Medicaid Documentation Standards for providers with a Certificate of Approval

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Based on the 410 and 309 Oregon Administrative Rules (OARs).
For contracted providers that hold a Certificate of Approval with the state.
Applying this checklist to your client charts can help make sure your documents are aligned with the OARs.

General information for the overall chart

Treatment, as defined in the Oregon Administrative Rules is, "the planned, individualized program of medical, psychological, and rehabilitative procedures, experiences, and activities meant to remediate symptoms of a DSM-5-TR diagnosis." 309-019-0105

- [ ] Client charts need to fully support the services that are billed.
  - [ ] The service notes and claims need to match (example: date, length of service, place of service, units of service, provider, etc.).
  - [ ] The services and documentation meet the criteria for medically necessary and medically appropriate services.
  - [ ] The services are provided and documented in a way that is consistent with the needs of the client documented in the assessment and with the service plan.
- [ ] The information in the client record meets the following standards:
  - [ ] Professional standards (examples: professional ethics, licensing standards, DSM, 5-TR, etc.).
  - [ ] Oregon Administrative Rules (OARs) relevant to the type of services being provided.
  - [ ] Contracts relevant to the agency and provider of services (examples: Oregon State Medicaid Plan, Coordinated Care Organization (CCO) contract, agency specific contracts).
- [ ] Services that are medically necessary are described as a health service required for a client to address one or more of the following:
  - [ ] The prevention, diagnosis, or treatment of a condition or disorder that results in behavioral health impairments or a disability.
  - [ ] The ability to achieve age-appropriate growth and development.
  - [ ] The ability for a client to attain, maintain, or regain independence in self-care, ability to perform activities of daily living, or improve health status.
  - [ ] They are also medically appropriate.
- [ ] Services that are medically appropriate are:
  - [ ] Services and supports that are needed to diagnose, stabilize, care for, and treat the client's behavioral health condition.
  - [ ] Rendered by a provider who has the training, credentials or license that is appropriate to treat the condition and deliver the service.
  - [ ] Based on the standards of evidenced-based practice and good health practice.
    Services provided are safe, effective, appropriate, and consistent with the diagnosis found in the behavioral health assessment.

- [ ] Connected to the service plan, which is individualized to the client. The services are also appropriate to achieve the specific and measurable goals that are written in the client's service plan.
- [ ] Not supplied only for the convenience or preference of the client, the client's family, or the provider of the service (this includes the frequency of the service).
- [ ] Not provided only for recreational purposes.
- [ ] Not provided only for research and data collection.
- [ ] Not provided only for meeting a legal requirement placed on the client.
- [ ] The most cost effective of the covered services that can be safely and effectively provided to the client (example: the client is placed at an appropriate level of care).

Assessment

As defined in the OARs as "the process of obtaining sufficient information through a face-to-face [in person or telehealth] interview to determine a diagnosis and to plan individualized services and supports." 309-019-0105

- [ ] Documentation that the assessment process began, was updated, or was completed at the time of entry.
  - [ ] Documentation was signed by a qualified program staff.
    Note: Qualified program staff are defined in 309-019-0125(12), and hold at least a QMHP
  - [ ] Documentation included any client presentation or circumstances that impacted ability to complete the above (if applicable)

- [ ] Each assessment must provide clinically relevant information, or documented review of past records that contain, at minimum:
  - [ ] Minimally sufficient information and documentation to justify a DSM-5-TR diagnosis that is the medically necessary reason for services. This includes documenting each DSM-5-TR criteria recognized per diagnosis, and the symptoms supporting each criterion.
    - [ ] If a DSM-5-TR diagnosis cannot be initially identified, ICD-10 "Z," "V," or "R," codes may be utilized to document initial diagnostic impressions for up to 90 days of initial service.
    - [ ] If applicable, "Z," "V," or "R," code was updated within 90-day timeframe.
  - [ ] The assessment documents the client's need for services, including functional impairments (how symptoms affect the client's daily functioning).
  - [ ] It is reflective of the client's strengths and preferences.
  - [ ] Screening for the presence of suicide risk and interventions.
    - [ ] Documentation of the decision regarding need for follow-up actions, additional services and supports, and the level of risk to the client and others.
    - [ ] The record (either assessment, service plan, or other document) includes a safety plan when the assessment indicates risk to the health and safety of the individual or to others and is updated as circumstances change.
    - [ ] For updated assessments, or for individuals returning in less than one calendar year, collateral information such as previous assessments can be used to inform the current assessment. Immediate risk screening must be verified in the initial assessment interview.

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- [ ] The assessment process takes less than 90 days. The assessment is considered comprehensive and complete when the following is documented as a part of the assessment within 90 days of the initial service:
  - [ ] Symptoms related to psychological trauma.
  - [ ] Symptoms related to physical trauma.
  - [ ] Current suicide risk.
  - [ ] Current substance use.
  - [ ] Current problem gambling behavior.
  - [ ] Current mental health conditions.
  - [ ] Additional and sufficient historical, biological, psychological, and social information relevant to planning services.
  - [ ] When indicated, documentation must contain recommendations for further assessment, planning, and intervention from an appropriate professional, either with the same provider or a collaborative community provider.
- [ ] The assessment is culturally and age relevant:
  - [ ] Consider reviewing the DSM-5-TR Cultural Formulation Interview and the National Culturally and Linguistically Appropriate Services Standards.
  - [ ] Consider reviewing the DSM-5-TR supplementary modules for specific populations, such as children, adolescents, and adults.
- [ ] The assessment is updated as needed.
  - [ ] The assessment is updated when there are changes to clinical circumstances.
  - [ ] Clients receiving services for one or more continuous years receive at least an annual updated assessment by a QMHP.
  - [ ] Tip: Updated assessments must document the medical need for continued services. They should document progress, barriers, and updates to symptoms, risk, and personal information.
- [ ] Should medical necessity not be possible to document at entry, the following services may be provided prior to an assessment being completed for up to 30 days (or at any time during a treatment episode):
  - [ ] Care coordination
  - [ ] Peer mentoring
  - [ ] Screening
  - [ ] Crisis intervention

