QRTIPS

Health Care Agency • Behavorial Health Services • CYS Quality, Review & Training

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Useful Documentation Reminders:

- What is the protocol for making changes or additions to a current existing Client Service Plan (CSP) so that it accurately reflects the services indicated on the Master Treatment Plan (MTP)?

  Answer: Intended client services listed on the MTP, but accidentally excluded on the CSP when the assessment was initially completed, **may** be handwritten on to the CSP at a later date if necessary. The originally overlooked service **must** be listed on the CSP in order to begin billing Medi-Cal for that particular service. Every added service **must** be accompanied by the initials of both the client and the clinician, and also include the date the service was added. This will clarify when the new service can begin billing to Medi-Cal.

  Second, write a "Note to Chart" with the same date as the changes to the CSP, indicating why the service was added or amended. Alternatively, you may review the changes to the MTP or CSP with the client and document that you did so in a billable case management note.

  In Summary, you need to do ONE of the following:

  1. Add the service to the CSP, with the change initialed and dated by **both** client and clinician.

  2. Add the service to the CSP, with the change initialed by both client and clinician. Then, write a corresponding "note to chart" or a billable case management note that provides the date of the addendum and an explanation for the change.

- What does the SIROP documentation format stand for and how is it documented correctly?

  Medical Necessity Blurb (located at top of progress note): This should include the client's existing **symptoms and/or problematic behaviors**, client's DSM **diagnosis** as determined by the symptoms, and the resulting **impairments** in the client's overall functioning. Often times the impairments are overlooked, despite the fact that it is the impairments that are critical to establish "medical necessity."

  [S] Symptoms and/or problems being reported on the day of service. These can be reported by the client, parents, social worker, probation officer, rehab worker, teacher, etc. The "medical necessity" blurb at the top of the progress note does NOT take the place of this section.

  [I] Interventions provided by clinician which are intended to target the symptoms and/or problems while always addressing the client's treatment goals and milestones delineated on their CSP.

  [R] Response of all participants present in a therapy session. In individual treatment, this will illustrate how the client responded to the clinician's interventions. In family therapy, it will indicate how each participant in the session responded to interventions.

  [O] Overall progress client is currently making toward his/her treatment goals and milestones.

  [P] Plan clinician has for client's treatment and/or case management going forward.