

CLINICAL DOCUMENTATION GUIDE

2020

Version 2.0

Updated included diagnoses



BEHAVIORAL HEALTH AND RECOVERY SERVICES

BHRS Documentation Manual v 8/25/2020

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Chapter 1. INTRODUCTION/COMPLIANCE

1.1. WHY DO WE HAVE THIS MANUAL?

As a behavioral health system, The Marin Behavioral Health and Recovery Services (BHRS) is committed to delivering client and family driven care. It is important that our service providers understand and embrace this philosophy. Client centered care has been recognized as a best practice in behavioral health. **“All services and programs designed for persons with mental disabilities should be consumer centered, in recognition of varying individual goals, diverse needs, concerns, strengths, motivations, and disabilities.”** Client centered care involves putting the consumer in the driver’s seat of the care they are receiving.

There’s a saying throughout the healthcare industry that “if it isn’t documented, it didn’t happen.” In order to give evidence that the services that BHRS provides reflect the values stated above, good documentation practices need to be followed. This manual has been developed as a resource for providers of BHRS. It outlines documentation standards and practices required within the Children, Youth and Family System of Care, Adult/Older Adult System of Care, contract providers, and Substance Use Services. It serves to ensure that providers within BHRS meet regulatory and compliance standards of competency, accuracy, and integrity in the provision and documentation of their services.

While this manual is not specific to any particular electronic medical record system, there are many specific items that refer to Clinician’s Gateway (CG). Where this is the case, it is usually stated as “In CG...”

As with any manual that incorporates policies and regulations, updates will need to be made as these policies and regulations change. When updates are distributed, please be sure to replace copies or sections that have been downloaded or printed.

Please note that this is primarily a CLINICAL documentation guide, i.e., the main focus through this manual is the clinical documentation in the medical record. There are other required documents which are more administrative. These are included in Appendix E.

Sources of Information

This Clinical Documentation Guide is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements. This manual includes information based on the following sources: Code of Federal Regulations (CFR) 45 and 42, the California Code of Regulations (CCR) Title 9, the California Department of Health Care Services’ (DHCS) Letters and Information Notices, American Health Information Management Association (AHIMA), the Marin County Behavioral Health and Recovery Services (BHRS) policies & procedures, directives, and memos; and the Quality Improvement Program’s interpretation and determination of documentation standards. Note that many policies may be titled under BHRS’ previous name, MHSUS. As policies are updated or revised, they will be renamed BHRS policies.

Suggestions and Feedback

Suggestions and feedback for enhancements, improvements, or clarifications to this manual are welcome. Please submit by using the [BHRS Clinical Documentation Guide Feedback Form](#) or by emailing Quality Improvement.

1.2. COMPLIANCE

Marin County Behavioral Health and Recovery Services (BHRS) is a county behavioral health organization (also referred to as a Mental Health Plan) that provides services to the community and then seeks reimbursement from state and federal funding sources. There are many rules associated with billing the state and federal government, thus the need for this documentation guide. In general, good ethical standards meet nearly all of the requirements. At times, there is a need to provide some guidance and clarity so staff can efficiently and effectively document for the services they provide.

BHRS has adopted a Compliance Program based on guidance and standards established by the Office of Inspector General (OIG), U.S. Department of Health and Human Services, (HHS). The OIG is primarily responsible for Medicare and Medicaid fraud investigations and provides support to the US Attorney's Office for cases which lead to prosecution. The State of California also has a Medicaid/Medicare Fraud Control Unit. Many California county behavioral health departments have already been investigated by State and Federal agencies, and in many of those counties either severe consequences known as Corporate Integrity Agreements have been imposed or fraud charges have been brought, or both. The intent of the Compliance Program is to prevent fraud and abuse at all levels through auditing and monitoring. These auditing and monitoring activities support the integrity of all health data submissions, as evidenced by accuracy, reliability, validity, and timeliness. It is the responsibility of every provider to submit a complete and accurate record of the services that they provide and to document those services in keeping with all applicable laws and regulations.

This guide reflects the current requirements for direct services reimbursed by Medi-Cal Specialty Mental Health Services (Division 1, Title 9, California Code of Regulations (CCR)) but also serves as the basis for all documentation and claiming by BHRS, regardless of payer source. All staff in County programs, contracted agencies, and contracted providers are expected to abide by the information found in this guide.

Compliance is accomplished by:

- Adherence to legal, ethical, code of conduct and best-practice standards for billing and coding, and documentation.
- Participation by all providers in proactive training and quality improvement processes.
- Providers working within their professional scope of practice.
- Having a Compliance Plan to ensure there is accountability for all BHRS, Community Programs activities and functions. This includes the accuracy of progress note documentation by defined practitioners who will select correct procedures and service location to support the documentation of services provided.

Chapter 2. GENERAL PRINCIPLES OF DOCUMENTATION AND AUTHORIZATION TIMEFRAMES

2.1. General Principles of Documentation

1. All Providers must refer and adhere to BHRIS-25, Documentation Standards for Outpatient Specialty Mental Health Services.
2. Until the EHR is completely electronic; BHRIS continues to maintain a hybrid health record system, which includes both paper-based and electronic documents. For new client admission and re-admission in Clinician's Gateway, the hybrid health record continues to include chart forms that require client's signature until signature pads and/or scanning capabilities become available system wide.
3. All Providers must use BHRIS approved forms or an approved electronic health record system for documentation. BHRIS Contract Providers must incorporate all BHRIS required documentation elements as reference in this Manual and adhere to the forms guidelines identified in MHSUS Policy 211-09.
4. Required documents include an accurate Assessment, Client Plan, and On-going Care Notes (Progress Notes). Remember that the medical records, both electronic and paper, are legal documents.
5. Only services that have been entered into CG, or for programs not using CG, services documented with progress notes, can be claimed.
6. All services shall be provided by staff within the scope of practice of the individual delivering service. Clinicians will follow specific scope of practice requirements determined by regulations, including those of the governing boards of the applicable licenses.
7. Progress notes should provide enough detail so that auditors and other service providers can easily ascertain the client's status and needs and understand why the service was provided without having to refer to previous progress notes.
8. Each progress note must show that the service was "medically necessary".

Progress notes should clearly indicate the type of service provided and how the service is medically necessary to address an identified area of impairment, and the progress (or lack of progress) in treatment.

Clinicians should document how the intervention provided relates to the clinical goals written in the client plan, addresses behavioral issues and/or links to the mental health condition written in the client plan. Remember a "medically necessary service" is one which attempts to impact a functional impairment brought about by a symptom of a covered diagnosis.

9. It is crucial that the staff providing the service records the correct procedure for the service provided and that the documentation supports and substantiates this service. In order for Marin County to receive the correct reimbursement for services provided, clinicians must ensure that they choose the correct procedure for the correct Program Facility/Program and for the correct client.
10. Primary Total Time should be noted on each progress note. Primary total time is the time spent face-to-face with client plus any administrative time (e.g., documentation time and travel time to and from site, if applicable). Please remember to bill for "actual" time spent providing the service (face-to-face and administrative) to the client. Do not bill in blocks of time (e.g., an hour for each individual therapy).

11. Timeliness of Service Documentation. Each Service contact is documented in a progress note and documentation must be finalized in a timely manner per the following guidelines.
 - A progress note is completed for each service contact. (Except for Crisis Stabilization Unit (CSU) and Crisis Residential services which have daily note requirements).
 - For group notes billing, staff must detail the purpose of the group and individualize the note for each client in the group which documents how the client participated in and benefited from the group as well as their individual response to the interventions provided during the group.
 - Every effort should be made to complete progress notes on the same day as the session.
 - Individual and Group Notes must be finalized within 72 hours or 3 business days from the date of the delivery of the service, except as follows:
 - Notes requiring Co-Signatures must be authorized by the supervisor within 10 business days from the date the note is written by the providing staff that require co-signature. Upon authorization, the staff requiring co-signature must then finalize the note so that the service can be claimed. If the supervisor is not available, the providing staff must coordinate with the program director or other designated supervisors for reviewing notes and other clinical documents for co-signature.
 - If notes are not finalized within 3 (or 10) days, the clinician must write “late entry” in the “Notes” section of the progress note. It should be documented at the beginning of the “S” portion of the formatted note (SIRP). Late entry services should **not** include documentation time when claiming.
12. Documentation must be readable and legible. Ensure that the spell check function is turned on. In Clinician’s Gateway, the “spell check function” button is located near the bottom of page. Always spell check prior to finalizing a document.
13. The use of abbreviations in clinical documentation must be consistent with approved BHRS abbreviations. (See [Appendix F](#) for a list of approved abbreviations.)
14. Restriction of Client Information: APS/CPS Reports, Incident Reports, Unusual Occurrence Forms, Grievances, Notice of Action, Utilization Review Committee recommendations or forms and audit worksheets should never be scanned into the electronic health record, or filed within the paper record or billed. Questions regarding other forms (not already listed) and their inclusion into the medical record should be directed to QA/QM staff.
15. Confidentiality: Do not write another client’s name in client’s chart. If another client must be identified in the record do not identify that individual as a behavioral health client unless necessary. Names of family members/support persons should be recorded only when needed to complete intake registration and financial documents. Otherwise, refer to the relationship - mother, husband, friend, but do not use names. May use first name or initials of another person when needed for clarification.
16. Copy and Paste: Do not copy and paste notes into a client’s medical record. Each note needs to be specific to the service provided. If using a CG template that brings forward text from the previous note, the narrative must be changed to reflect the current service being documented. Progress notes that are submitted which appear to be worded exactly like, or too similar to, previous entries may be assumed to be pasted, i.e., containing inaccurate, outdated, or false information, therefore claiming associated with these notes could be considered fraudulent.

2.2. SIGNATURES:

Clinician signature is a required part of most clinical documents. In an EHR, the signature is electronic. In order to be able to sign documents electronically, the following are required.

- Your signature must be on file in order to use the Electronic Health Record (EHR). Clinician’s Gateway maintains a file of clinician unique identifiers/signatures.

