

**ODMHSAS and OHCA Documentation Requirements Crosswalk**

	<b>ODMHSAS- Chapter 17 &amp; ICIS</b>	<b>OHCA- Part 21 &amp; Provider Manual</b>
<p><b>Screening And Assessment</b></p>	<p><b>Screening-</b></p> <ul style="list-style-type: none"> <li>■ All consumers shall receive a face-to-face screening and the service shall be documented including:                             <ul style="list-style-type: none"> <li>■ How the consumer was welcomed and engaged, how they were assisted to identify goals and experience hope; how they received integrated screening to identify immediate and on-going needs; and how they were assisted to determine appropriateness of admission and/or to access other appropriate services.</li> </ul> </li> </ul> <p><b>Assessment-</b></p> <ul style="list-style-type: none"> <li>■ Assessments shall include:                             <ul style="list-style-type: none"> <li>■ Demographic Information</li> <li>■ Sufficient psychological-social information to develop an individualized service plan, containing, but is not limited to, all of the required areas (i.e., history of presenting problem, previous treatment, etc.)</li> </ul> </li> <li>■ ODMHSAS has two services that can be billed for screening and assessment functions:                             <ul style="list-style-type: none"> <li>■ Mental Health Evaluation and Referral- This is a process of evaluation of presenting problems which results in the referral of an individual to relevant service resources, including for Clinical Evaluation and Assessment. Services can include time spent on screening, completion of most psychological-social assessment elements and other intake related evaluation, and referral. Can not include making a diagnosis, or completing a Clinical Interpretive Summary (including treatment recommendations). This service is performed by BHRS or MHP.</li> <li>■ Clinical Evaluation and Assessment- This is a face to face formal evaluation to establish problem identification, clinical diagnosis, or diagnostic impression. This service is performed by MHP.</li> </ul> </li> <li>■ These services can be provided with what ever duration and frequency is clinically necessary.</li> </ul>	<p><b>Screening-</b> Not Applicable</p> <p><b>Assessment-</b></p> <ul style="list-style-type: none"> <li>■ Gathering and assessment of historical and current information which includes face-to-face contact with the person and/or the person’s family or other informants, or group of persons resulting in a written summary report and recommendations.</li> <li>■ All agencies must assess the medical necessity of each individual to determine the appropriate level of care.</li> <li>■ This service is performed by an LBHP or AODTP for AOD.</li> <li>■ The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in paragraph (1) of this subsection for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours.</li> <li>■ For a moderate complexity, it is two hours or more.</li> <li>■ This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency.</li> <li>■ This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.</li> </ul>

