefore does not meet medical-necessity criteria for CSU.

Gio has a diagnosis of Major Depressive Disorder, Recurrent, Severe, but his symptoms are not causing significant risk factors at this time. He therefore does not meet medical-necessity criteria for CSU.

Where else is medical necessity documented?

- Even once the client meets medical necessity overall for SMHS, each individual intervention provided must be medically necessary for that particular client.
- The medical necessity of any intervention (including Crisis Stabilization) is documented in the progress note.
- Services *must* be intended to diminish the client's identified functional impairments/risk factors (not just symptoms).
- Notes *must* document the functional impairment/risk factor targeted by the intervention.
- Notes *should* also document the client's diagnosis (to give context).

CSU Procedure Codes

614 - CSU Non Medi-Cal Claimable

- “A service lasting less than 24 hours, to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit.”
- Can include (but not limited to):
  - Assessment – Evaluating the current status of a client's mental, emotional, or behavioral health
  - Collateral – Coordinating with significant support people
  - Therapy – Helping a client process emotions or develop insight into behavioral patterns
  - Targeted Case Management – Coordinating for hospital placement or discharge planning, or advocating with service providers.
- Requires that client meet medical necessity for specialty mental health services
- Requires one progress note per client per shift

666 – CSU Assessment Non-Qualifying Dx

- Assessment that determines a client does not have a qualifying primary diagnosis
- Bill only for the time spent doing the assessment (including interview, chart review, collateral information, consultation & writing assessment and progress note), even if the client remains at CSU (e.g., due to lack of safe discharge plan)

NPC – No Procedure Code

- Can be used to add clinical information to chart that is not a billable intervention
- E.g., Interventions like phone calls for clients open to treatment teams that do not require Crisis Stabilization

Progress Notes

Progress Notes: Why?

- Clinical Care
  - Documenting a client's history & progress
  - Coordinating between treatment team members

- Legal Requirement
  - Therapists can be charged with unprofessional conduct for failing to keep records consistent with "sound clinical judgment, the standards of the profession, and the nature of the services being rendered."
  - Defense against any accusation of negligence

- Medi-Cal/Insurer Requirement
  - "Invoice" documenting services rendered for payment
  - Documents why service was medically necessary and why insurer should pay for it

Progress Note: Medical Necessity

- All chart documentation must establish that:
  - The client continues to meet medical necessity *and*
  - The service was medically necessary.

- Focus on
  - Resolving the crisis so client can go home
  - Hospitalization or referral to CRU

- Description of services provided to justify why Medi-Cal should reimburse

Progress Note Format

- P - Purpose
- I - Intervention
- R - Response
- PL - Plan

- Why PIRPL?
- Because DHCS requires that every progress note describe the purpose of the intervention, the intervention, the client's response to the intervention, and the plan.

P – Purpose

- Why did you provide the intervention?
- Generally a good place to establish medical necessity components
- Focus on reducing impairments/risk factors, not symptoms
- Good practice to mention the billing code description
- Needs to match what you *actually* did, not necessarily what you planned to do.

Purpose Examples

P - (Purpose): Crisis Stabilization Services to decrease Andrea's risk of suicide due to symptoms of PTSD.

P - (Purpose): Crisis Stabilization Services to maintain client safety while finding hospital placement for Bill, whose symptoms of Schizophrenia are causing grave disability.

P - (Purpose): Assessment to determine if Corinne qualifies for CSU admission.

I – Intervention

- "What **I** did"
- Should be heavy on the verbs: *Provided, helped, advocated, assessed, gathered information, reviewed*
- Needs to be centered on treatment of mental-health condition and the impairments/risk factors caused by its symptoms, and appropriate to the procedure code
- No client responses in this section

Intervention Examples

I – (Intervention): Discussed Andrea's suicide attempt and started to develop safety plan.

I – (Intervention): Called Marin General to ask about any available beds. Advocated for Bill with social worker, despite Bill's previous unsuccessful hospitalizations at Marin General.

I – (Intervention): Completed CSU Assessment for Corinne, including current symptoms, psychosocial history, substance use, risk behaviors, diagnosis, and disposition.

R – Response

- How the client responded to the above interventions
- Include objective description of client's presentation, response, and progress in terms of functional impairments/risk factors
- Attribute all quotations
- Limit background information. Focus on response to *this* intervention.
- No clinician interventions in this section

Response Examples

R – (Response): Andrea was pleasant and made more eye contact than last night. She reported feeling less suicidal and had a clear plan to keep herself safe. Because of her current psychiatric fragility and recent suicide attempt, she continues to meet CSU criteria.

R – (Response): Marin General social worker was hesitant to accept Bill given previous hospitalizations. She said to send in a referral packet and she would discuss it with her supervisor.

R – (Response): Corinne has a primary diagnosis of Amphetamine-Type Substance Use Disorder, Moderate, which means she does not qualify for CSU services.

PL – (Plan)

- What's the next step, based on client's response to this intervention?

- Document any clinical decision-making, *especially* if the response to the intervention was negative.

Plan Examples

PL – (Plan): Andrea will remain at CSU until morning shift, when she will be re-evaluated.

