Behavioral Health Compliance Office
Compliance Corner

Department of
Public Health
Office of Compliance &
Privacy Affairs (OCPA)

December 2019

COMPLIANCE

Introducing MD-App effective January 2020

What is MD-App?

MD-App is a new, secure online application that will allow providers to log on and submit their Credentialing/Certification and Verification Applications electronically from anywhere.

MD-App is effective Jan 1, 2020!

Benefits of MD-App includes:

- Applicants can login, modify, and submit applications online from anywhere using the web browser on their computer, laptop, iPhone, iPad, or Android phone/tablet

- Documents can be uploaded and signed electronically using DocuSign

- MD-App includes built-in lookup tables and reference addresses that will minimize the time needed to fill out the application. This will also expedite the application process and reduce errors.

Starting January 1, 2020:

MD-App will replace the following paper applications:

- Certification and Verification for Avatar Staff ID (Licensed/ Waivered/ Registered/ Certified Staff)

- Certification and Verification for Avatar Staff ID (Attestation for Non-Licensed Staff)

All new providers who are licensed, waivered, registered and/or certified must complete an Online Credentialing Application along with any required documents using MD-App.

All new non-credentialed providers and Avatar users must complete an online Certification and Verification Application (Attestation Non-Licensed Staff) using MD-App.

Here are the steps for All NEW Staff applying for Staff ID for the first time:

1. Submit your Avatar Account Request form.
2. You will receive an email with link to the appropriate application from noreply@mdstaff.com
3. You will need to create a new password following the instructions in the email.

What about existing providers? Will they need to be credentialed?
For **existing providers** to become credentialed for the first time, the Compliance Office will reach out to each program starting in January 2020 to provide them with a list of staff who requires Full Credentialing. This process will be done by programs in alphabetical order starting with civil service programs followed by contracted programs.

What fields will need to be completed in the MD-App?

➢ Personal information (name, DOB, degree, gender, etc.)
➢ Program/Agency Information (including your Supervisor name, phone, and email address)
➢ License/ Registration Information (Your current license number, issue date, expiration date, issuing state)
➢ For MD & NPs- List current DEA registration number(s)
➢ For LPHAs- Education (Graduate School contact details & provider details)
➢ For LPHAs- Employment Information (resume in lieu of is acceptable)
➢ Electronic Signatures via DocuSign

TIP: If you cannot complete the application in one sitting, you can always save the application as a draft and come back at a later time to complete it.

FAQs for MD-App

1) How do I login into MD-App?

You should have received an email with a link to create your password. If not, contact the facility you are applying to and they will resend the email.

2) How do I upload scanned documents or files?

When logged into MD-App / Edit Application there is a section called Files or Upload Files (or similar) on the navigation bar (left hand side). Click on that and you can begin to upload files.

3) How Do I Use DocuSign?

Go to the section called "Documents to Sign" on the application page. Click on the sign button and type in full name select the "I acknowledge checkbox". Click **CONTINUE** to begin the signing process.

4) How do I submit my application?

After you enter and upload the proper information there will be a formal submission button on bottom of the application - click that to complete the submission process.

5) Why can't I submit my application/ Submit button won't click?

Confirm all fields have been filled in, look for red items in the menu on the left, etc.

6) How long would this new credentialing/ verification process take with MD-App?

The whole process (including obtaining an Avatar Staff ID number for new providers) will take approximately 10 business days.

> **Questions can be directed to:**
>
> Felicia Davis (415) 255-3786 Felicia.Davis@sfdph.org and
>
> Carla Love (415) 255-3406 Carla.Love@sfdph.org

DO NOT USE

AFTER

Dec. 31, 2019

Reference: SUD Desk Reference Guide April 2019. Shortcut link: ***tiny.cc/SUDref***

Narcotic Treatment Plan/ Methadone Maintenance Programs

1. **Circle One: (The ASAM LOC form/ Physical Exam/ An Initial Treatment Plan**) should be completed to generate continuing services justification.

2. **Circle One:** Progress notes documentation for NTP Counseling- a minimum of **(15 / 30 / 50)** minutes of counseling must be provided for each calendar month of treatment and shall not exceed **(120 / 180 / 200)** minutes.

3. **Circle One:** NTP progress notes must be completed within **(5 / 14 / 28)** calendar days of counseling session by counselor conducting session.

4. **Circle One:** NTP Dosing- A MD should review the client's dosage level every **(1 month / 3 months / 6 months/ 12 months).**

Outpatient/Intensive Outpatient Treatment and Residential (OS/ IOT/ RES)

5. **Circle One:** The client's diagnosis must be made within **(5 days / 14 days / 30 days)** of the client's admission, and AFTER the client's assessment.