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<p><b>Integrated Service Plan / Behavioral Health Services Plan Development</b></p>	<p><b>Integrated Service Plan-</b></p> <ul style="list-style-type: none"> <li>■ The integrated service plan is developed after and based on information obtained in the mental health assessment and includes the evaluation of the assessment information by the clinician and the consumer.</li> <li>■ Performed with active participation of the consumer and a support person or advocate if requested by the consumer.</li> <li>■ In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. In addition, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.</li> <li>■ Comprehensive integrated service plan contents shall address the following: consumer strengths, needs, abilities, and preferences; identified presenting challenges, needs and diagnosis; goals for treatment with specific, measurable, attainable, realistic and time limited objectives; type and frequency of services estimated to be provided; the practitioner(s) who will be providing and responsible for each service; specific discharge criteria; description of consumer's involvement in and responses to the treatment plan and his/her signature and date; date each objective is initiated and target date for completion; and any needed referrals for services.</li> <li>■ Service plans must include dated signatures for: consumer (over age 14), parent/guardian (under age 18 or as applicable), and primary service practitioner.</li> <li>■ For adults, the service plan must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.</li> <li>■ Comprehensive integrated service plans must be completed within five (5) treatment sessions for each program service to which a consumer is admitted.</li> <li>■ Integrated Service Plan updates should occur at a minimum every 6 months during which services are provided.</li> </ul>	<p><b>Behavioral Health Services Plan Development-</b></p> <ul style="list-style-type: none"> <li>■ The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member.</li> <li>■ BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member.</li> <li>■ In the case of children under the age of 16, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.</li> <li>■ Comprehensive and integrated service plan content addresses the following: (i) member strengths, needs, abilities, and preferences; (ii) identified presenting challenges, problems, needs, and diagnosis; (iii) specific goals for the member; (iv) objectives that are specific, measurable, attainable, realistic, and time-limited (unless the individual is on a recovery maintenance/relapse prevention services plan, then objectives may be broad while the progress notes are detailed); (v) each type of service and estimated frequency to be received; (vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize; (vii) the practitioner(s) name and credentials that will be providing and responsible for each service; (viii) any needed referrals for services; (ix) specific discharge criteria; (x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; (xi) service plans are not valid until all signatures are present (signatures are required from the member, the parent/guardian when applicable, and the primary LBHP); and (xii) changes in service plans can be documented in a service plan update (low complexity) or in the progress notes until time for the update (low complexity).</li> <li>■ For adults, it is focused on recovery and achieving maximum community interaction and involvement</li> </ul>
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	<ul style="list-style-type: none"> <li>■ This service is performed by any level of service provider, with oversight from MHP. MHP must review and sign off on the treatment plan.</li> </ul>	<p>including goals for employment, independent living, volunteer work, or training.</p> <ul style="list-style-type: none"> <li>■ The Behavioral Services Plan must be completed within four sessions (up to 16 fifteen minute units).</li> <li>■ Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.</li> <li>■ This service is performed by an LBHP or AODTP for AOD.</li> </ul>
<b>Progress Notes</b>	<p><b>Progress Notes-</b></p> <ul style="list-style-type: none"> <li>■ Outpatient staff must document each visit or transaction including missed appointments.</li> <li>■ Shall chronologically describe the service provided, the consumer's response to the services provided, and the consumer's progress in treatment.</li> <li>■ Progress notes, except for in PSR programs, shall address the following:             <ol style="list-style-type: none"> <li>1) Date;</li> <li>2) Person(s) to whom services were rendered;</li> <li>3) Start and stop time for each timed treatment service;</li> <li>4) Integrated service plan needs, goals and /or objectives addressed;</li> <li>5) Type of Service provided;</li> <li>6) Progress or lack of progress made in treatment as it relates to service plan needs, goals and /or objectives;</li> <li>7) Consumer's response, and family's response when applicable, to the treatment services provided;</li> <li>8) Any new need(s), goals and/or objectives identified during the treatment service;</li> <li>9) Signature of the service provider; and</li> <li>10) Credentials of service providers.</li> </ol> </li> <li>■ Progress notes for PSR programs shall address the following:             <ol style="list-style-type: none"> <li>1) Date(s) attended during the week;</li> <li>2) Start and stop time(s) for each day attended;</li> <li>3) Specific service plan goal(s) and/or objectives addressed during the week;</li> </ol> </li> </ul>	<p><b>Progress Notes-</b></p> <ul style="list-style-type: none"> <li>■ Treatment Services must be documented by progress notes.</li> <li>■ Progress notes shall chronologically describe the services provided, the member's response to the services provided and the member's progress, or lack of, in treatment and must include the following:             <ol style="list-style-type: none"> <li>(i) Date;</li> <li>(ii) Person(s) to whom services were rendered, must be HIPAA compliant if other individuals in session are mentioned;</li> <li>(iii) Start and stop time for each timed treatment session or service;</li> <li>(iv) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or Xeroxed signatures are allowed. Electronic signatures are acceptable following OAC 317:30-3-4.1 and 317:30-3-15;</li> <li>(v) Credentials of therapist/service provider;</li> <li>(vi) Specific treatment plan problems(s), goals and/or objectives addressed;</li> <li>(vii) Services provided to address need(s), goals and/or objectives;</li> <li>(viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;</li> <li>(ix) Member (and family, when applicable) response to</li> </ol> </li> </ul>

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	<p>4) Type of skills training provided during the week;</p> <p>5) Consumer satisfaction with staff intervention(s);</p> <p>6) Progress made toward goals and objectives;</p> <p>7) Any new needed supports identified during the week;</p> <p>8) Signature of psychiatric rehabilitation practitioner; and</p> <p>9) Credentials of the psychiatric rehabilitation practitioner.</p> <ul style="list-style-type: none"> <li>■ PSR staff must maintain a daily member sign-in/sign-out record of member attendance, and shall write a progress note daily or a summary progress note weekly.</li> <li>■ Community living program staff shall complete a summary note monthly identifying the name of the person served and the day(s) the person received the service.</li> <li>■ Crisis intervention counseling services must include a description of the crisis situation and significant functional impairment.</li> </ul>	<p>the session or intervention; (what did the member do in session? What did the provider do in session?);</p> <p>(x) Any new need(s), goals and/or objectives identified during the session or service.</p> <ul style="list-style-type: none"> <li>■ In addition to the items listed in (1) of this subsection: <ul style="list-style-type: none"> <li>(A) Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment;</li> <li>(B) a list of participants for each Group rehabilitative or counseling session and facilitating BHRS, LBHP, or AODTP must be maintained; and</li> <li>(C) for medication training and support, vital signs must be recorded in the progress note, but are not required on the behavioral health services plan;</li> </ul> </li> <li>■ Progress notes for intensive outpatient behavioral health, substance abuse, or integrated BHR programs may be in the form of daily or weekly summary notes and must include the following: <ul style="list-style-type: none"> <li>(A) Curriculum sessions attended each day and/or dates attended during the week;</li> <li>(B) Start and stop times for each day attended;</li> <li>(C) Specific goal(s) and objectives addressed during the week;</li> <li>(D) Type of Skills Training provided each day and/or during the week;</li> <li>(E) Member satisfaction with staff intervention(s);</li> <li>(F) Progress, or barriers to, made toward goals, objectives;</li> <li>(G) New goal(s) or objective(s) identified;</li> <li>(H) Signature of the lead BHRS; and</li> <li>(I) Credentials of the lead BHRS.</li> </ul> </li> <li>■ Concurrent documentation between the clinician and member can be billed as part of the treatment session time, but must be documented clearly in the progress notes and signed by the member.</li> </ul>
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