# Utilization Review/Quality Management/Compliance Tip Sheet – Organizational Provider

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| **Topic:** | • **Treatment Plan Signatures**<br>• **Unplanned Services** |
| **Who is Affected:** | Contracted Organizational Providers |
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| **Who to contact for more information:** | UR/QM/Compliance 225-5170 |
| **Reference:** | Title 9, Section 1810.440(c)(2)(A)(B); DHCS Contract Exhibit A, Attachment 9, pages 4 and 5; MHSUDS Information Notice No: 17-040; Shasta County P&P "Long Term Care Client" |

## *Summary*

***The client and staff signature requirements in this tip sheet are based on regulations and Shasta County policies and procedures. Your organization may have additional requirements for client and staff signatures. If so, you must also meet the standards required by your organization.***

### A. STAFF TREATMENT PLAN SIGNATURE REQUIREMENTS:

Client treatment plans must be *signed and dated* by a licensed/registered/waivered staff (LPHA) to be a valid treatment plan. If the treatment plan is developed by a non-LPHA staff, the treatment plan must be co-signed by a LPHA. The LPHA signature date is the effective date of the treatment plan.

**Staff signature includes**: signature or electronic equivalent, the type of professional degree, licensure or job title, the relevant identification number if applicable, and the date.

Per Shasta County Treatment Plan P&P, "If the provider is not using an Electronic Health Record, the provider signature must be legible (or include printed name in addition to signature) and include professional licensure and date."

### B. EFFECTIVE DATE OF THE TREATMENT PLAN AND BILLABLE SERVICES:

**New client treatment plans become effective the date of the LPHA's signature.**

- Prior to the LPHA's signature on the treatment plan, ONLY **"Unplanned"** services may be billed. (See below for list of unplanned services.)

Annual treatment plans for continuing services: **When there is a gap between the end of the last treatment plan and the beginning of the new treatment plan, the effective date of the new treatment plan is the date of the LPHA's signature.**

- During the gap between the treatment plans, ONLY **"Unplanned"** services may be billed.

**Unplanned services include**:

1. Assessment
2. Plan Development
3. Crisis Intervention
4. Medication Support Services –

   For assessment, evaluation, or plan development; or if there is an urgent need. Urgent need for the service must be documented.
5. Targeted Case Management (TCM) and Intensive Care Coordination (ICC) –

   For assessment, plan development, and referral/linkage to help a beneficiary obtain, needed services including medical, alcohol and drug treatment, social, and educational services.

## C. CLIENT PARTICIPATION AND AGREEMENT WITH THE TREATMENT PLAN:

**Documentation of the client's participation in the development of, and agreement with, the treatment plan is REQUIRED.** Examples of documentation include:

1. Reference in the treatment plan to the client's participation in the development of and agreement with the plan;
2. A description in the medical record (e.g., in a progress note) of the client's participation in the development of and agreement with the treatment plan; or
3. The client's signature on the treatment plan.

The parent/guardian, legal representative's, or caregiver's participation must be documented if the client is too young or mentally unable to understand, participate, and agree to the treatment plan.

See Page 4 for examples of documenting client non-signature on the treatment plan.

Example progress note documenting client's participation in and agreement with the treatment plan:

- Met with client to create treatment plan. The client participated in developing their treatment plan goals and interventions; in particular, the goals for <state goals that the client gave specific input for>. The client was satisfied with the treatment plan and stated verbal agreement with the plan.

## D. CLIENT SIGNATURE REQUIREMENTS:

The signature of the client or the client's legal representative is required. Best practice is to obtain the client's signature if they are able to participate and agree to the plan even if

the legal representative's/parent's/guardian's signature is also obtained.

When the client is unavailable, refuses, is too young or is incapable of participating and agreeing to the plan, there must be a written explanation on the treatment plan of the refusal, unavailability, age or capacity.

## E. REASONS AND PROCEDURES FOR DOCUMENTING THE "CLIENT NON-SIGNATURE"

***Note**: These directions are specific to Cerner Behavioral Health electronic health record (EHR) and may not translate directly to a different EHR. You should adapt the directions to your EHR.*

1. **Client is Unavailable to Sign:**
   - **A. If the client is unavailable to sign the treatment plan** (e.g., the plan is developed over the phone, the client leaves the premises before signing it, there are technical difficulties, plan is developed in the field, etc.)
     - **i.** Choose the **"Document Client Non-Signature"** option in the EHR (or your EHR's equivalent).
     - **ii.** Document in the text box provided that **<u>the client participated and agrees to the plan</u> and that they were unavailable to sign because…** (enter reason for unavailability)**. See progress note dated…** (enter date of plan development note). See example text on page 4 (F#1, a,b,c).
   - **B.** Best practice is to obtain the client's signature at the next face to face service.
2. **Client Refuses to Sign:**
   - **A. If the client *<u>refuses</u>* to sign the treatment plan**
     - **i.** Choose the **"Document Client Non-Signature"** option in the EHR.
     - **ii.** Document clearly in the text box provided that the client participated in developing the plan, agrees to the plan, that they refused to sign and why. See example text on page 4 (F#2, a,b).
   - **B.** Best practice – subsequent interventions with the client should show that effort was made to obtain the client signature **or** why it was not pursued. For some clients, it may not be in their best interest or in the best interest of the therapeutic relationship to continue to try to obtain the client's signature. This should be documented in the record.
   - **C.** If the client **refuses to participate in developing the plan but engages in planned services and benefits from services**, that is a special situation which may require team development of a treatment plan and special documentation.
3. **Client is too young to Sign:**
   - **A. If the client is too young to participate in and agree to the plan**
     - **i.** Choose the **"Document Client Non-Signature"** option in the EHR.
     - **ii.** Document in the text box provided the reason for client non-signature (for example: client is 5 years old and too young to participate in and agree to the plan. Client's guardian/caregiver participated and agrees to the plan). See further example text on page 4 (F#3, a,b).

iii. Document the guardian's/caregiver's participation in and agreement with the treatment plan. (This may be the parent, a relative caregiver, the social worker, etc.)

iv. Obtain the guardian's/caregiver's signature on the plan.

## F. EXAMPLE TEXT FOR DOCUMENTING NON-SIGNATURE ON THE TREATMENT PLAN

**#1 – Client is unavailable to sign the treatment plan:**

a) "Client participated and agrees to the treatment plan. Client was unavailable to sign the plan due to plan being developed over the phone as noted in progress note dated <date>."

b) "Client participated and agrees to the plan. Client was unavailable to sign the plan due to an increase in mental health symptoms which caused him to leave the treatment session before signing the plan. See progress note dated <date>."

c) "Client and caregiver participated and agree to the plan. Client was unavailable to sign the plan as it was developed with the family in the field. See progress note dated <date>."

**#2 – Client refuses to sign the treatment plan:**

a) "Client participated and agrees to the plan. Client was unwilling to sign the plan because they do not believe they have a mental illness, however, client continues to participate in treatment and benefit from mental health services. See progress note dated <date>."

b) "Client participated and agrees to the plan. Client refuses to sign the plan due to severe paranoia. See progress note dated <date>."

**#3 – Client is too young to understand, participate in developing, and agree to the plan:**

a) "Client is 3 years old and too young to understand and participate in the treatment plan process and sign the plan. See progress note dated <date>."

You would only need to include information about the caregiver if they were unable to sign at that time. In that case, you would also document their non-signature. See example b below.

b) "Developed the treatment plan over the phone with the parent. Client is 3 years old and too young to participate and sign the plan. Parent was unavailable to sign due to the plan being developed over the phone. See progress note dated <date>."