

OUTPATIENT MENTAL HEALTH CLINIC CERTIFICATION WITHDRAWAL CHECKLIST

Purpose

This checklist is intended to guide mental health outpatient clinics through voluntarily withdrawal from the state certification by identifying applicable requirements and suggested guidelines.

Background

Assembly Bill 463 and Senate Bill 246 in 2007 allowed insurance companies and Medicaid to directly reimburse licensed clinical social workers, licensed marriage and family therapists and licensed professional counselors. As a result of the legislative change, clinic owners have an option to withdraw from the state certification to begin their private practice. Some clinics may cease its entire operation, some may switch to private practices, or some may partner with other therapists to form small clinics.

Covered Entity

DHS Chapter 35 Outpatient Psychotherapy Clinic

Applicable Laws, State Regulations, and References

Wisconsin Administrative Code – DHS Chapters 35, 92, and 94
Wisconsin State Statutes – Chapters 51, 457
MPSW 20
Medicaid Provider Handbook
JCAHO Accreditation Manual
COA Accreditation Manual
CARF Accreditation Manual

Name – Clinic		Certificate Number	
Physical Address		City	State Zip Code
Mailing Address (<i>if different than the clinic's physical address</i>)		City	State Zip Code
Branch Office Address (<i>if applicable</i>)		City	State Zip Code
Telephone Number	Fax Number	E-mail Address	
SIGNATURE – Clinic Administrator		Name – Clinic Administrator (Print or type.)	Date Signed

Wis. Admin. Code	Clinic Response	Elements			
RESPONSIBILITY					
DHS 35.123(1)		<i>Identifying Information of Person Responsible for Oversight of the Transition of Clinic through State Certification Withdrawal</i>			
		Name:			
		Title:			
		Mailing Address:			
		City:	State:	Zip Code:	
		Telephone:	Fax:		
		E-mail:			
STATE CERTIFICATION WITHDRAWAL NOTIFICATION					
DHS 35.09 Applicable Accreditation Provider Manual Applicable Contract Language Medicaid Provider Certification Handbook	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinic administrator notifies the department in writing of the decision to withdraw certification no later than the effective date of change.			
		Submit a written notification to the assigned surveyor with authentic signature from the clinic administrator.			
		Indicate the certification withdrawal effective date.			
		If the clinic is accredited by JCAHO, COA, or CARF, clinic administrator notifies the appropriate personnel from the accreditation organization of the state certification withdrawal decision and the effective date.			
		If the clinic had made public announcement or advertisement (i.e., yellow pages, newspaper, business card, and web site) that the clinic is state certified, the clinic will rescind the public announcement no later than the effective date of the state certification withdrawal.			
		If the clinic withdraws the state certification prior to the certification expiration date, the clinic agrees to surrender the original certificate by mailing it back to the assigned surveyor no later than 5 days after the withdrawal date.			
		If the clinic has a contract with a county human services department, HMO, Family Care organization, department of corrections, school districts, or other agencies, the clinic administrator will inform the contracted agencies in writing of its decision to withdraw state certification no later than the effective date of certification withdrawal.			
Upon request from assigned surveyor, the clinic agrees to provide a copy of the certification withdrawal notification sent to contracted providers for verification.					
If the clinic is Medicaid Certified, clinic administrator notifies the Medicaid Provider Maintenance Section, in writing, of the state certification withdrawal and the effective date.					
CLIENT RIGHTS					
Ch. 457.04(8) and Ch. 51.61(5)(e), Wis. Stats. DHS 35.18(1)(h)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Since the certification withdrawal has been announced, did the clinic explain client rights, grievance procedure, and review the clinic's referral policy and procedure with the clients and/or guardians prior to discharge?			
		Clinic administrator notifies the client and health care agent/parent or guardian, if applicable, of any fee change the client or responsible guardian will be expected to pay for the proposed services and treatment.			

