Division of Behavioral Health

Clinical Documentation Requirements
Training Module Goals

1. Describe Regulation Requirements for General Clinical Record Documentation

2. Describe Specific Documentation Requirements for:
   a) AST (Alaska Screening Tool)
   b) CSR (Client Status Review and CSR Form)
   c) Professional Behavioral Health Assessments
   d) Treatment Plan
   e) Short Term Crisis Intervention / Stabilization
General Clinical Record Documentation Requirements

Community behavioral health services providers (CBHS) “must maintain a clinical record for each recipient in accordance with the standards used for the Medicaid Program” [7 AAC 70.100(a)(6)]

7 AAC 135.130 Clinical Record

• A CBHS must maintain a Clinical Record that contains the following:
  – Screening using AST
  – Client Status Review
  – Behavioral Health Assessment
  – Treatment Plan
  – Progress Notes (for each service / each day service provided)

• A Medicaid Provider must retain a Record of Service for each Recipient according to requirements noted in 7 AAC 105.230

• To Document Active Treatment A Medicaid Provider must Describe or List Active Interventions provided to a Recipient

• All changes to Assessments and Treatment Plans must be noted in the Recipient’s Clinical Record
General Clinical Record Documentation Requirements

7 AAC 105.230

• A provider shall maintain accurate records necessary to support the services for which the provider requests payment, and ensures that the provider’s staff meet the requirements of this section

• A provider’s record must identify all the following:
  – Recipient name
  – Specific services provided
  – Extent of each service provided
  – Date of service
  – Individual who provided service
General Clinical Record Documentation Requirements

7 AAC 105.230 (con’t)

• A Provider shall maintain a Clinical Record for each Recipient in accordance with professional standards applicable to the provider that includes:
  – Recipient’s diagnosis
  – Medical need for each service
  – Prescribed Service or Plan of Care
  – List of prescription drugs
  – Stop and Start Times for time-based codes
  – Case Notes of services provided signed / dated by person who provided service
Behavioral Health Screening

Alaska Screening Tool (AST)

• AST Adopted by Reference in 7 AAC 70.160.900
• A CBHS must complete the AST for each new or returning recipient of behavioral health services before a behavioral health assessment is conducted [7 AAC 135.100(a)]
• AST does NOT have to be completed for Recipients receiving:
  – SBIRT
  – Short-term Crisis Intervention / Crisis Stabilization
• AST is a Reimbursable Medicaid Service [7 AAC 145.580]
Client Status Review

The department will pay a CBHS for completing a client status review with the client present if it is used as relevant clinical information concurrent with:

1. An Initial Behavioral Health Assessment
2. CSR Conducted Every 90-135 Days
3. Discharge from Treatment [7 AAC 135.100(b)]

- Administer using the Dept. **CSR Form**
- Document by placing CSR Form in Clinical Record
- Report CSR Data to Dept.
- Use to help determine Recipient’s Level of Functioning
- Use by Directing Clinician to:
  a. Measure Treatment Outcomes
  b. Make Treatment Decisions
  c. Revise Treatment Plan
Professional Behavioral Health Assessments

If a behavioral health screening (AST), or a referral by a court or other agency, has identified an individual suspected of having a behavioral health disorder that could require behavioral health services, the Dept. will pay a CBHS for one of the following behavioral health intake assessments [7 AAC 135.110]:

1. Mental Health intake assessment
2. Substance Use intake assessment
3. Integrated MH and Substance Use intake assessment
4. Psychiatric Assessment (used as Intake Assessment)
Professional Behavioral Health Assessments

Elements of **ALL** Behavioral Health Assessments:

- Written Report
- Documentation that Results of AST were Reviewed and Considered
- Information on Functional Impairment
- Information from a concurrent, initial client status review
- Treatment Recommendations that form basis of a Treatment Plan
- Identification of Need for Recipient Support Services: Hx of Violence/Need for Vigilance & Location/Frequency of RSS
- Updates as New Information becomes available
Behavioral Health Assessments, Cont.

Mental Health Intake Assessment

• Conducted by a Mental Health Professional Clinician

• Conducted for the purpose of determining:
  – Recipient’s Mental Status, Social & Medical Histories
  – Nature & Severity of Mental Health Disorder(s)
  – Complete DSM Multi-axial Diagnosis
Behavioral Health Assessments, Cont.

Substance Use Intake Assessment

• Conducted by a Substance Use Disorder Counselor, Social Worker, or other Qualified Staff Member working within the scope of their authority, training, and job description

• Conducted to Determine:
  – If Recipient has Substance Use Disorder
  – Nature & Severity of Disorder
  – Correct Diagnosis
Integrated Mental Health and Substance Use Intake Assessment

• Conducted by a Mental Health Professional Clinician (Able to Diagnose BOTH Mental Health & Substance Use Disorders)

• Conducted for the purpose of determining:
  – All Requirements for Mental Health Intake Assessment
  – All Requirements for Substance Use Intake Assessment
Psychiatric Assessments

The department will pay a community behavioral health services provider for a psychiatric assessment that is to serve as the professional behavioral health assessment if the recipient's condition indicates the need for a more intensive assessment, including an assessment to evaluate the need for medication. [7 AAC 135.110(f)]

A psychiatric assessment must be conducted by a licensed practitioner working within the scope of their education, training, and experience, if the provider has prescriptive authority, and if the provider is enrolled under 7 AAC 120.100(c) as a dispensing provider:

- Physician
- Physician Assistant
- Advanced Nurse Practitioner
Psychiatric Assessments (Cont’)

• 2 Types of Psychiatric Assessments:
  1. Psychiatric Assessment Interview
  2. Interactive Psychiatric Assessment (uses equipment and devices)

• Both Types must include:
  – Review of Medical & Psychiatric History or Problem;
  – Relevant Recipient History;
  – Mental Status Examination;
  – Complete Multi-axial DSM Diagnosis
  – Listing of Identified Psychiatric Problems
Psychological Testing and Evaluation

Dept will pay a CBHS, or psychologist for psychological testing and evaluation to assist in the diagnosis and treatment of mental and emotional disorders [7 AAC 135.110(g)]

• Psychological testing and evaluation must be conducted by a Mental Health Professional Clinician working within the scope of their education, training, and experience.