- Authentication – BHRS maintains a signed Electronic Signature Agreement for the terms of use of an electronic signature signed by both the individual requesting electronic signature authorization and the BHRS Director or designee. Electronic signatures based on login name and passwords are valid for six (6) months. Renewal of the password renews the electronic signature agreement.
- Agencies wanting to use their own electronic signatures must provide BHRS with policies and procedures on electronic signatures.

Each clinician signature must include a license or designation (e.g., ASW, MD, AMFT, LCSW, MFT, MHRS, PhD waived, etc.). Staff without a license or discipline must include a job title (e.g. Resource Counselor)

2.2.1. Co-Signatures

Co-signatures for staff may be required on documents for several reasons. The State Department of Health Care Services (DHCS) requires that some documents, e.g., client plans, be approved by a Licensed, Registered, or Waivered clinician. Additionally, County policy requires that some documents be reviewed and co-signed by a supervisor as part of the authorization process. Also, some staff are required to have progress notes co-signed for specific or indefinite periods. For example, new and reassigned staff are required to have co-signed notes for three months. Other co-signature requirements may be assigned for purposes of quality assurance and/or compliance. Staff should consult with their supervisor for additional specifics. Clinician’s Gateway enforces the requirement for Co-Signature.

2.3. ESTABLISHMENT OF SERVICE AUTHORIZATION PERIOD

The date in which the initial client’s Client Plan is finalized is considered to be the start date of the service authorization period. This date is important because it informs the service provider about the treatment cycle, annual reassessment period and helps BHRS comply with State and Federal regulations for the delivery of services.

For example: If a Client Plan is finalized on 1/19/2018. The service authorization period will be 1/19/2018-1/18/2019.

The service provider will be given cues/flags on the ongoing care note which will indicate that the authorization period will end

- 45 days prior to the end of the Authorization Period, the “plan due date” field will be highlighted in Yellow.

Plan due date: 1/18/2020

- 30 days prior to the end of the Authorization Period, the “plan due date” field will be highlighted in Red.

Plan due date: 1/18/2020

For annual Client Plans, if they are finalized prior to the end of Authorization Period, the Authorization period end date will not change (with the exception of the year).

For example: The previous Authorization Period was 1/19/2019 – 1/18/2020. The annual Client Plan was completed/finalized on 1/10/2019. The Service Authorization Period will be 1/19/2019 – 1/18/2020.

If the Client Plan was renewed/finalized after 1/18/2019, the Service Authorization period will shift and begin on the date the Renewed Client Plan was finalized.

For example: Using the Authorization Period from the previous example, the annual Client Plan was Renewed/Finalized on 1/30/2019. The new Service Authorization period would be 1/30/2019 – 1/29/2020. Any

planned service provided the “gap” (between 1/18/2019 – 1/29/2019) will be disallowed as there was no Client Plan in effect ([See lockout section for exceptions.](#))

2.4. TIMEFRAMES FOR SUBMISSION OF DOCUMENTATION FOR SERVICE AUTHORIZATION

As previously stated, staff must open an episode **prior** to providing a service. Additional documentation must be submitted within 60 days of opening if services are to continue. (See also Appendix G.)

Required forms prior to Onset of Services or at first contact:

- Admission and Discharge
- Client Profile Form
- Consent to Treatment
- Financial Responsibility Form (UMDAP - Uniform Method of Determining the Ability to Pay)
- Notice of Privacy Practices
- Advance Healthcare Directive Information
- Authorization to Exchange Protected Health Information (HIPAA Form 03-01)
- Behavior Checklists (for Children under 18)
- Family History Form (for Adult clients, if applicable)
- Consents for Medication (if applicable)

The following forms need to be completed within sixty (60) days of an initial opening for both Adult and Children’s System of Care providers or for an episode where the client was closed for services for over 180 days (6 months) and is being re-opened to services.

- Initial Clinical Assessment
- Client Plan
 - Medical Necessity Tab
 - Adult/Child Client Plan Tab
- Obtain Signature of Beneficiary (Client Plan Signature Addendum)

Note: Some clients may have had episodes of services prior to this admission from providers that were not part of the integrated plan: For example: Access Team, Contracted Network Providers, Crisis Stabilization Mobile and Triage Team.

Tip: Remember, it’s a best practice to complete the Initial Clinical Assessment within 30 days and submit with the Client Plan. That will avoid authorization gaps due to the time involved in getting co-signatures and sending a Client Plan for authorization

ADDITIONAL TREATMENT TEAM PROVIDERS

When client is opened to additional treatment teams, the on-coming service provider is responsible for ensuring the timely submission of Intake and Annual Forms for service authorization.

Prior to Onset of Services or at first contact:

- Admission and Discharge form
- Client Profile Form
- Consent to Treatment
- Financial Responsibility Form (UMDAP - Uniform Method of Determining the Ability to Pay)
- Notice of Privacy Practices
- Advance Healthcare Directive Information
- Authorization to Exchange Protected Health Information (HIPAA Form 03-01)
- Behavior Checklists (for Children under 18)
- Family History Form (for Adult clients, if applicable)
- Consents for Medication (if applicable)

The on-coming provider must complete the following within 30 days of the opening of the episode:

- Client Plan
 - Adult/Child Client Plan Tab
- Obtain Signature of Beneficiary (Client Plan Signature form/Client Plan Signature Form)
- Medication Consents (if applicable)

The service authorization period remains fixed and is based on the finalized date of the initial Client Plan.

ANNUAL RENEWAL OF SERVICES

On an annual basis, a reevaluation of the individual's status and needs must be completed in order to obtain continued authorization for services. It is good practice to review the limits of confidentiality and risks and benefits with the individual as often as clinically relevant.

When the service authorization period ends, the primary author is responsible for the completion of the Client Plan and Reassessment. The primary author is responsible for collaboration and monitors goals/objectives amongst the various service providers so that the Client Plan remains relevant to the client's current behavioral health needs.

The following will determine who the primary author is:

- All clients open to our system of care, should have a County Case Manager/Therapist who is the primary author for overseeing the renewal of the Client Plan and any required annual documents at the time of the annual renewal period.
- If client is open to Medication Only, the medication practitioner will be primary author.
- If client is not open to a County team, then the primary Organizational/Network provider becomes the primary author

The Primary Author is responsible for the completion of the following forms, which may be completed within the 30 days prior to the end of the Service Authorization period:

- Annual Clinical Re days
- Annual Client Plan:
 - In order to create the plan for the new authorization period, the "**RENEW**" option on CG should be used.
 - Review Objectives and interventions to reflect progress and note target dates. Remove any outdated treatment goals, objective, and interventions from your program only, or from any programs that the client is no longer open to, and complete corresponding progress note reflecting any changes made to existing Client Plan.

- Primary Author shall also work in collaboration with other service providers to ensure that the Client Plan is current and relevant to the care being provided.
- Primary Author: Review and Update Medical Necessity Tab to determine if current diagnosis and impairments continue to meet Medical Necessity Criteria for continued authorization.
 - Complete Change of Diagnosis form when there is a change in diagnosis.
- Obtain Signature of Beneficiary (Client Plan Signature Form)
- Authorization to Exchange Protected Health Information (if expired and needed for ongoing sharing of information with outside non-exempt entity.)
- CSI Update form
- Financial Responsibility Form

Chapter 3. ESTABLISHMENT OF MEDICAL NECESSITY

THE FLOW OF CLINICAL INFORMATION

As each client begins services with BHRS there is a flow of information designed to support staff in providing services that help the clients meet their recovery goals.



1. The Clinical Assessment is the first step toward establishing Medical Necessity and the start of services.
2. The Assessment supports staff in developing a Clinical Formulation that informs the diagnostic process.
3. The Diagnosis records the areas of need and supports Medical Necessity.
4. The Client Plan creates a framework for the services we provide. Together with clients we develop goals and planned interventions that support the clients in their recovery.
5. Each Service provided links back to an issue identified on a Client Plan through the Assessment.

Throughout the course of treatment, from Assessment to discharge, all services are based on Medical Necessity. Meaning, every service provided to the client/family is medically necessary to support the client/family in their path to recovery.

3.1. ASSESSMENT

The Assessment is more than an information gathering process. The Assessment is the first step towards building a trusting and therapeutic relationship between client and service provider. It is also an important beginning to understand and appreciate who the client is and the interrelationship between the client's symptoms/behaviors and the client as a whole person.

The initial assessment is an important first step to get a clear account of the current problems. Providers have a responsibility to fully understand the individual and family, their strengths, abilities, and past successes, along with their hopes, dreams, needs, and problems in seeking help. Attending to the issues of culture in the process of the assessment is critically important. The provider must understand how culture and social context shape an individual's and family's behavioral health symptoms, presentation, meaning and coping styles along with attitudes towards seeking help, stigma and the willingness to trust.

The assessment can be completed in one contact or over the course of several contacts.

The assessment must contain:

1. Presenting problems and relevant conditions affecting physical and mental health status (e.g. living situation, daily activities, and social support, cultural and linguistic factors and history of trauma or exposure to trauma);
2. Mental health history, previous treatments dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, and consultation reports; and
3. Physical health conditions reported by the client are prominently identified and updated;
4. Name and contact information for primary care physician;
5. Medications, dosages, dates of initial prescription and refills, and informed consent(s);
6. Past and present use of tobacco, alcohol, and caffeine, as well as, illicit, prescribed, and over-the-counter drugs.
7. Client strengths in achieving goals.
8. Special status situations and risks to client or others;
9. Allergies and adverse reactions, or lack of allergies/sensitivities;
10. Mental Status Examination (included on the psychosocial Assessment)
11. Diagnosis consistent with the presenting problems, history, mental status examination and/or other clinical data, and,
12. For children and adolescents, prenatal events, and complete developmental history, and,
13. Additional clarifying formulation information, as needed.

It is important to note the name of the Primary Care Physician (PCP) on the assessment.

Yes No Does the client have a current physician other than psychiatrist?

List name & Phone #

Date(s) last seen:

The Clinical Assessment/Reassessment found in CG is compliant with all State and Federal Regulations. However, the service provider (author) must ensure that all sections of the Clinical Assessment/Reassessment are filled out. Use the “leading questions” located next to each section header. Do not leave sections blank as this may cause a mandated section to remain unassessed and may lead to disallowances.