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>If the clinic ceases its own operation after the state certification withdrawal, does clinic administrator send written notification to clients and/or guardians? The written notification may include, but is not limited to, the following elements:</p> <ul style="list-style-type: none"> Reason of service termination Emergency therapy procedures Name, title, telephone number, and address of the person designated by the clinic to answer questions through the time of service termination Name, title, telephone number, and address of the person designated by the clinic to respond to referral questions after service termination
Ch. 51.62(3)(a)1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<ul style="list-style-type: none"> Records request procedure, records retention period and where records will be stored after service termination Referral policy and procedure Information to client's health care agent, parent, or guardian of their right to pursue remedies with protection and advocacy agencies

RECORDS – STORAGE AND RETENTION

DHS 92.12	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Clinical records generated by the certified clinic and other treatment records retained by the certified clinic up through the certification withdrawal date are subjected to the minimum record retention requirements under DHS 92.12(1)-(5).</p> <p>Does the clinic administrator account for all open and closed clinical records up through the certification withdrawal date?</p>
DHS 35.23(4)(b) DHS 35.23(2)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Clinic administrator ensures all treatment records remain in the custody of the clinic.</p> <p>Does the clinic designate a location to securely store current and closed clinical records to meet all conditions identified under DHS 92.12 and applicable confidentiality regulations?</p> <p>Note: Confidential records include clinical supervision or collaboration records, appointment books, billing sheets, or any document with client's identifying information.</p> <p><i>Location of Storage Area:</i></p> <p>Street Address:</p> <p>City / State / Zip Code:</p>

RECORDS - CUSTODIAN

DHS 35.23(4)(b) DHS 92.03(1)(c)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><i>Name(s) and Title(s) of the Designated Record Custodian(s):</i></p> <p>Name / Title:</p> <p>Name / Title:</p> <p>Mailing Address:</p> <p>City / State / Zip Code:</p> <p>Telephone: _____ Fax: _____</p> <p>Does the record custodian have an inventory of all closed and current records?</p>
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RECORDS – TRANSFER AND CLIENT NOTIFICATION

DHS 92.03(1)(d)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the clinic administrator display a notice prominently to notify client of the record access and request procedure?</p>
DHS 92.03(1)(d)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the notice displayed prominently and made available for inspection and copying?</p>
DHS 35.23(3)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the record custodian obtain a written authorization to disclose clinical information in a timely manner to ensure continuity of care?</p> <p>How does the clinic inform current community providers, referral sources, and new providers where client records will be stored, how they may request copies, and who will process those requests?</p>

RECORDS – PROCESSING REQUEST

	<input type="checkbox"/> Yes <input type="checkbox"/> No	If the clinic ceases its operation upon state certification withdrawal, did the clinic establish a forwarding address prior to service termination to handle written requests or correspondences received after service termination?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the new forwarding address good for at least up to 1 year?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	If business partners dissolve their partnership from forming a certified clinic and withdraw state certification to allow each partner set up his or her own private practice, does each partner follow the identified record request procedure to request clinical record according to client's authorization?

RECORDS - DISPOSITION

DHS 35.23(4)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the clinic have a written policy and procedure to oversee the disposition of clinical records?
		<i>Name and Title of Person Designated to Oversee Disposition Process:</i>
		Name:
		Title:

TRANSITION TOWARD SERVICE TERMINATION

	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have clients been informed of the emergency therapy procedures in place up until the time of service termination?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the clinic have a written transition plan which includes a timeline to complete each task in preparation for service termination?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the clinic regularly evaluate the transition plan and adjust the plan accordingly? [<i>Coordination of Alcohol, Drug Abuse, and Mental Health Services, CSAT, TAP Series #4</i>]
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the clinic solicit feedback from clients, parents, health care agents or guardians, if applicable, other resources and the community?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the clinic ensure clients who receive psychotropic medications from the clinic psychiatrist have enough refills of current medications up to their first appointment with the new physician?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the clinic ensure that operations are compliant with all applicable regulatory practices through the date of service termination?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Based on the planning process, did the clinic identify clients who may be at risk for transfer trauma? <i>Describe the resources available to clients at risk.</i> [<i>PacifiCare Behavioral Health, Inc. Provider Manual, 2000</i>]
		<i>Describe how the clinic will provide adequate staffing and necessary resources in order to provide uninterrupted services to clients through the date of service termination.</i>