PL – (Plan): Clinician will complete referral packet for Marin General. Client will remain at CSU while awaiting hospital placement.

PL – (Plan): Due to her current unstable behavior and homelessness, Corinne will remain at CSU until it is safer to discharge her.

What If the Client's Asleep or Otherwise OK?

Talk about why it's not clinically ok to discharge them yet.

- P – (Purpose): Crisis Stabilization to address Andrea's suicidal behavior due to symptoms of Major Depressive Disorder.
- I – (Intervention): Checked on Andrea to determine if she was safe.
- R – (Response): Andrea is currently sleeping.
- PL – (Plan): Andrea to remain at CSU through the night to ensure her safety. Wil be reassessed at morning shift.

- Documenting "suicidal behavior" as the reason she's at CSU establishes medical necessity for the service.
- Documenting "to remain at CSU through the night to ensure her safety" establishes that she *continues* to meet medical necessity criteria, or that she must be re-evaluated before determining she does not.

All the parts of the note should flow together:

- **Purpose:** Here's the **clinical reason** I did what I did

- **Intervention:** Here's what I did

- **Response:** Here's how the client responded to what I did

- **Plan:** Here's what we'll do next

Miscellaneous Stuff

- Use the client's name
- Don't use other clients' names
- Identify support people by relationship ("father," "neighbor"), not by name, unless absolutely necessary
- It's ok to name professional support people (hospital social workers, therapists, etc.)
- Abbreviations and acronyms are often confusing
- Write one note per client per shift

Progress Notes: Claiming for Services

- Bill the exact number of minutes a service took, including documentation
- Prorate time if providing service to more than one client
- Divide documentation for services provided on separate days into separate notes
- “Face to Face” time is in-person contact with the client or family, not phone contact or time face-to-face with anyone other than client or family
- Chart review in preparation for a billable service is billable & considered part of the billable service
  - Add the chart review time to the “non face-to-face time”
  - Include “Reviewed chart” as part of the intervention

There aren’t any “tricks”

- Write down what you did and why you did it.
- Use the procedure code that best fits what you did.
- Remember that you are part of the treatment team! Talk about the *treatment* you provided.
- “Connect the dots” to show a reviewer that the service was medically necessary, but don’t make them drown in jargon or “clinical-ese.”

TimeSaver Coding

- 60 General Administration
- 70 Direct Client Care
- 68 Quality Assurance & Utilization Review
  - Training, being trained on, or developing trainings on Medi-Cal requirements
  - Attending QIS
  - Auditing/QA/peer review of charts
  - NOABDs
  - Grievances
  - Sentinel Event reporting
  - This training!

Respectful Language & Cultural Considerations

Recovery-Oriented and Respectful Language

- Our job is to help people learn skills and develop supports to get better, not to judge them
- Remember that unconditional positive regard is a vital element of mental healthcare
- Clients are people, not diagnoses (e.g., “She’s a borderline” vs. “She has a diagnosis of Borderline Personality Disorder”)
- Overly clinical and jargon-y language impedes communication
- What does “high-functioning” or “decompensating” actually mean?
- How will your reader know?

Example Language

From *Recovery Oriented Language Guide 2nd Ed.,* Mental Health Coordinating Council 2018

Language of Acceptance, Hope, Respect & Uniqueness	Worn-out words
• Kylie is having a rough time • Kylie is having difficulty with her recommended medication • Kylie's medication is not helping her • Kylie is experiencing unwanted effects of her medication • Kylie disagrees with her diagnosis • Kylie is experiencing …	• Kylie is decompensating • Kylie is treatment resistant • Kylie is uncooperative • Kylie doesn't accept she is mentally ill • Kylie has no insight

Example Language

From *Recovery Oriented Language Guide 2nd Ed.,* Mental Health Coordinating Council 2018

Language of Acceptance, Hope, Respect & Uniqueness	Worn-out words
• Sam is trying really hard to self-advocate and get his needs met • Sam may need to work on more effective ways of getting his needs met	• Sam is manipulative, irritable • Sam is demanding and unreasonable • Sam has challenging or complex behaviors • Sam is dependent
• Kylie is choosing not to… • Kylie would rather look for other options	• Kylie is non-compliant • Kylie has a history of non-compliance

Particular Documentation Concerns for LGBTQIA+ Clients

- Name in “Admission (Outpatient)” form must match Medi-Cal card

BUT!

- Use the name, gender, and pronouns the client uses in your written documentation.

- Be careful making assumptions about a client’s gender, pronouns, sexual orientation (or any other qualities!). “Samantha was previously married to a man” does not mean “Samantha is straight.”

Culturally Responsive Documentation

- Be aware of your own social position and how that may be shaping your response to clients
- Clinical language and models of “health” often pathologize historically marginalized populations and healing practices
- Mainstream white American culture often emphasizes independence at the expense of family, results at the expense of relationships, “being nice” at the expense of discussing problems
- Stay aware of your own social position, especially on axes where you hold more power – and remember that simply by being a “provider,” you hold power over clients (especially if they’re on a hold!)
- If your client holds more power than you on certain axes, please don’t feel you are required to suffer slurs, harassment, or other serious abuse. Talk to your manager/supervisor about possible options.

Questions?

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