Service plan

As defined in the Oregon Administrative Rules is “a comprehensive plan for services and supports provided to or coordinated for an individual and their family, as applicable, that is reflective of the assessment and the intended outcome of services.” 309-019-0105

- [ ] The service plan is created with the participation of the client and their family members, as applicable. The document shows evidence of their participation.
- [ ] The service plan must be started prior to beginning treatment services, with a comprehensive plan completed no later than 90 days from the date of initial service contact.
- [ ] At minimum, each service plan must include:
  - [ ] Treatment objectives that are individualized.
  - [ ] Treatment objectives that meet the assessed needs of the individual.
  - [ ] Signatures as indicated below.

The comprehensive plan completed within 90-days must include the below requirements:

- [ ] The service plan is individualized to the client and their presenting needs.
  - [ ] It is comprehensive and designed to improve the client’s condition to the point where the client’s continued participation in services is no longer necessary.
  - [ ] It is reflective of the assessment in its most updated form.
  - [ ] It is reflective of the client’s diagnosis, and needs.
  - [ ] It addresses the areas of concern identified in the assessment that the client agrees to address.
  - [ ] It is reflective of the client’s strengths and preferences.
  - [ ] It has a specific statement outlining the intended outcome for treatment.
- [ ] The service plan has the following elements that are individualized to the client:
  - [ ] Date the service plan was created, and date the clinician signed it.
  - [ ] The client’s diagnosis.
  - [ ] The specific therapeutic and social services and supports that will be used to meet objectives (example: individual therapy, case management, peer support, etc.).
  - [ ] The expected frequency of each type of planned service or support (example: individual therapy, 60 minutes, two times per month).
  - [ ] The type of personnel that will be furnishing the services.
  - [ ] The schedule for re-evaluating the service plan.
- [ ] The service plan objectives must:
  - [ ] Be individualized.
  - [ ] Meet the assessed needs of the client.
  - [ ] Be measurable to help the client evaluate their progress.
  - [ ] Support the use of evidence-based practices and interventions appropriate to the diagnosis.

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- [ ] The service plan is completed and signed as required
  - [ ] Be started prior to rendering of treatment services by QMHP in collaboration with the client. This must also be signed by QMHP prior to rendering of treatment services
  - [ ] For MH services, a QMHP who meets the qualifications of a Clinical Supervisor shall recommend services and supports by signing the service plan within 10 business days of the start of services.
  - [ ] For MH services, a QMHP who meets the qualifications of a Clinical Supervisor shall approve the service plan at least annually for each individual receiving MH services for one or more continuous years.

Service note

As defined in the Oregon Administrative Rules, "the written record of services and supports provided, including documentation of progress toward intended outcomes consistent with the timelines stated in the service plan." 309-019-0105

- [ ] The service note connects to the service plan:
  - [ ] The note must document the specific objective(s) that the service is addressing.
  - [ ] The note must have information regarding how the objective was addressed.
  - [ ] The note includes periodic updates describing the client's progress.
- [ ] The service note has an evidence-based intervention appropriate for the diagnosis:
  - [ ] The note documents the specific evidence-based practice being used (example: Cognitive-Behavioral Therapy, Internal Family Systems, etc.)
  - [ ] The note documents the intervention/how the evidence-based practice was applied to meet the specific and measurable goals in the service plan.
- [ ] The service note documents the extent of the services provided (example: Peer Support Specialist met face to face with the client in the community for skills training). Tip: Think type of contact and setting.
- [ ] The service note has:
  - [ ] The number of services being provided (units of service).
  - [ ] The client's diagnosis.
  - [ ] Name, signature, and credentials of individual who provided the service.
  - [ ] The date on which the service was provided, as well as date of signature.
  - [ ] Specific service provided (name or CPT Code).
  - [ ] Start and stop times and duration (be exact, such as 11:01 to 11:58 AM – 57 min).

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- [ ] Service note documentation is completed, signed and dated before it is billed.

Service note (or service record) documents any decisions to transfer the client. Documentation must contain:

- [ ] The date of the transfer.
- [ ] The reason to transfer the client (to an internal or external provider).
- [ ] Referral to any follow-up services and/or other behavioral health providers.
- [ ] All outreach efforts made, as applicable.

The above information is based on OAR 410-172, 410-120, and 309-019 rules. There are additional clinical and administrative requirements outlined in the OARs, Oregon Medicaid State Plan, and CCO contract. Please see the Behavioral Health Outpatient Requirements Handout for additional information, as well as the OAR webpage for the most up to date information. If you have questions or would like more information, please contact your Metro Regional Leadership or your Provider Relations Specialist (PRS).