1. IDENTIFICATION: (e.g.: Age, gender, race/ethnicity/preferred language, sexual orientation, and other identifiers. Name any special needs such as interpreter, disabilities and accessibility issues)

Answer the “leading questions” →

(e.g.: Age, gender, race/ethnicity/preferred language, sexual orientation, and other identifiers. Name any special needs such as interpreter, disabilities and accessibility issues)

2. REASON FOR Seeking Help/Present Symptoms and Behaviors: (e.g.: Referral source, precipitating events, client's statement of what brings him/her in including current symptoms & behaviors as reported by client or significant support persons)

Answer the “leading questions” →

(e.g.: Referral source, precipitating events, client's statement of what brings him/her in including current symptoms & behaviors as reported by client or significant support persons)

TIMELINESS OF ASSESSMENTS

The assessment process needs to be completed within sixty (60) days of an initial opening for both Adult and Children's System of Care providers or for an episode where the client was closed for services for over 180 days (6 months) and is being re-opened to services.

It is strongly suggested that the Initial Clinical Assessment is completed and submitted for review and co-signature (if required) within 30 days of episode opening.

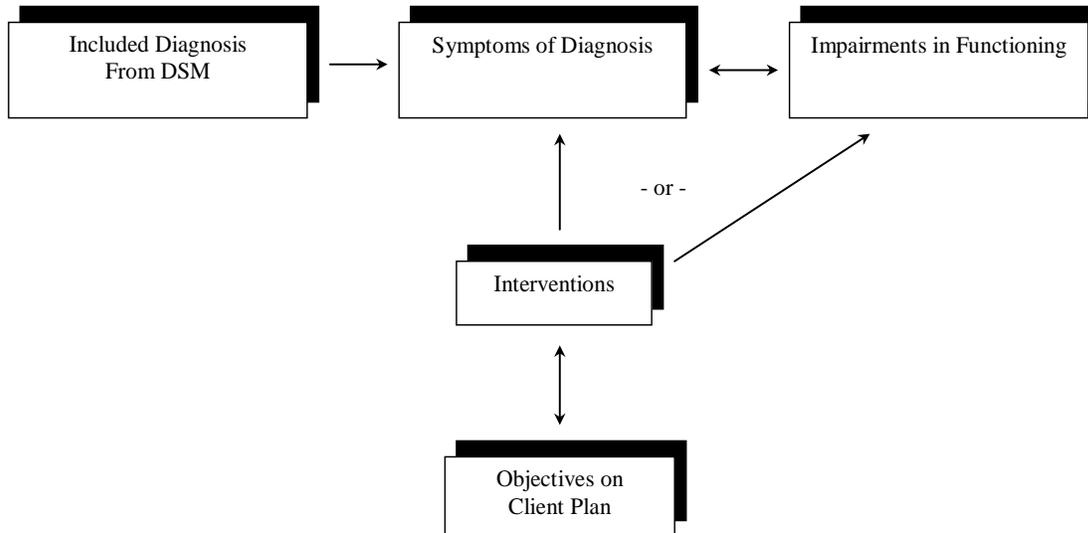
Assessment information must be updated on an annual basis. Annual Clinical Reassessments are to be completed and finalized within 30 days prior to the end of the established/current authorization period.

If a change in diagnosis occurs during the annual Clinical Reassessment, the diagnosing clinician must submit the change using the Admission and Discharge Form to update the Share Care system.

3.2. MEDICAL NECESSITY

Medical Necessity is established through the Assessment and Client Plan process. Diagnosis and identification of the client's functional impairments further strengthen and reaffirm the need for behavioral health services that support the client/family's road to recovery.

A medically necessary service is one which attempts to impact a functional impairment brought about by a symptom of an included diagnosis.



During the assessment process, the clinician should identify the client's areas of life functioning which are impacted by their behavioral health, examples found in CG are listed below:

- Problems with primary group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems

- Problems with access to healthcare services
- Problems related to interaction with legal system/crime
- Other psychological or environmental problems

Although Medical Necessity is established during the Assessment, it should permeate every service that is offered and delivered to the client/family. Ongoing reassessment and documentation of Medical Necessity is required throughout the client/family's course of treatment.

The assessment is critical for establishing the diagnostic impression and identifying functional impairments. The Client Plan takes the information gathered during the assessment process and directs the focus of services. The Client Plan also links the interventions to the impairments. The Progress Notes describe the specific service provided and establish that the service is meant to address the impairment in keeping with the Plan.

The Assessment, Client Plan and Progress Notes all work in concert to establish the presence of medical necessity and continued need for services

3.3. COMPONENTS OF MEDICAL NECESSITY

In order to be eligible for Medi-Cal reimbursement, services must meet **all three of the following criteria for Medical Necessity.**

3.3.1. **Diagnostic Criteria:** The primary diagnosis must be in the list of [Covered Diagnoses \(Appendix B\)](#) in order for the diagnostic criteria to be met. Diagnoses must be made using DSM-5.

Please note that having a diagnosis that is **not** covered does not exclude a client from receiving services, as long as they also have a **covered** diagnosis that is primary and is the focus of treatment.

Also note that practitioners are expected to list any substance related diagnosis as a secondary or tertiary diagnosis as appropriate.

3.3.2. **Impairment Criteria:** The client must have at least one of the following as a result of the mental disorder(s) identified in the diagnostic criteria:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

3.3.3. **Intervention Related Criteria:** Must meet all conditions listed below:

1. The focus of the proposed intervention is to address the condition identified in impairment criteria above, and
2. It is expected the proposed intervention will benefit the consumer by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare-based treatment.

Regarding **Autism Spectrum Disorder**: With Information Notice No.: 20-043, dated June 8, 2020 DHCS now lists Autism Spectrum Disorder, F84.0, as a covered diagnosis.

DHCS had made an exception allowing the use of DSM-IV diagnoses to differentiate between the included and excluded diagnoses within the autism spectrum. With inclusion of Autism Spectrum Disorder in the list of covered diagnoses, there is no longer a need to use DSM-IV codes to make this differentiation.

As a result, the following DSM-IV diagnoses have been removed from the list of [Covered Diagnoses \(Appendix B\)](#):

- Rett's Disorder (F84.2)
- Childhood Disintegrative Disorder (F84.3)
- Asperger's Disorder (F84.5)
- Other Pervasive Developmental Disorder (F84.8)
- Pervasive Developmental Disorder Unspecified (F84.9)

They are collapsed under the added covered DSM-5 diagnosis, Autism Spectrum Disorder, F84.0.

No Medical Necessity

It is possible that some clients will not meet Medical Necessity criteria for Specialty Mental Health Services. When this is determined, practitioners should consult with their supervisors to identify appropriate referrals. Access Team and other Points of Access providers should then complete a Notice of Adverse Benefit Determination ([NOABD](#)). A Notice of Adverse Beneficiary Determination is a written notice that gives Medi-Cal Beneficiaries an explanation when a denial or only a limited authorization is made in response to a request for services. NOABDs can also be notifications of the reduction, suspension or termination of a previously authorized service; denial of payment for a service rendered by a provider, etc., depending on the situation.

NOABDs should include the effective dates of coverage and the changes made to the level of benefits/services received. NOABD Forms will also include a "Your Rights" document about appeals, expedited appeals, timeframes, etc. should the client not agree with the decision made or determination made.

4.1. CLIENT PLAN

Key points of Client Plan documentation

1. Provides the focus of treatment
2. Contains Client's Goals, including their hopes and dreams
3. Highlights client's/family's strengths to achieve their goals.
4. Lists Objective(s) - that which is to be accomplished by the treatment
 - Needs to be "specific, observable and/or measurable".
 - Must focus on impairments which are related to an included diagnosis.
5. Identifies Intervention(s) – how the service provider intends to address the impairment (not just the modality).
 - Include the frequency and duration of the intervention
 - Needs to be consistent with the client's goals and clinical objectives
6. Is completed prior to the delivery of planned services and within 60 days of the start of service, and no less than annually thereafter.
7. Client signature documents their participation in the development of the Client Plan.
8. Clients are offered a copy of the plan and whether they accept or decline is documented.

Marin Behavioral Health and Recovery Services (BHRS) embraces the "One Client Plan" model for the delivery of services. This means that all programs, whether from BHRS programs or community partners, create treatment objectives for their specific program with the client/family in a Client Plan. If more than one program or provider is involved, these program specific objectives are coordinated into one overall Client Plan. This model helps the client understand who is providing what services and more specifically, what the expectations are for each provider.

The Client Plan, co-created by the client/family and the provider, outlines the goals, objectives, interventions and timeframes. The Plan must substantiate ongoing medical necessity by focusing on diminishing the impairment(s) and/or the prevention of deterioration that has been identified through the assessment process and the clinical formulation. The impairment(s) and/or deterioration to be addressed must be consistent with the diagnosis that is the focus of treatment. Program objectives should be consistent with the client's/family's goals as well. Strength-based and recovery oriented treatment planning is strongly encouraged.

Translating Client Goals into specific, observable/measurable objectives requires considerable skill. Usually what is involved is uncovering concrete issues, behaviors, or barriers that are preventing the client from accomplishing their goal. Following this is a discussion to frame the issue/barrier in a way that is acceptable to the client but is also meaningful in terms of focusing services. These discussions can all be claimed as Plan Development. An ideal objective is one that meets both the client's needs in working towards the goal and is specific and measurable enough to be able to chart progress.

W&I Code Sec. 5600.2. (a) (2) states (Persons with mental disabilities) "Are the central and deciding figure, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. Planning should also include family members and friends as a source of information and support."

The client's participation and understanding of all elements of the plan is essential for successful outcomes and is required by state regulations. The only exception is when a person has a legal status that removes individual decision-making power, e.g., an LPS Conservatorship.