DISCHARGE PLANNING

	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the clinic initiate an interdisciplinary plan of care by involving clients, parents, health care agents or guardians, and providers in the discharge planning process? [<i>The National Board for Certification in Continuity of Care Handbook, 1999</i>]
DHS 94.09(5)(b)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the clinic identify consumer needs and make necessary referrals with the consumer consent?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the clinic obtain written consent from the client and/or guardian, if applicable, prior to discharge from the clinic in order to share information to other referring agencies?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the clinic consider mental and physical health including stability and frequency, intensity, variety, and coordination of services when planning for care after discharge? [<i>Providing Continuity of Care and Referrals, Nursing School Curriculum, University of North Carolina at Chapel Hill</i>]
DHS 35.23(1)(a)4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the clinic document the date of transfer, the level of care, and the applicable criteria that are being recommended to the appropriate level of care to which the client is being transferred in the client record?
DHS 35.22(1)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a discharge summary been placed in the client's record, including recommendations regarding care after discharge, descriptions of the reasons for discharge, client's treatment status and condition at discharge, and the final evaluation of progress toward the goals set forth in the treatment plans?
DHS 35.22(2)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the discharge summary been signed and dated by the mental health professional who was primarily responsible for providing services to the client?

REFERRAL

DHS 35.23(1)(a)5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clinic administrator ensures all involved staff document outside referrals in the clinical records.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clinic administrator notifies clients, parents, or guardians and health care agents, if any, and referral sources of the decision to withdraw state certification in writing.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe the back-up process for notifying clients, parents or guardians, and health care agents if the initial contact was not successful for notification purposes.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there an opportunity for clinic staff to meet with clients, parents or guardians, and health care agents to discuss transfer concerns? Describe.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clinic administrator ensures collaboration takes place between the clinic and the contracted agencies when discharging or referring clients to other community providers in order to ensure continuity of care and treatment for clients. Describe the process.

<input type="checkbox"/> Yes <input type="checkbox"/> No		Did the clinic seek support for available resources to coordinate care for all current clients?
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Evaluating Resources. Did the clinic identify the following when evaluating available referral resources? [<i>Providing Continuity of Care and Referrals</i>, Nursing School Curriculum, University of North Carolina at Chapel Hill]</p> <ul style="list-style-type: none"> • Name, address, telephone number, hours of operation • Philosophy and values of service • Services available • Reimbursement and funding options • Wait time, distance, travel cost, cultural variables • Specialized services for people with disabilities, including visual, hearing, and physical impairments • Handicapped accessibility • Involvement with client and guardian, if applicable
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Making a Referral. Did the clinic do the following when making a referral for the clients?</p> <ul style="list-style-type: none"> • Assess and identify client needs. • Help client identify and articulate his or her needs. • Identify single vs. multiple needs of the client; select one agency or several agencies to serve the client. • Confirm ideas with client. • Discuss and negotiate service alternatives with client. • Provide inter-professional consultation.
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Connecting the Referral. Did the clinic do the following when connecting a referral for the clients? [<i>Providing Continuity of Care and Referrals</i>, Nursing School Curriculum, University of North Carolina at Chapel Hill]</p> <ul style="list-style-type: none"> • Explain client's needs to receiving agency. • Explain receiving agency to client. • Assist client in using receiving agency's resources.

REFERENCES

1. *The National Board for Certification in Continuity of Care Handbook*, 1999.
2. Joint Commissions on Accreditation of HealthCare Organization: "*Helping you Choose Quality Behavioral Health Care.*"
3. *PacifiCare Behavioral Health, Inc. Provider Manual*, 2000.
4. *Coordination of Alcohol, Drug Abuse, and Mental Health Services*, CSAT, TAP Series #4.
5. *Providing Continuity of Care and Referrals*, Nursing School Curriculum, University of North Carolina at Chapel Hill.