6. **True or False:** The ASAM Placement can be completed by a counselor and co-signed by a LPHA.

7. **True or False:** The indicated level of care on the ASAM Placement must be supported by the severity ratings in each of the dimensions and document client-specific facts cited in each dimension.

(OS/ IOT/ RES) Documentation Timing

8. **Circle One:** On the treatment plan, both the client and LPHA signature must be within **(5 days / 15 days / 30 days.)**

9. **Circle One:** For OS and IOT programs, if the client will be in treatment for more than **(three months / six months / one year)**, then a LPHA reevaluation of medical necessity for the client and document that the services would be clinically appropriate between five and six months.

10. **Circle One:** All case management progress notes must be completed, signed and dated with **(5 business days/ 5 calendar days/ 7 calendar days.)**

GENERAL

11. **Which two of the following are non-billable residential services?**

- Intake
- Individual & Group counseling
- Collateral services
- Staff breaks during treatment services
- Crisis intervention services
- Treatment planning

- Discharge services
- Appointment reminder
- Transportation services
- Patient education
- Family therapy

Source: DHCS AOD Certification Standards
https://www.dhcs.ca.gov/Documents/DHCS_AOD_Certification_Standards_1.pdf

All Substance Use Disorder programs must have policies in order to demonstrate that they are in compliance with the various laws, regulation, and guidance that apply with them. Even if your program's practices conform to these rules, auditors will generally not be satisfied if the policy is not written down.

Some necessary policies are dictated by DHCS, but the Medical Director and other executive staff must determine what other policies are required. DHCS's "Alcohol and/or Other Drug Program Certification Standards" requires that certified SUD programs have policies regarding the following:

• Admission and Readmission	• Intake
• Discharge	• Individual and group sessions
• Alumni involvement	• Use of volunteers
• Recreational activities	• Detoxification services, if applicable
• Program administration	• Personnel policies
• Client grievances/complaints	• Fiscal practices
• Continuous quality management	• Client rights
• Confidentiality	• Community relations
• Use of prescribed medications by clients	• Maintenance and disposal of client files
• Drug screening	• Client code of conduct

• Staff code of conduct as specified in the DHCS AOD Standards

• Maintenance of program in a clean, safe, and sanitary physical environment

• Nondiscrimination in provision of employment and services

A program will need more policies than these, but these are the minimum required by the state. Program Medical Directors should consider what medical policies your program requires, and draft those accordingly. Policies should also be updated when necessary, and regularly reauthorized in order to ensure that policies are still reflective of current practices.

Finally, policies are only any good if employees know and use them. Supervisors should ensure that all employees know the policies that apply to them, and know where to find the most recent versions of your program's policies.

Answers to the SUD Quiz

1. ASAM LOC form   2. 50 mins; 200 mins   3. 14 calendar days   4. 3 months
2. 30 days   6. True   7. True
8. 30 days   9. Six months   10. 7 calendar days
11. Staff breaks during treatment services. Appointment reminder services.

Progress notes are used to record the services that result in claims (billings), and are confidential and protected legal documents. When you write a billable progress note, you are submitting a bill to State and Federal agencies. Progress notes are also the communication tool used by and between providers to inform about the client's treatment and provide a means for measuring and monitoring the client's "progress." Therefore, all progress notes must be accurate and factual, and regulatory and clinical standards for the documentation of services must be followed.

COMPLIANCE REQUIREMENTS

The MHP (Mental Health Plan) Contract requires that progress notes include the following:

1. Relevant aspects of client care including documentation of medical necessity
2. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternate approaches for future interventions
3. Specific interventions applied and client's response to the interventions
4. Location of the interventions
5. Date the services were provided
6. The amount of time taken to provide services
7. Documentation of referrals to community resources and other agencies, when appropriate
8. Documentation of follow-up care, or as appropriate, a discharge summary
9. Signature of provider (or electronic equivalent) including professional degree, licensure, or job title
10. The date the documentation was entered into the client record

Source: SF MHP (Mental Health Plan Contract)