4.1.1. CLIENT PARTICIPATION AND SIGNATURES:

1. Client participation is documented by obtaining the signature of the client/parent/guardian on the “Client Plan Signature Form” or by electronic signature on the plan. The following signatures should be present on the “Client Plan Signature Form”:
 - Client or Legal Responsible Party (if the client is under the age of 12 or is a conserved adult).
A minor can legally sign their Plan if he/she is at least 12 years old. It is encouraged that a parent/legal responsible party, i.e., CFS worker, conservator, etc. signature be obtained whenever possible. (See also section 8.1, Minor Consent.)
 - Program staff member completing the Plan;
 - All BHRS county Client Plans must be authorized by program supervisor.
 - All contractor Client Plans must be authorized by county program supervisor or designated contractor supervisor.
 - The authorization signature will also act as a co-signature for staff that need co-signatures on documentation.
2. If a client or parent/guardian refuses to sign or is unavailable to sign, the clinician completes the box on the client plan documenting the reason that the parent/guardian signature was not obtained in a timely manner. *Continue to attempt to get a signature and document these attempts in progress notes. The following signature related activities should be documented.*
 - Phone contact(s) or letters (keep a copy in the chart under correspondence)
 - Discussions between client/family and provider when the provider discusses the Client Plan goals over the phone and the parent/guardian accepts/agrees to the Client Plan goals.
 - When a copy of the Client Plan is mailed to parent/guardian for a signature along with any follow-up until the sign copy is received and filed.
3. In addition to the client’s signature as evidence of the client’s participation on the Client Plan, the service provider should document and date that they offered of a copy of the Client Plan to the client/guardian. This field is required.

4.1.2. TIMELINESS OF CLIENT PLANS

The Initial Client Plan must be completed within sixty (60) days of an admission for both Adult and Children’s System of Care providers or for an episode in which the client was closed for services for over 180 days (6 months) and is being re-opened to services:

Due to the time involved in sending a Client Plan for authorization, getting co-signatures and possibly other providers’ contribution of objectives and interventions, it is strongly suggested that the Client Plan, along with the Initial Clinical Assessment, be completed and submitted within 30 days of opening.

As previously stated, documentation of the client’s participation (client’s signature) is mandatory and must be entered into the record within the same time frames.

Client Plans must be reviewed and renewed on an annual basis. For example, the “established service authorization period” is 2/15/19 to 2/14/20, the Annual Client Plan must be finalized and signatures obtained by 2/15/19 so that there is no break in service authorization.

If there is a lapse between expiration and renewal dates, then those services covered by the plan occurring during the lapse will not be claimed, will be disallowed. It is important to avoid lapses in renewals of annual Client Plans. [See also Lockouts and Limitations.](#)

4.1.3. REVISIONS TO THE PLAN:

The Client Plan should be revised any time there is a significant development or change in the focus of treatment. Examples of significant developments may include hospitalizations, increasing risk factors or changes in level of functioning which would precipitate a new or revised objective.

Evidence that a Client Plan needs revision would be when there is an increasing disconnect between what is documented in the progress notes, and the objective that the service is supposedly linked to.

Revisions can include the addition of goals/objectives to address a new issue, or to make the plan more relevant. Revisions can also include the addition of a different treatment modality.

The Client Plan can be revised at any time during the authorization period. If this happens mid-year, the existing Client Plan can be revised by adding the new information and goal(s)/objective(s) to reflect the change in treatment. When a revised Client Plan is generated, it will generate a new CP number and a new client signature must be obtained. Client Plans can also be changed as part of the annual renewal.

4.2. COMPONENTS OF THE CLIENT PLAN

The Client Plan, as laid out in Clinician Gateway contains the following components, which reflect the elements and processes fulfill to regulatory requirements as well as facilitate good clinical practice.

Start and end dates

Goals

Strengths

Obstacles

Objectives

Interventions

Confirmation

Authorization

Client Plan Process Elements

The overall process of creating the Client Plan is outlined below and is followed by sub-sections with more specific details and examples for each component of the process. When creating a Client Plan, the service provider will:

Synthesize information gathered from the assessment and the client, to establish treatment goals.

Explore what strengths the client brings to treatment that could help achieve the goals.

Investigate with the client any potential obstacles that could prevent achievement of the goals

Formulate specific objectives based on goals, strengths, obstacles and the interventions that seem most clinically appropriate. Negotiate these so that they are acceptable to the client, appropriate clinical direction, and satisfy BHRS' requirements.

Confirm client signature, client copy, and grievance requirements are all addressed.

Submit for Authorization and Finalization.

Accomplish all this within 60-day time frame (30 is preferred).

Component Details and Examples

4.2.1. Client Plan Dates:

Client Plan “Start”, and “End” dates coincide with the “established service authorization period.” The Client Plan dates run for the course of **one year**.

As an example:

If the initial treatment plan was finalized on February 15, 2019, then the initial Client Plan dates are 2/15/2019 – 2/14/2020. This initial Client Plan is “finalized.” In the event that the client is opened for services with another program during this same year (let’s say another episode opened on 5/3/19) the “add-on” program will need to enter treatment objectives for their facility. The “add-on” program will add their treatment objectives on a “revised” plan. Remember, there is only one Client Plan per client regardless of the number of programs providing services to the client.

All objectives will show the date they were created. These dates coincide with the dates for which the client receives services within the program(s). In our example above, the individual objectives for the add-on program would reflect the 5/3/19 date. Authorization for the add-on program would end on 2/14/20 which is in line with the initial finalized plan.

4.2.2. Client’s Goals (Stated in Client’s Own Words)

This statement is located at the beginning of the Client Plan and it is intended to be a space where the client’s goals are freely stated. Individual goals are generally related to important areas of life functioning affected by the client’s mental health condition. Areas of life functioning include living situation, daily activities, school, work, relationships, social support, legal issues, safety, physical health.

This space should indicate the client’s desired outcome if treatment is successful and should include the client’s “hopes, dreams and plans for the future”.

A goal is stated in the client’s own words and relates to a quality of life goal. For example:

“I want a job”

“I want to go back to school to get a degree”

“I want to be less depressed”

“I want a girlfriend/boyfriend”

“I want to live in an apartment by myself”

“I want to get off of SSI and be self-sufficient”.

Client Goals are:

- Ideally expressed in the words of the individual, their family and/or other supportive individuals.
- Manageable in a reasonable amount of time.
- Easily understandable in the clients preferred language
- Appropriate to the person’s culture; reflects values, traditions, identity, etc.
- Written in positive terms
- Consistent with abilities / strengths, preferences and needs
- Embody hope/alternative to current circumstances

4.2.3. Client Strengths

Strengths are qualities that the client brings to treatment that help increase the likelihood of achievement of goals. Client strengths are internal and external factors that should be identified and emphasized as helpful to the treatment process. Examples are:

- Community supports, family/relationships, work, etc. May be unique to racial, ethnic, linguistic and cultural (such as lesbian, gay, bisexual, transgender and queer) communities
- Client/Family's best qualities
- Strategies already utilized to help (what worked in the past)
- Competencies/accomplishments interests and activities, i.e. sports, art identified by the consumer and/or the provider
- Motivation to change
- Employed/engaged in volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Acknowledges need for change
- Values medication as a recovery tool
- Has a spiritual program/connected to a church
- Good physical health
- Adaptive coping skills/ help seeking behaviors
- Capable of independent living

Use the information from the Assessment on strengths (including cultural strengths) to identify the individual/family attributes and skills. Identify resources that will be particularly significant to supporting the client in achieving their goals.

When considering strengths, it is beneficial to explore different areas. Examples may be an individual's most significant or most valued accomplishment; what motivates them; educational achievements, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, personal heroes, most meaningful compliment ever received, etc.

It is important to take the time to acknowledge the value of the individual's existing relationships and connections. If it is the individual's preference, significant effort should be made to include these "natural supports" and unpaid participants as they often have critical input and support to offer to the treatment team. Treatment should complement, not interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones.

Strengths should be utilized in every part of treatment process.

- Strengths identified in the assessment process
- Set objectives to build on strengths in the Client Plan
- The progress notes help us show how our interventions help build up the strengths that help individuals thrive.

4.2.4. Obstacles to Achieving Goals

Obstacles or barriers can take many forms. Clinically, these may include the symptoms of mental illnesses that impair judgment and appropriate social behavior, cause difficulty in recognizing maladaptive patterns of behavior, or make motivation a struggle. These could be among the "impairments in functioning" mentioned in the medical necessity section of this manual.

Obstacles or barriers can also be more situational, such as limited financial resources, transportation needs, and limited knowledge of the healthcare system, poor physical health, inadequacies in insurance coverage, poor support system, language capability and stigma.

Each client has a unique set of barriers in place which prevents him or her from achieving goals. The clinician must process with the client and identify these behavioral health barriers and document in the chart. It may take time to build an understanding with our clients about the symptoms/challenges/barriers they may be experiencing. Sometimes this lack of understanding may be an obstacle itself.

If applicable, indicate whether or not client's substance use is in sustained in full remission and if the client does not want a substance use related objective at this time.

Indicate on the plan whether or not Substance Use is "denied". Answer per client report, regardless of whether the evidence points to the contrary (e.g. client's breath smell of alcohol or observation of use). Include any observations within the final formulation of the Clinical Assessment and any relevant progress notes.

- Substance use is in sustained full remission - client does not want a related objective at this time.
- Substance use is denied.

4.2.5. Objectives

Objectives are the clinical tasks that are needed to fulfill that client's goals. These tasks must be **"specific, observable or measurable"** and stated in terms of the specific impairment identified in the Assessment, diagnosis and clinical formulation of Medical Necessity. They should be related to specific functioning areas such as living situation, activities of daily living, school, work, social support, legal issues, safety physical health, substance abuse and psychiatric symptoms.

Characteristics of Objectives:

- Incremental achievements on the path toward reaching a goal
- Specific enough to achieve a high degree of inter-provider understanding
- Achievable in a timeframe that is realistic and meaningful to the client
- Clear enough that the client can effectively direct effort toward their achievement
- Appropriate to the setting/level of need/stage of change
- Appropriate for the person's age, development and culture
- Observable and/or measurable and quantifiable
- Time limited

TIP: Writing too many objectives can make a treatment plan overwhelming and unwieldy to both practitioner and the client. By consolidating objectives, the treatment plan can have greater focus and clarity

How specific, observable, measurable should objectives be?

They should be specific, observable, and measurable enough so that both you and the client are likely to agree on the point in time when the objective/goal is achieved. The focus of the objective is the actual demonstration of new skills and/or abilities and/or the decrease of an obstacle or impairment.