• Psychological Testing and Evaluation includes:
  – assessment of functional capabilities
  – administration of standardized psychological tests
  – interpretation of findings.
Behavioral Health Treatment Plan

- Documented according to 7 AAC 135.130
- Based on Behavioral Health Assessment Recommendations
- Developed with Recipient or
  - Recipient’s Representative if Recipient 18 & older
  - Treatment Team if Recipient is under 18
- Supervised by Directing Clinician
- Remains current based on Client Status Review conducted every 90-135 days
Behavioral Health Treatment Plan (Cont.)

Documentation Requirements [7 AAC 135.130(a)(7)]:
• Recipient’s identifying information
• Date that Plan will be implemented
• Treatment Goals related to Assessment findings
• Services & Interventions employed to address Goals
• Frequency and Duration of Services & Interventions
• Name, Signature & Credentials of Directing Clinician
• Signature of Recipient or Recipient’s Representative
Behavioral Health Treatment Plan (Cont.)

Treatment Team for Recipient under 18 **MUST** include:

- Recipient
- Recipient’s Family Members (including parents, guardians, or others providing general oversight of Recipient)
- OCS Staff Member if Recipient in State Custody
- DJJ Staff Member if Recipient in DJJ Custody
- Directing Clinician
- Case Manager, if Recipient is SED

Treatment Team for Recipient under 18 **MAY** include:

- Representative(s) from Foster Care, Residential Child Care, or Institutional Care
- Representative(s) from Recipient's Educational System
ALL Treatment Team Members shall:

- Attend Team Meetings In-person or by Telephone
- Be involved in Team Decisions *unless:*

Clinical Record Documents –

1. Other Team Members determine that participation by Recipient or other Individual involved with Recipient care is detrimental to Recipient's well-being

2. Family Members, School District Employees, or Government Agency Employees refuse or unable to participate *after Provider's responsible efforts to encourage participation* or

3. Weather, Illness, or Other Circumstances beyond Member's control prohibits participation
Behavioral Health Treatment Plan (Cont.)

Directing Clinician

Definition 135.990(13): Substance Use Disorder Counselor or Mental Health Professional Clinician working within the scope of their education, training, and experience who, with respect to the recipient’s Treatment Plan:

1. Develops or oversees Development of Plan
2. Periodically Reviews & Revises Plan
3. Signs Plan each time Plan is changed
4. Monitors & Directs Delivery of Services identified in Plan

‘By Signing Treatment Plan, Directing Clinician Attests in their Professional Judgment that Services Prescribed are:

✓ Appropriate to Recipient’s Needs
✓ Delivered at Adequate Skill Level
✓ Achieving Treatment Goals’
Progress Notes

Requirements: [7AAC 135.130(a)(8)]

- Progress Note for Each Service / Each Day Service Provided
- Date Service was Provided
- Duration of Service Expressed in Service Units or Clock Time
- Description of “Active Treatment” Provided
- Treatment Goals that Service Targeted
- Description of Recipient’s Progress toward Treatment Goals
- Name, Signature & Credentials of Individual who Rendered Service
Short-term Crisis Intervention

Provided by a Mental Health Professional Clinician who:

1. Conducts Initial Assessment:
   a. Nature of Crisis
   b. Recipient's Mental, Emotional, & Behavioral Status
   c. Recipient's overall Functioning related to Crisis

2. Develops Crisis Intervention Plan
   a. Using Dept. Form

3. Directs ALL Services (except Pharmacologic Management Services)
Short-term Crisis Intervention

Clinician may Order & Deliver ANY *Medically Necessary and Clinically Appropriate* Behavioral Health Clinic or Rehabilitation Service or intervention to:

- ✔ Reduce Symptoms
- ✔ Prevent Harm
- ✔ Prevent further Relapse or Deterioration
- ✔ Stabilize the Recipient
Short-term Crisis Intervention

ST Crisis Intervention Plan **MUST** Contain:

• Treatment Goals derived from Assessment

• Description of *Medically Necessary and Clinically Appropriate Services*

• Documentation by Individual who Delivered Service
Short-term Crisis Stabilization

7 AAC 135.170

Provided by a Substance Use Disorder Counselor or Behavioral Health Clinical Associate who:

1. Conducts Initial Assessment of Recipient's Overall Functioning in relation to Crisis

2. Develops Short-term Crisis Stabilization Plan

3. Orders ANY Medically Necessary and Clinically Appropriate Rehabilitation Service to:
   a. Return Recipient to Level of Functioning before Crisis Occurred

4. Documents Assessment, Stabilization Plan, and Services on Dept. Form
Short-term Crisis Stabilization

ST Crisis Stabilization includes:
✓ Individual or Family Counseling
✓ Individual or Family Training & Education related to Crisis and Preventing Future Crisis
✓ Monitoring Recipient for Safety Purposes
✓ Any other Rehab Service

ST Crisis Stabilization May be Provided:
☐ Any Appropriate Outpatient or Community Setting
  ➢ Premises of CBHS
  ➢ Crisis Respite Facility
  ➢ Recipient’s Residence, Workplace or School

Documented by Individual who Provides the Service