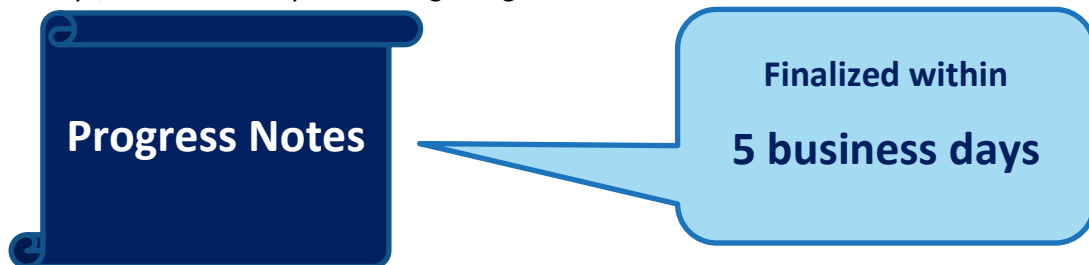| AVATAR FIELDS |
| --- |
| 1. Service Date |
| 2. Service Code |
| 3. Location/ Place of Service |
| 4. Total Time in Minutes (FTF Doc/ Travel) |
| 5. Practitioner electronic signature including professional degree, licensure or job title |
| 6. Language used for services if other than English; indicate if an interpreter is used |
| 7. Service program |
| 8. Note type |
| 9. Status |
| 10. Finalized Date |

Frequency of Progress Notes

Progress notes shall be documented at the frequency by type of service indicated below:

Every Service Contact	Mental Health Services: individual therapy, group therapy, assessment, plan development, individual rehab, group rehab, collateral
	Medication Support Services
	Crisis Intervention
	Targeted Case Management; or Intensive Care Coordination
Daily	Crisis Residential
	Crisis Stabilization (1x/ 23 hr.)
	Day Treatment Intensive
Weekly	Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service
	Day Rehabilitation
	Adult Residential

Source: SF MHP Contract

PROGRESS NOTE TIMELINE

Progress notes must be completed in a timely manner according to the following guidelines.

- Every effort should be made to complete the progress notes on the same day as the session.
- Individual notes must be finalized within 5 business days from the date of service.
- Group Notes must be finalized within 5 business days from the date of service. For group notes billing, staff must make sure that there is a group note and an individual note for each client in the group.
- Co-sign Notes must be finalized within 5 business days from the date of service. If the supervisor is not available, interns/staff must coordinate with the program director or other designated supervisors for reviewing notes and other clinical documents for co-signature.
- After 5 business days, label "late entry" at the beginning of the note.

Progress Notes

Finalized within 5 business days

Source: 2017 BHS Documentation Manual, Shortcut Link: tiny.cc/MHref

PROGRESS NOTE CONTENT/ MEDICAL NECESSITY

It is not enough to document that you have seen a client. A progress note must accurately represent the service provided/ claimed. Each progress note needs to justify the service provided and must meet medical necessity. Medical necessity is established by ensuring that documented interventions meet the following two criteria:

1. The focus of the intervention is to address the identified **functional impairment(s)** which are as a result of an "included diagnosis," and

2. Documentation must include the **specific intervention** that was provided, how the intervention provided reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the client plan, and the beneficiary's response to the intervention.

   The interventions should be described in such a way that a reviewer reading the note would be able to determine whether the interventions were clinically appropriate to the impairments and whether there was a reasonable likelihood that the interventions would **reduce those impairments, restore functioning, prevent deterioration, or allow developmental progress as appropriate**.

Source: DHCS MHSUDS Info Notice 17-040

WHEN YOU WRITE A PROGRESS NOTE, ASK YOURSELF:

➢ **What did I do?**

➢ **What was the purpose of what I did?**

➢ **Why was the service provided?**

➢ **What benefits was provided to the client?**

➢ **Does the service/ intervention match an objective on the TPOC?**

➢ **How did the intervention help the client improve support or maintain an important area of life function?**

THE BILLING PROCESS

Deliver the service → **Document Service in Progress Note** → **Use Correct Code to Support Service** → **Bill the Service Code**

PROGRESS NOTE FORMAT

All progress notes should stand alone as support for the service provided/ claimed. SF BHS has adopted the P-I-R-P format which enables service providers to utilize progress notes as a communication tool that will provide a clear picture of services and client status. **P-I-R-P** is an acronym for:

Problem (in that session)	**The Problem:** Use a clear and complete notation or description regarding the client's current complaint(s), condition(s), assessment of client and/or reason(s) presented during the session. Use behavioral terms, and include an assessment of the client. This is not a statement of diagnosis but rather a statement of why this session is necessary. • Is progress being made? • Any remaining impairments? • Is the diagnosis still valid?
Intervention (provided by staff)	**The Intervention:** Use descriptive sentence(s) about staff's interventions (what you did). Identify skills used to cope/ adapt/ respond/ problem solve. Reinforce new behaviors and strengths. Identify specific skills that are taught/ modeled/ practiced. The intervention elements of the progress note shall describe the following: • Clinician's interventions • Clinician's assessment, including a risk assessment when applicable • Document advice/ recommendations given to client/ family
Response (of the client in that session, and to the interventions)	**The Response** of the Client to Staff Intervention: Use descriptive sentences about the client's response to the staff's intervention; describe the response to the intervention in behavioral terms and include the client's progress or lack of progress. Intermittently document the client's progress or lack of progress towards the Plan of Care goals. The Response may also include a description of other significant changes in client status. Any new assessment findings? If there is a lack of improvement: • Explain the reason for the lack of improvement • Obtain a consultation, if needed, to verify the diagnosis or treatment plan • Explain the need for additional treatment due to Medical Necessity • Include outcome measures in documentation, as appropriate
Plan (Next appointment, homework, assignments, clinical decisions, collateral, referrals, etc.)	**The Plan** component outlines clinical decisions regarding the POC, collateral contact, referrals to be made, follow-up terms, homework assignments, treatment meetings to be convened, etc… Any referrals to community resources and other agencies when appropriate, and any follow-up appointments may also be included. • Are new goals needed? • Document that the treatment goals remain appropriate, or revise as needed • Consider treatment titration and plan for discharge If you have updated the treatment plan of care, goals/ objectives, or interventions, or it is part of your plan to do so, please reference your plans/ updates in the progress note.

PROGRESS NOTE DETAILS

SERVICES PROVIDED BY MULTIPLE STAFF

When two or more staff provide significant and distinct services in a single contact, each staff should write a separate note and claim separately to an appropriate to an Avatar code for the service provided by that individual staff member. To receive reimbursement for specialty mental health services where two or more providers are providing services to one or more clients, the following conditions and documentation requirements must be met:

1. Staff must be intervening at the same time.
2. A legitimate reason for multiple staff must be documented.
3. Each staff person's involvement must be documented in the context of the mental health needs of the client (nature, scope, effectiveness and duration of the interventions).
4. The exact number of minutes claimed for each staff person must be documented separately by separate claims or the same claim with time for each staff person separately indicated.
5. Signatures of each staff person providing the service (or electronic equivalent), their type of professional degree, licensure OR job title and the date the documentation was entered in the medical record.

TWO OR MORE SERVICES IN ONE CLIENT CONTACT

When two or more significant and distinct services or service types are delivered within a single contact with a client, each service must be documented in a separate progress note that meets all documentation requirements. It is not appropriate to combine multiple significant and distinct services under a single progress note that simply reflects the predominant service. The exception to this rule is "Plan Development" which may be combined with another service under the same progress note documenting a single contact with a client.

SERVICES INVOLVING TWO OR MORE PEOPLE

Define the Role of Others Involved in the Service – for example, the client's mother participated in the session.

When the Service Involves Another Professional – Use the name and role of the professional; for example, Sally Jones, Probation Officer.

When the Service Involves Another Client – Do not write a client's name in another client's chart.

When the Service Involves a Family Member or Support Persons – If needed, you may use a first name or initials of another family member. Limit what you say about family members. It is not their chart.

When the Service Involves Two or more Clients Who Are also Family Members – Write a note for each and split the time accordingly.

Source: 2017 BHS Documentation Manual

MEDICARE CLAIMING

Although the predominant payer for services provided to our adult clients remains Medi-Cal, it is critical that we are scrupulous in documenting services for clients who are insured by Medicare, or who have Medicare/Medi-Cal coverage. Accurate claiming is necessary for full compliance with State and Federal law.

Even though Medicare and Medi-Cal both utilize Federal dollars, they do not follow the same rules. Medicare will reimburse for services according to strict definitions, using a medical model that does not emphasize a rehabilitative focus. Only face-to-face time is reimbursable to Medicare. We cannot submit claims for the time spent on the telephone, documenting services, or in collaboration unless connected to a face-to-face service. The key to Medicare compliance is through the use of correct service charge codes and by accurately recording the location where services are provided.

MEDICAL RECORD CLONING

This practice involves copying and pasting previously recorded information from a prior note into a new note, which is considered misrepresentation of medical necessity. Each progress note needs to be specific to the service provided, and must contain documentation showing the differences and the needs of the client for each visit/encounter. If using a template, it must be customized for each session.

CMS Medicaid Program Integrity, EHR Fact Sheet (2015, December)

CLAIMING SERVICES BASED ON MINUTES OF TIME

1. The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.
2. When a person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.
3. The time required for documentation and travel is reimbursable when the documentation or travel is component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.
4. Plan development for Mental Health Services and Medication Support Services is reimbursable. Units of time may be billed regardless of whether there is a face-to-face or phone contact with the beneficiary.

CCR Title 9, Chap 11, Section 1840.316