Not all objectives should be based on a year timeline. The client's annual plan may involve planning for one year but the timeframe of an objective should be specific to the person's needs. The client should have enough time to work through meeting their objectives, but not make it so long that the client/family has little opportunity for smaller successes along the way. It is also helpful to include baselines to demonstrate measurable progress, not only for documentation purposes, but also to reflect on successes or areas of improvement with the client at the time of the annual Client Plan renewal.

Note: The objectives must relate back to an identified problem /challenge/strength noted in the psychosocial Assessment and the challenge statement.

Formulating an objective:

- Jessica is a 15-year-old girl
- Jessica and her mother came to the county for help with her anxiety issues
- Jessica is anxious about being in school
- She has low self-esteem and feels her peers do not like her
- She feigns illness frequently to avoid going to school
- Sometimes she comes home from school early or skips altogether, returning home after mother leaves for work
- Jessica and her mother fear she will fail her classes because of absences

Objective = Subject (client) + Action Word + What +How + When + Measurement

- ✓ Subject (client): Jessica
- ✓ Action Word: will manage
- ✓ What: anxiety
- ✓ How: by learning and implementing use of 3 coping skills
- ✓ When: daily, in response to anxiety, for 6 months
- ✓ Measurement: client will report decreased anxiety and client and mother will report improved school attendance.

4.2.6. Interventions

The Interventions section defines the concrete strategies and techniques the service provider utilizes to facilitate the client's progress of the clinical objectives in order to achieve their personal goals. These interventions are behavioral health interventions and address the impairment(s) identified in the Assessment. They are best stated using the five W's:

- **Who:** Clinical discipline of practitioner (e.g., practitioner, case aide)
- **What:** Modality/Service provided
- **When:** Frequency/intensity/duration
- **Where:** Location
- **Why:** Purpose/intent/impact to address a specific mental health impairment

Interventions define the concrete strategies/actions that will be utilized to assist the client/family to meet the objectives. In addition to the client's goals and objectives being developed in relationship to the diagnosis and/or impairments, it is essential that the interventions and timeframes outlined in the Client Plan reflect what the provider will do.

There can be multiple interventions (different service types) for the same problem/goal/objective cluster. Service types often include medication services, group counseling, individual counseling, brokerage, and for the full service partnership clients, intensive case management. Each of the interventions needs to be specific and non-duplicative.

Examples of Interventions include:

- Therapist will offer stress reduction techniques in weekly group therapy sessions for the next three months at the clinic to reduce anxiety

- Provider will support client to express unresolved grief to reduce symptoms of depression in bi-weekly individual sessions for the next six months. Sessions to be provided in office and at client’s home as negotiated.
- Over the coming year, case aide will meet with client and house manager monthly at client’s home to discuss behavior problems or coordinate around other issues that might affect placement.

Example of <u>unacceptable</u> documentation of an intervention:	Example of an <u>acceptably</u> documented intervention:	Explanation of acceptable documentation:
Brokerage as needed for the next year	Practitioner will provide brokerage services twice monthly for the next year to support the client in maintaining current residential placement.	In the acceptable intervention we have written something that is specific and will help the client to understand our intended services
Group services for 12 months	Practitioner will facilitate the XYZ group weekly for the next 12 months to help reduce her feelings of isolation	This intervention has a specific group and duration.
Medication support	Psychiatrist will meet with Jason every six weeks for medication support visits to ensure medication is still helping his feelings of anxiety.	These are specific and clear. Jason could read these interventions and know why medication support may help him.
	Clinic Nurse will meet with Jason every 4 weeks and will provide medication support and injection to alleviate (specify symptoms).	

Qualities of a good Client Plan

Culturally Relevant: The plan should consider all types of cultural issues to arrive at a meaningful understanding of the client’s worldview. These considerations include ethnicity but are expanded to include family of origin, traditions and holidays, religion/spirituality, education, work ethic etc.

Client-Centered: The plan should be written in a way that is culturally sensitive and personally relevant. The plan is developed in collaboration with the client and uses language that is understandable and is acceptable to the client.

Strengths-Based: The plan identifies strengths of the individual and utilizes client strengths to reduce barriers. The plan focuses on the person’s competencies as well as what the person needs to do to overcome impairments.

Reality-Based: A good treatment plan reflects “where the client is at”. For example, if a client is in the early stages of change, the objectives should be reasonable and consistent with the client’s willingness and ability to accomplish them.

Chapter 5. PROGRESS NOTES

The progress note is used to record the services that result in claims (billing). Please remember that when a clinician writes a billable progress note a bill to the state is being submitted, therefore, all progress notes must be accurate and factual. Errors in documentation (e.g., using an incorrect location or procedure) directly affect BHRS' ability to submit true and accurate claims. This is an aspect of compliance, and compliance is the personal responsibility of all clinical and administrative staff.

What makes a good progress note? A good progress note accurately represents the service provided. Each progress note needs to justify the claim for the service provided. Every billable service must be medically necessary. Medical Necessity is established by ensuring that interventions meet the following two criteria:

1. The focus of the proposed intervention is to address the condition identified in the impairment criteria related to the "covered diagnosis", and

REMEMBER
*Progress Notes
are
Legal Documents!*

2. It is expected the proposed intervention will benefit the consumer by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning. Clinicians should check how the proposed intervention helps the client improve or maintain functioning in important areas of life.

Progress notes are also used to inform other clinical staff about the client's treatment, to document and claim for services, and to provide a legal record. Progress notes may be read by clients/family members. Use your judgment about what to include. Aim for clarity and brevity when writing notes. Lengthy narrative notes are discouraged.

Who are we writing the note for?

Progress notes should be written as if an attorney and/or the client/family will read the document. You should be able to explain or defend every statement that is made in the progress note. Use quotes when stating what other people said.

Clear and concise documentation is crucial to client care. Progress notes are used, not only to claim for services, but to document the client/family's course and progress in treatment. Progress notes should clearly indicate the type of service provided and how the service is medically necessary to address an identified area of impairment, and the progress (or lack of progress) in treatment.

In order to meet regulatory and compliance standards, Progress Notes:

1. Must be related to the client's progress in treatment
2. Must provide timely documentation of relevant aspects of client care, including medical necessity
3. Must document:
 - Client Encounters
 - Interventions
 - Follow up care
 - Clinical decisions, when made
 - Client's response to interventions
 - New assessment information, when relevant
 - Referrals to community responses, when appropriate

- Date services were provided
 - Location where services were provided
 - Amount of time taken to provide the services
 - If service is provided in a language other than English, state the language used. If an interpreter is used, include the name of the interpreter in the progress note.
 - Signature of the person providing the service, including professional degree, licensure or job title
4. Progress notes are the method by which other treatment team members or other reviewers (such as the State, Federal or contracted reviewers) are able to determine Medical Necessity and level of care/treatment for the client.
 5. The client's presenting signs, symptoms or other clinical problems should be clearly described in order to support the need for the service.
 6. Each progress note must have components that show what has been done to help a client reach their goal or objective.
 7. If two practitioners are providing a service to a client together, each person's role and participation in the intervention needs to be clearly documented.

5.1. PROGRESS NOTE FORMAT (SIRP)

BHRS requires that practitioners use a SIRP format for notes. This format helps to ensure that all the requirements of the note are met. This format also enables service providers to utilize progress notes as a communication tool that will provide a clear picture of services and client status.

SIRP is an acronym for:

- **S**ituation
- **I**ntervention
- **R**esponse
- **P**lan

The Situation: Use a clear and complete notation or description regarding the client's current complaint(s), condition(s), an assessment of client and/or reason(s) presented during the session. Use behavioral terms and include an assessment of the client. This is not a statement of diagnosis but rather a statement of why this session was necessary.

Situation

- Observation of client's presentation at time of service, e.g. hygiene, speech, mood, etc.
 - What impairments are the focus?
 - Is the diagnosis still valid?
 - Is progress being made?
-

The Intervention: Use descriptive sentence(s) about staff's interventions (what you did). Identify skills used to cope/adapt/respond/problem solve. Reinforce new behaviors, strengths. Identify specific skills that are taught/modeled/practiced.

Intervention

The intervention elements of the progress note shall describe the following:

- Clinician's interventions: what did clinician do?
- Clinician's assessment, including risk assessment when applicable
- Document advice/recommendations given to client/family

The Response of the Client to Staff Intervention: Use descriptive sentences about the client's response to the staff's intervention; describe the response to the intervention in behavioral terms and include the client's progress or lack of progress. Can also include general response to treatment. Response may also include a description of how the client received the intervention.

Response

- Any new Assessment findings
- Is there progress or a lack of improvement – explain latter
- Did client understand, accept, intervention or appear resistant?
- Explain the need for additional treatment due to Medical Necessity
- Include outcome measures in documentation, as appropriate.

Brokerage service responses may include response from agency that was being linked to. In instances where there is no direct contact with client or agency, response can be deferred to following note.

- Response from agency receiving referral, linkage, coordination

The Plan: The Plan component outlines clinical decisions regarding the client, collateral contact, referrals to be made, follow-up items, homework assignments, treatment meetings to be convened, etc. Any referrals to community resources and other agencies when appropriate, and any follow-up appointments may also be included.

Plan

- Are new goals needed?
 - Document that the treatment goals remain appropriate or revise as needed.
 - If lack of improvement, obtain a consultation to verify the diagnosis or consider change in treatment strategy
 - Consider treatment titration and plan for discharge.
-

5.2. TIMELINESS OF DOCUMENTATION OF SERVICES

All client-related services must be entered and finalized in the client electronic health records within 72-business hours or 3 business days from when the service was provided. Any other documents related to a client (i.e. discharge summaries, labs, etc.) must also be entered/scanned in the client's clinical record as soon as practical. State regulations drive timeliness standards, which are based on the idea that documentation completed in timely fashion has greater accuracy and makes needed clinical information available for best care of the client. State guidelines and auditors' practice established the 72-hour documentation time (or three business days) frame utilized in BHRS.

The intent of the 72-hour/3 business day documentation policy is to establish a trend of timely documentation. Timely documentation is not only about compliance with State expectations, but it is also about insuring that clinically relevant and accurate information is available for the best care of the client.

