Behavioral Health Provider Memorandum

Subject: Unified Clinical Documentation & Service Delivery Standards for Behavioral Health Providers

To: Mental Health & SUD Clinicians, Program Leadership, Compliance Teams, Outreach Staff, Billing Personnel, and Certified Peer Support Specialists
From: Compliance & Quality Improvement

Purpose:
To provide a consolidated, user-friendly training resource outlining documentation, assessment, service planning, and service delivery expectations across EOCCO and GOBHI. This memo integrates requirements from the *Initial Stabilization Service Guidance* and the *GOBHI Clinical Documentation Policy* to reduce barriers to care, support rapid access, and ensure compliance with Oregon Administrative Rules (OARs).

I. Intake Requirements

Access Expectations

- Walk-in, same-day, or electronically completed intake documents are considered best practice.
- Intake must be available without unnecessary administrative barriers.

Required Intake Documents

- Program description in the member's preferred language, including risks/benefits of services.
- Declaration for Mental Health Treatment availability.
- Individual rights information.
- Notice of Privacy Practices.
- Signed voluntary informed consent (unless emergency exceptions apply).
- Releases of information, as applicable.

Timelines for Assessment Initiation

- **Routine needs:** Begin assessment within **7 days** of completed intake documents.
- **Urgent/emergent needs:** Begin assessment within **24–48 hours**.

Screening Prior to Full Assessment

If the full assessment cannot be completed in the first encounter, a qualifying screening may be used to initiate services.

Who may complete screenings:

- **Mental Health:** LPC, LMFT, LCSW, QMHP, QMHA
- **SUD:** CADC I–III, MAC, or SUD program staff

Minimum screening elements:

- Medically necessary reason for services *or* documentation of immediate needs, safety risks, trauma impacts, and suicide risk when diagnosis cannot yet be established.
- Appropriateness for treatment.
- Suicide and safety risk.
- Immediate needs.
- Trauma identification.
- Intoxication/withdrawal symptoms (if applicable).
- Referrals to address risk or withdrawal management needs.

Interim Service Plan:

Members must receive an interim plan before any services begin.

II. Assessment Requirements

General Standards

- Assessments must be initiated at entry and completed within **90 days**.
- Must meet OAR 309-019-0135 and medical necessity requirements.
- Must be completed by qualified staff:
  - **MH:** QMHP or higher
  - **SUD:** CADC-level or higher
  - **Problem Gambling:** Certified Problem Gambling Specialist

Initial Assessment or Screening (First Encounter)

Documentation must include:

- Medically necessary reason for services supported by DSM-5-TR criteria *when possible*.

- If diagnosis cannot yet be established, documentation must include:
    - Suicide risk screening
    - Immediate needs
    - Safety risks
    - Trauma impacts
    - Appropriateness for treatment
    - Intoxication/withdrawal (if applicable)

Complete Assessment Requirements

A complete assessment (billable only when finalized) must include:

Mental Health Assessments

- Relevant biopsychosocial history.
- DSM-5-TR diagnosis with criteria and symptoms supporting each criterion.
- Suicide risk screening and interventions.
- Trauma identification.
- Current substance use (if ASAM not required).
- Problem gambling screening.
- Current MH and medical conditions, including medications.
- Recommendations for further assessment or services.

SUD / ASAM Assessments

- Multidimensional ASAM assessment.
- ASAM Level of Care determination for each dimension.
- Overall Level of Care determination with justification for discrepancies.
- Dimensional admission criteria.
- Historical and current substance-related risks.
- Severity rating for each dimension.
- Overall severity of risk.

Assessment Updates

- **MH:** Annually or with significant clinical change.
- **SUD:** At level-of-care transitions or significant change.

III. Diagnosis Requirements

- All services must meet medical necessity per OAR 410-172-0620.
- Z-codes and R-Codes may be used during initial assessment and service planning when diagnostic clarity is still developing.
- Diagnosis must be supported by documented DSM-5-TR criteria in the complete assessment.

IV. Service Planning Requirements

Timing

- Service plans must begin after the assessment (or portion thereof) and **before treatment services**, except for limited routine services.
- Any delay must be documented with rationale.

Required Elements

Service plans must:

- Reflect the most current assessment.
- Address identified needs and include a safety plan when indicated.
- Demonstrate participation and agreement of the individual/family.
- Include individualized, measurable goals with baseline data.
- Identify specific services/supports, provider qualifications, and expected frequency/amount/duration.
- Include a schedule for reevaluation.

Co-Occurring Considerations

- Address holistic needs.
- Use harm-reduction approaches when appropriate.
- Support long-term wellness.
- Align with the stage of change for both MH and SUD.

V. Services Allowed Before Completion of Service Plan

Per OAR 309-019-0140, the following may be provided prior to a completed service plan:

- Care Coordination

- Case Management
- Peer Services

No additional services may be provided until the assessment and service plan are complete.

VI. Service Note Requirements

Every service note must include:

- Specific service/support provided.
- How it relates to the service plan (or reason plan not yet completed).
- Date, start/end time, and total duration.
- Provider name, credentials, and signature.
- Setting of service.
- Progress updates (progress or lack thereof).

Notes Prior to Service Plan Completion

Must explicitly document:

- Reason the service plan is not yet complete.
- Expected completion date.
- Medical Necessity.

VII. Medical Necessity Requirements

- All services must meet OAR 410-172-0630 definitions of medically necessary and medically appropriate care.
- Payment Integrity audits will require demonstration of medical necessity for **every** service.
- Routine services provided before a service plan must still demonstrate medical necessity.

VIII. Transitions & Service Termination

Documentation must include:

- Date of transfer/termination.
- Reason for transition.
- ASAM level of care and risk severity (for SUD/co-occurring).
- Referrals to follow-up services.

- Outreach attempts per OAR requirements.

IX. Compliance & Audit Expectations

- EOCCO and GOBHI may conduct chart audits at any time.
- Providers must ensure documentation is legible, timely, and compliant with OARs.
- Services provided solely for convenience, recreation, legal requirements, or research are **not reimbursable**.

X. Alignment With EOCCO Access Goals

This unified guidance supports:

- Rapid access to behavioral health services.
- Early identification of risk.
- Person-centered engagement.
- Reduction of administrative barriers to care.