

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

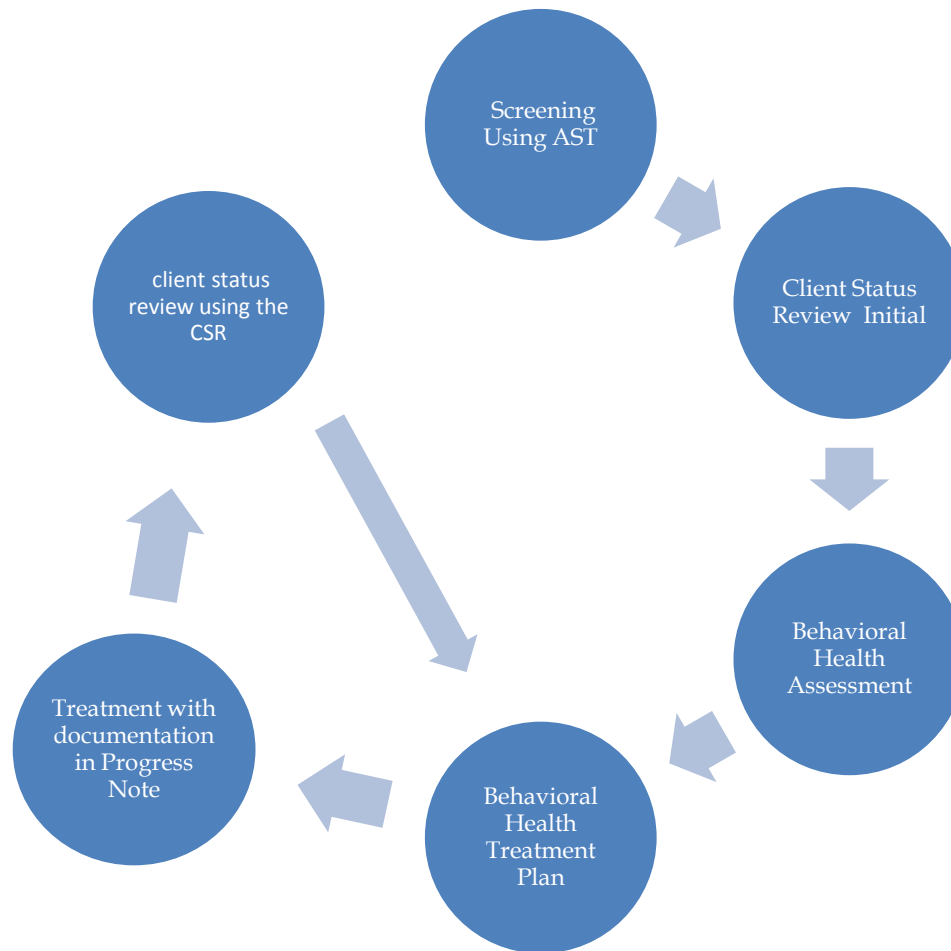
- A provider shall maintain accurate records necessary to support the services for which the provider requests payment, and ensures that the provider's staff meet the requirements of this section
- A provider's record must identify all the following:
 - Recipient name
 - Specific services provided
 - 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

Flow of Treatment



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

Behavioral Health Assessments, Cont.

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

Behavioral Health Assessments, Cont.

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

Behavioral Health Assessments, Cont.

Psychiatric Assessments (Con't)

- 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

Behavioral Health Treatment Plan (Cont.)

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
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- 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