However, perfection is not expected. QI recognizes that documentation cannot always be completed within 72-hours/3 business days. Situations may arise that prevent timely documentation, such as sickness, client crisis, or scheduling challenges. As with any trend's longevity, timely documentation is meant to be evaluated on a long-term basis.

There are often questions on how the timeline expectation applies to services that occur at the end of the business day on Fridays or the day before a holiday. Progress notes need to be completed within 72 hours-3 business days from when the service was provided. The same rules apply for staff working alternative or modified schedules, the 72-hour business hours includes all regular hours of BHRS operation (excluding weekends and holidays) even if it coincides with a regularly scheduled day off that fall on a BHRS business day. For example, staff working four 10-hour days with Fridays off must consider that their regularly scheduled Friday off is still part of the calculations for the 72-business hour documentation standards.

There are some staffing classifications, such as new employees or interns, who require a reviewer or clinical supervisor to review the progress notes prior to finalization. Even in these instances, the 72-business hour standards apply. Generally, the practitioner completes a progress note, selects the "co-signature" option, and finalizes the progress note. This process sends the reviewer a "to do" message in their CLINICIAN'S GATEWAY inbox. The reviewer then reviews the progress note and provides the practitioner with feedback, if any. The use of supervision to provide feedback on progress notes is always encouraged, however, the feedback may be provided by e-mail or telephone. Depending on the feedback, the practitioner has the option to "append" the progress note to include any necessary information regarding the service provided. If the progress requires more than the use of the append option, please contact QI for support.

5.3. FINALIZING A PROGRESS NOTE

- When a practitioner finalizes the progress note they are providing a legal electronic signature that the information they are submitting is accurate.
- Finalizing a progress note generates a billing for the services provided to the client.

Chapter 6. SPECIALTY MENTAL HEALTH SERVICES

Specialty Mental Health Services include individual, group, or family therapies and interventions that are designed to reduce mental disability and/or facilitate improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. Services are directed toward achieving the consumer/ family's goals and must be consistent with the current Client Treatment Plan. These services include:

- Assessment
- Mental Health Rehabilitation & Group Rehab
- Collateral
- Brokerage
- Plan Development
- Therapy & Therapy Group
- Medication Support
- Crisis Intervention

6.1. Descriptions of Specific Service Procedures:

6.1.1. ASSESSMENT

This procedure is used to document the clinical analysis of the history and current status of the individual's mental, emotional, or behavioral condition. It includes appraisal of the individual's functioning in the community such as living situation, daily activities, social support systems, and health history and status. Assessment includes screening for substance use/abuse, establishing diagnoses and may include the use of testing procedures. Assessment services must be provided by a licensed and/or licensed waived practitioner consistent with their scope of practice.

Assessment services may include:

1. Gathering information to gain a complete clinical picture.
2. Interviewing the client and/or significant support person.
3. Administering, scoring and analyzing psychological tests if within scope of practice.
4. Formulating a diagnosis if within scope of practice. Completing an Initial Clinical Assessment and Annual Clinical Reassessment.
5. Observing the client in a setting such as milieu, school, etc. May be indicated for clinical purposes.

A good Assessment note includes some observations or findings relating to the Assessment. *It is not acceptable to simply write a note indicating an Assessment was completed.* The note needs to include why the Assessment is being completed and preliminary findings or observations of the client's behaviors during the assessment process. BHRS requires the adult or child assessment template is used for the finalized assessment.

Assessment notes can contain elements which only licensed/registered or waived staff can perform, such as assigning diagnoses or with a license or by protocol with specific training, such as performing mental status examinations. Psychological testing can only be performed by licensed/waivered psychologist with adequate training. Other elements of assessment notes include gathering of information which does not require being licensed/registered or waived. Staff should only provide and document assessment services within their scope of practice.

6.1.2. PLAN DEVELOPMENT

This procedure is used to document the development of Client Plans, getting approval and client signature for the plan and updating or revising the Client Plan. Plan Development may be claimed by any practitioner. Plan Development is expected to be provided during the development of the initial plan and for subsequent client plan updates. However, it may be used during other times than the periodic update cycle, as clinically indicated to modify the plan to make it relevant to client needs. For example, when the client's status changes (i.e., significant improvement or deterioration), there may be a need to update the client plan. Documentation of Plan Development should include a description of the, revision, or update made to the plan, or a statement that the Client Plan was reviewed and found to remain appropriate in addressing client's impairments and level of functioning.

Plan development activities include:

- Development and client approval of Client Plans
- Negotiating plan objectives with client
- Verification of medical or service necessity for services listed on Client Plan
- Evaluation and justification for modifying the Client Plan
- Updating, revising, renewing Client Plans

Client Plans may be developed by non-licensed clinical staff, who can claim for this procedure. However, Client Plans need to be approved by licensed and/or licensed waived staff.

6.1.3. REHABILITATION

This procedure is used to document services that assist the client in improving a skill or the development of a new skill set. "Rehabilitation" means a recovery or resiliency focused service activity identified to address a behavioral health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. This procedure may be provided in an individual or group format. This procedure may be claimed by any practitioner.

Rehabilitative Mental Health Services are provided as part of a comprehensive specialty behavioral health services program available to Medicaid (Medi-Cal) clients that meet medical necessity criteria established by the State, based on the client's need for Rehabilitative Services established by an Assessment and documented in the client plan.

Rehabilitative skills may include:

- Daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication compliance.
- Counseling of the consumer including psychosocial education aimed at helping achieve the individual's goals.
- Education around medication, such as understanding importance of taking as prescribed and how to effectively communicate with prescriber (within the practitioner's scope).

6.1.4. INDIVIDUAL THERAPY

Therapeutic intervention includes the application of strategies incorporating the principles of development, wellness, adjustment to impairment, and recovery and resiliency. Therapy should assist a client in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a client or group of beneficiaries and may include family therapy directed at improving the client's functioning and at which the client is present.

- Progress notes need to adequately document the therapeutic intervention(s) or therapy activity that was provided

Only Licensed/Registered/Waivered Staff and trainees who have the necessary training and experience can provide individual therapy.

6.1.5. FAMILY THERAPY

There are many times when family therapy is warranted in treatment, particularly in children's services in order to assist the client. Family Therapy involves the client and one or more family members for the purpose of addressing the client's behavioral health impairments through changes in family member interactions.

May include:

- ✓ support family members to understand client's mental health impairments
- ✓ the family member learning coping strategies to support the client
- ✓ improve family communication and resolve conflicts
- ✓ facilitate attachment between child and caregiver
- ✓ teach, model and reinforce parenting skills

Licensed/Registered/Waivered Staff and trainees can utilize this procedure provided that they are working within their scope of practice.

6.1.6. GROUP THERAPY

Specialty Mental Health Services may be provided to more than one individual at the same time. One or more practitioners may provide these services and the total time for intervention and documentation may be claimed. Up to 3 practitioners may be claimed and a varying amount of time may be claimed for each practitioner.

Only one group progress note is written for each client even if 2 or 3 practitioners lead the group. One practitioner writes and signs/finalizes the progress note. A good group note includes specific interventions and specific responses/observations for each client in the group. When multiple providers are involved, the progress note also must clearly document the involvement of each provider. Example: Group leaders facilitated role play activity...

Note: Please refer to the Clinician's Gateway User Guide v.3.9 for step-by-step instructions.

Example: A group service is provided by two practitioners for a group of seven clients, and the reimbursable service, including direct service, travel time, and documentation time took 1 hour and 35 minutes (95 minutes). The time reported for each staff will be totaled then divided by the number of clients. CG will provide the allocation of time for each client present; rounded to the nearest minute. In this example, each client account will be claimed for 27 minutes. (95 minutes x 2 staff = 190 minutes / 7 clients = 27.1 minutes rounded to 27.)

6.1.7. COLLATERAL

This procedure is used to document contact with any "Significant Support Person" in the life of the client (e.g., family members, roommates) with the intent of improving or maintaining the mental health of the client. This generally excludes other professionals involved in the client's care. Collateral may include helping significant support persons understand and accept the client's challenges/barriers and involving them in planning and provision of care. Remember, there must be a current release of information in the chart to include these supports. These services must be included in the client's treatment plan to support the client's recovery

Collateral may include, but is not limited to:

- The client may or may not be present
- Consultation and training of the significant support person to assist in better utilization of behavioral health services by the client.
- Consultation and training of the significant support person to assist in better understanding of the client's serious emotional disturbance (e.g., psychoeducation).

COLLATERAL PROGRESS NOTES DESCRIBE:

- List people involved in the services and their role
- Training/Counseling provided to the Significant Support Person

- Describe how the client's behavioral health goals were addressed through the collateral support.
- Document the collateral support person's response to the interventions.
- Follow-Up Plan (if needed).

Note: When consulting with other professionals involved with the care, use Brokerage, not Collateral.

6.1.8. MEDICATION SUPPORT SERVICES

This service is used exclusively by medical staff where it is within their scope of practice to provide such services. This service type may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate); how the use of the medication may improve the effectiveness of other services a client is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing to not take medications. Medication Support Services supports beneficiaries in taking an active role in making choices about their behavioral health care and helps them make specific, deliberate, and informed decisions about their treatment options.

Note: Medication support services may only be provided within their scope of practice by a Physician, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Physician Assistant, a Nurse Practitioner, and a Pharmacist.

TYPES OF MEDICATION SERVICES

- **MEDICATION ASSESSMENT**
Initial Assessment including medical and psychiatric history, current medication, chart review. Observation of need for medication due to acuity. Consultation with clinician, M.D., or nurse regarding medication.
- **MEDICATION**
Prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, side effects and compliance to medication. Obtaining informed consent for medications.
- **MEDICATION INJECTION**
Specifically for the injection and all that an injection entails under guidelines of administration/evaluation of medication.

6.1.9. BROKERAGE

While included as a Specialty Mental Health Service, Brokerage services are technically not a mental health service. Brokerage, also known as Case Management (CM), Linkage, or Targeted Case Management (TCM) are services that assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service; monitoring of the client's progress once he/she receives access to services; and development of the plan for accessing services.

Case management is identified in CG as "Brokerage".

When Brokerage services will be provided to support a client to reach program goals, it must be listed as an intervention on the client treatment plan.

Brokerage includes, but not limited to, the following:

- Inter-and intra-agency communication, coordination and referral.
- Monitoring service delivery to ensure an individual's access to service and the service delivery system.

- Linkage services focused on acquiring transportation, housing, or securing financial needs.

Brokerage services also include placement service such as:

- Locating and securing an appropriate living environment.
- Locating and securing funding.
- Pre-placement visit(s).
- Negotiation of housing or placement contracts.
- Placement and placement follow-up.
- Accessing services necessary to secure placement.

Institutional reimbursement limitations apply when brokerage is billable for clients in acute settings like the hospital (e.g. Marin General Inpatient Psychiatric Unit). For clients in these facilities, brokerage services are billable only for the following purpose:

- Use Brokerage when services are directly related to discharge planning for the purpose of coordinating placement of the client upon discharge.
- Use keywords like “Placement” or Discharge Planning” in the narrative.
- For services not related to placement or discharge planning, document services using the Non-Billable versions of the service procedure, or “Other Non-Billable Chart Note” service procedure.

Lockouts for Brokerage Services (See also [Lockouts and Limitations](#))

- IMDs (Institutions for Mental Disease), MHRCs (Mental Health Rehabilitation Centers), Jail, and Juvenile Hall: No Medi-Cal claimable services, including Brokerage services. Use only Non-Billable procedures and for Jail or Juvenile Hall, use location code “Jail.”
- Acute Psychiatric Inpatient: May use Brokerage if service activity is related to coordinating placement within 30 days of discharge for up to 3 nonconsecutive 30-day periods.

6.1.10. CRISIS INTERVENTION

Crisis Intervention is an immediate emergency response that is intended to help a client cope with a crisis (potential danger to self or others, severe reactions that is above the client’s normal baseline).

Examples of Crisis Intervention include services to clients experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves, (including provision/utilization of food, clothing and shelter) due to a mental disorder. Service activities may include, but are not limited to Assessment, collateral and therapy to address the immediate crisis. Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.

Crisis Assessment Progress Notes Describe:

- The immediate emergency requiring crisis response
- Interventions utilized to stabilize the crisis
- Safety Plan developed
- The client’s response and the outcomes
- Follow-up plan and recommendations

EXAMPLES OF CRISIS INTERVENTION ACTIVITIES:

- Client in crisis - assessed mental status and current needs related to immediate crisis.

- Danger to self and others – assessed/provided immediate therapeutic responses to stabilize crisis.
- Gravely disabled client/current danger to self – provided therapeutic responses to stabilize crisis.
- Client was an imminent danger to self/others - was having a severe reaction to current stressors.

Note: Crisis Intervention progress notes may not always link to the client's treatment plan.

Lockouts for Crisis Intervention (§1840.366):

Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services. Crisis Intervention is allowed on day of discharge from those facilities.

6.2. NON-BILLABLE SERVICES

Some services are not claimable to Medi-Cal, even though they may be useful to the client. Also, some activities may be valuable to document in the record even though they are not claimable. Use of Non-Billable procedure types and certain service locations in these instances will prevent the service from being claimed to Medi-Cal and other payors.

The following services are not Medi-Cal claimable:

1. Purely clerical activities (faxing, copying, calling to reschedule, appointment, etc.)
2. Supervision. This applies to both the provision of supervision to clinical staff as well as receiving supervision from or consulting with a supervisor.
3. Traveling to a site when no service is provided due to a “no show”. Leaving a note on the door of a client or leaving a message on voicemail.
4. No service provided: Missed visit. Waiting for a “no show” or documenting that a client missed an appointment.
5. Providing transportation ONLY
 - NOTE: “Travel” is not “Transportation.”
 - Travel involves the provider going from their “home office,” to the location where a service will be provided.
 - Transportation involves the provider taking the client/family from one location to another.
 - If a “behavioral health service” is provided during the time a provider is transporting the client/family, then the time spent providing the service is not “transportation” and that portion of service time can be claimed.
6. Preparing documents for court testimony for the purpose of fulfilling a requirement; whereas when the preparation of documents is directly related and reflects how the intervention impacts the client’s behavioral health treatment and/or progress in treatment, then the service may be billable.
7. Completing the reports for mandated reporting such as a CPS or APS.
8. Academic/Educational services, i.e., actually teaching math or reading, etc.
9. Vocational services which have, as a purpose, actual work or work training.
10. Recreation or general play.
11. Socialization-generalized social activities which do not provide individualized feedback.
12. Services under 5 minutes.
13. Personal care services provided to individuals including grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals.
14. Childcare/babysitting.

15. Case Conference attendance by non-involved/contributing staff. Only practitioners directly contributing (involved) in the client's care may claim for their services. See also [Case Conferences](#)
16. Utilization management, peer review, or other quality improvement activities.
17. Interpretation/Translation; however, an *intervention* in another language may be claimed.
18. Any service after the client is deceased. Includes "collateral" services to family members of deceased.

Comparison between claimable and non-claimable activities

Assuming the other aspects of medical necessity are present, the following are comparisons between claimable and non-claimable activities in some specific situations.

1. Academic/Educational Situations:
 - a. **Claimable:** Developing and practicing relaxation techniques with the consumer to help reduce the consumer's anxiety about school tasks which is impairing academic performance.
 - b. **Not Claimable:** Assisting the consumer with homework.
 - c. **Not Claimable:** Teaching a typing class at an adult residential treatment program.
2. Recreational Situations:
 - a. **Claimable:** Providing linkage to a recreation center and reinforcing appropriate participation.
 - b. **Not Claimable:** Teaching the individual how to lift weights is not reimbursable.
3. Vocational Situations:
 - a. **Claimable:** Responding to the employer's call for assistance when the client is in tears at work because he/she is overwhelmed at needing to learn to use a new cash register-- if the focus of the intervention is assisting the individual to decrease anxiety enough to concentrate on the task of learning the new skill.
 - b. **Not Claimable:** Visiting the consumer's job site to teach them how to use a cash register.
4. Travel/Transportation Situations:
 - a. **Claimable:** Driving to a client's home to provide a service – travel time is added to the service time if the client is there and the service is provided.
 - b. **Claimable:** Providing supportive interaction with a client while accompanying the client from one place to another in a vehicle. Claimable time is limited to time spent interacting.
 - c. **Not Claimable:** Taking a client from one place to another during which no interaction takes place.

6.3. LOCKOUTS AND LIMITATIONS

Lockouts and limitations refer to specific billing or claiming rules that either prohibit or limit claiming. The rules are specific to different situations. Services may be provided and should be documented, but care needs to be taken regarding how the services are entered so that no prohibited claiming takes place.

LOCKOUTS exist when, due to a client staying in a specific type of facility, some or all of the usual outpatient services may not be claimed. Lockouts vary depending on the type of facility. Additional details and a list of specific facilities in the different categories can be found in the [Facility Lockout Assistant](#).

IMDs (Institutions for Mental Disease), **MHRCs** (Mental Health Rehabilitation Centers), **SNF** (Skilled Nursing Facility) with STP (Special Treatment Program): All Medi-Cal Claimable services are locked out. Use only Non-Billable Brokerage or Other Non-billable Chart Note.

Jail and Juvenile Hall: All Medi-Cal Claimable services are locked out. Use “Jail” or “Juvenile Hall” as the service location for any service if that is where the client is when providing the service. Clinician’s Gateway will automatically block illegal claiming by using this location. Use any procedure code within scope of practice, as long as the service location is Jail or Juvenile Hall.

Acute psychiatric inpatient: Partial Lockout. May use Brokerage if service activity is documented as relating to placement or discharge planning. Additional restriction is that Brokerage must be within 30 days of discharge, up to 3 non-consecutive 30-day periods. Medication related services, if within scope, provided while consumer is hospitalized, use Non-Billable Medication. May use Other Non-Billable Chart Note.

All services provided on day of admission, but before admission are allowed. All services allowed on day of discharge.

Crisis Residential: Partial Lockout Brokerage services allowed. Medication services are allowed if within scope of practice. Mental Health Services, i.e., Individual, Group, Rehab, Collateral, Crisis Intervention are not allowed. May use Non-Billable versions of Individual, Group, Rehab, Collateral or Non-billable Chart Note.

Crisis Stabilization (CSU). Partial Lockout Brokerage services only allowed after admission. Other services allowed same day but prior to admission.

Medical Skilled Nursing Facilities (SNF): without Special Treatment Program (**STP**): has no Medi-Cal lockout.

Other residential treatment - Residential treatment other than Crisis Residential, such as SUS residential has no Medi-Cal lockout.

Other Acute Inpatient – Medical (non-psychiatric) Inpatient services do not have a Medi-Cal lockout.

LIMITATIONS refer to either a maximum number of hours per day that a specific type of service can be claimed for a client, or to the types of service that are allowed before the completion of a client plan, or during lapses in client plans.

Limits for Medication Support Services - The maximum amount claimable for Medication Support Services for a client in a 24-hour period is 4 hours. Is client specific and based on staff time, i.e., staff and co-staff providing a 2-hour service to a client would equal 4 hours. Note that these maximums are based on total staff time and are not program specific. For example, if an MD and an RN are co-staffing a med service that takes two hours, the claimed time is 4 hours. Also, if an MD from one program is providing a med service in the morning and an RN from another program is providing a med service in the afternoon, the time for both will count toward the daily maximum.

Limits for Crisis Intervention - The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours and is based on staff time and is not program specific, as described for medication support services.

Limitations on Services prior to completion of the Client Plan or during Plan lapses - Services allowed prior to the Plan's completion are Assessment, Plan Development.

Brokerage and Medication Support are also allowed but restricted to the following: Brokerage is limited to linkage to needed services. Monitoring and goal related follow-up activities are not allowed. Medication Support services are limited to Assessment, Plan Development or if there is a documented urgent need. These restrictions and limitations also apply to lapses in Client Plans.

6.4. SERVICE TYPE COMPARISON

Sometimes the same intervention activity can be described differently, making it look like either one service type or another. Some common examples are:

- **Brokerage vs Rehab**

Context (Situation) Client has had difficulty following through with previous attempts at either getting into or remaining in a vocational program. Successfully completing the program is an objective on the client plan. The client's goal is to become independent and get a paying job.

Brokerage intervention: Met with client to assist getting into vocational program. Discussed what have been barriers to getting into or staying with program on previous attempts, such as his perceptions that staff don't like him and anxiety related to this. Discussed ways to focus on **getting into and completing program** so can get a paying job.

Rehab intervention: Met with client to getting assist with completing vocational program. Discussed what have been barrier to getting into or staying with program on previous attempts such as his perceptions that staff don't like him and anxiety related to this. Practiced anxiety reducing strategies to **improve coping skills**. Also assisted with replacing negative self-messages about staff not liking him with positive self-messages about rewards of getting through program and getting decent job in order to **improve focusing skills**

The situation is the same, but with Brokerage, the emphasis on linking with the program, while with Rehab, the emphasis is on skill development.

- **Collateral vs Brokerage**

Context (Situation) There is some confusion about how to provide support to the client. Spoke to xxxxx to clarify roles, and to provide guidance about consistency when providing support.

Collateral intervention: Spoke with **family member** in order to provide support for her efforts at setting limits and being consistent when applying consequences for breaking rules.

Brokerage intervention: Coordinated with **housing program staff** to facilitate consistency in setting limits, communicating house rules, and applying consequences for breaking rules.

The intervention is very similar, but the distinction is in who the clinician is talking to. When providing service to a “significant support person”, i.e., a family member, it’s considered a Collateral service. Coordinating with the staff of another program is included in the definition of Brokerage.

Note that this distinction is similar for providers of [Katie A.](#) procedures. **IHBS** would be similar to Collateral in that providers are working with significant support persons, while with **ICC** services, the focus is multi-agency collaboration, which is similar to Brokerage services.

6.4.1 COMBINING MULTIPLE SERVICE TYPES

Sometimes during a single session with a client, two distinct types of service get provided. While it’s ok to write two separate notes for the different services, it’s also acceptable to combine the services into one note. When deciding which type of service to select for claiming, staff should use the “**preponderance rule**”, i.e., choose the service type that took the most time or has the most information in the note. Documentation of the preponderant service should be at the beginning of the note.

6.5 CASE CONFERENCES

A “case conference” is not a specific service type. It refers to a discussion between direct service providers that are involved in the care of the client. While it may be similar to a multi-disciplinary team meeting, it is **not** a “check-in” about a client but should be necessary and with a specific outcome. The type of outcome would depend on the type of case conference and direct the type of service claimed as listed below.

- If the case conference concerns the development of a treatment plan for a shared client, the conference would be claimed as Plan Development.
- If the discussion is focused on communication, coordination, and referral, the conference could be claimed as Brokerage.

Staff participating in case conferences must describe their role and involvement in the conference. Involvement may include both sharing and receiving of information. Documentation of participation **must** include what information was shared and how it is to be used in providing services to the client as described below.

- for a conference claimed as Plan Development, specific information will be documented as being included in a revision of the Client Plan, or that an evaluation of the plan concluded no change was needed;
- for a conference claimed as Brokerage, information shared will be documented as being used in coordinating services between providers or making referrals and following up on those referrals.

Chapter 7. SCOPE OF PRACTICE/COMPETENCE/WORK

Staff must only provide services that are within their scope of practice and scope of competency. Scope of practice refers to how the law defines what members of a licensed profession may do in their licensed practice. It applies to the profession as a whole. Scope of competence refers to those practices for which an individual member of the profession has been adequately trained. Scope of work refers to limitations imposed by BHRS to ensure optimal utilization of staff resources.

Some services are provided under the direction of another licensed practitioner. "Under the direction of" means that the individual directing service is acting as a Program Supervisor or manager, providing direct or functional supervision of service delivery, or review, approval and signing client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service provided. Services are provided under the direction of a physician, a psychologist, a waived psychologist, a licensed clinical social worker, a registered associate clinical social worker, a marriage and family therapist, a registered associate marriage and family therapist, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).

"Waivered Professional" is defined as: A psychologist candidate, an individual employed or under contract to provide services as a psychologist who is gaining the experience required for licensure and who has been granted a professional licensing waiver to the extent authorized under State law; or

Prior to providing services, "waivered" clinicians must provide the following to the Quality Management Unit (20 North San Pedro Rd, San Rafael):

- State Waiver Form
- School Transcript
- Resume

Waiver packet will be reviewed and sent to the State Compliance for processing. Waiver is good for six (6) years.

"Registered" Professional (Associate MFT*, ASW, Associate PCC*) is defined as: A marriage and family therapist candidate, a clinical social worker candidate, or a professional clinical counselor candidate, respectively, who has registered with the corresponding state licensing authority for marriage and family therapists, clinical social workers or professional clinical counselors to obtain supervised clinical hours for marriage and family therapist or clinical social worker or professional clinical counselor licensure, to the extent authorized under state law.

Prior to providing services, "registered" clinicians must provide the following to the Quality Management Unit (20 North San Pedro Rd, San Rafael):

- Copy of Certificate Board Issued Associate/Intern Registration

* Effective January 1, 2018, the titles for marriage and family therapist interns and professional clinical counselor interns are changed to Associate Marriage and Family Therapist or Associate Professional Clinical Counselor.

7.1. BHRS PROFESSIONAL CLASSIFICATIONS AND LICENSES

Below are tables containing the most common licenses or professional classifications in the Behavioral Health field, with brief definitions and characteristics. In conjunction with information and tables from the preceding sections, these following tables can be used to help further clarify what clinical activities are within the scope of practice of particular professionals.

AA, Bachelor's, and/or Accrued Experience	
Title	Definitions/Characteristics
MHRS (Mental Health Rehabilitation Specialist)	<p>Possesses a bachelor's degree (BS or BA) in a mental health related field <i>and</i> a minimum of four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.</p> <p><i>Or</i>, an associate arts degree <i>and</i> a minimum of six (6) years of experience in a mental health setting.</p> <p><i>Or</i>, graduate education may be substituted for the experience on a year-for-year basis. For example, someone with a bachelor's degree, 2 years of graduate school, and 2 years of experience in a mental health setting can qualify to be an MHRS.</p>
Other, Unlicensed	<p>Any other direct service staff providing client support services that does not meet any of the other specified licensure or classification definitions or characteristics, i.e., Staff without BA/BS and 4 yrs. experience/or AA & 6 yrs. experience.</p>

Graduate School (pre-Master's or pre-Doctoral)	
Title	Definitions/Characteristics
Psychologist Intern (pre-Doctoral)	<p>Completed academic courses but have not been awarded their doctoral degree.</p> <p>Completing one of the final steps of clinical training, which is one year of full-time work in a clinical setting supervised by a licensed psychologist.</p> <p>Intern status requires a formal agreement between the student's school and the licensed psychologist that is providing supervision.</p>
Psychologist Trainee (pre-Doctoral)	<p>In the process of completing a qualifying doctoral degree.</p> <p>Often called "Practicum Students."</p> <p>Receiving academic credit while acquiring "hands-on" experience in psychology by working within a variety of community agencies, institutions, businesses, and industrial settings.</p> <p>Supervised by a licensed psychologist.</p>

MSW Intern	In the process of completing an accredited Masters of Social Work program. Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. Completing clinical hours as part of their graduate school internship field placement.
MFT Trainee	In the process of completing a qualifying doctorate or master's program. Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. Completing clinical hours as part of their graduate school trainee practicum course.
LPCC Trainee	In the process of completing a qualifying doctorate or master's program. Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. Completing clinical hours as part of their graduate

Post-Master's, Pre-License	
Title	Definitions/Characteristics
ASW (Associate Social Worker)	Completed an accredited Masters of Social Work (MSW) program. In the process of obtaining clinical hours towards a LCSW license Registered with the CA Board of Behavioral Sciences (BBS) as an ASW Possesses a current BBS <i>registration</i> certificate (which contains a valid BBS <i>registration</i> number)
AMFT (Associate Marriage and Family Therapist) or RAMFT (Registered Associate Marriage and Family Therapist) As of December 31, 2018, the former designation of MFTI or MFT Intern may no longer be used.	Completed a qualifying Doctorate or Master's degree. In the process of obtaining clinical hours towards an MFT license Registered with the CA Board of Behavioral Sciences (BBS) as an AMFT or RAMFT Possesses a current BBS <i>registration</i> certificate (which contains a valid BBS <i>registration</i> number)
APCC (Associate Professional Clinical Counselor) or RAPCC (Registered Associate Professional Clinical Counselor) As of December 31, 2018, the former designation of PCCI or PCC Intern may no longer be used.	Completed a qualifying Doctorate or Master's degree. In the process of obtaining clinical hours towards an LPCC license Registered with the CA Board of Behavioral Sciences (BBS) as an APCC or RAPCC Possesses a current BBS <i>registration</i> certificate (which contains a valid BBS <i>registration</i> number)

Licensed	
Title	Definitions/Characteristics
Psychologist (Licensed)	Licensed by the CA Board of Psychology Possesses a current CA Board of Psychology <i>license</i> certificate (which contains a valid <i>license</i> number)
Psychologist (Waivered)	Issued a waiver by the State of CA Department of Mental Health to practice psychology in CA. Possess valid waiver. Waiver is limited to 5 years.
LCSW (Licensed Clinical Social Worker)	Licensed by the CA Board of Behavioral Sciences (BBS) Possesses a current BBS <i>license</i> certificate (which contains a valid BBS <i>license</i> number)
LMFT or MFT (Licensed Marriage and Family Therapist)	Licensed by the CA Board of Behavioral Sciences (BBS) Possesses a current BBS <i>license</i> certificate (which contains a valid BBS <i>license</i> number)
LPCC (Licensed Professional Clinical Counselor)	Licensed by the CA Board of Behavioral Sciences (BBS) Possesses a current BBS <i>license</i> certificate (which contains a valid BBS <i>license</i> number)

Scope of Practice is defined by Title 9, CCR, Section 1810.227 and further clarified by DMH Letter No. 02-09, The grid above provides an outline but does not authorize individual practitioners to work outside their own scope of competence.

Some staffing classifications require a co-signature where the clinical supervisor provides clinical supervision using the co-signature as a supervision tool. State laws and regulations specify that a co-signature does not enable someone to provide services beyond their scope of practice.

Medical	
Title	Definitions/Characteristics
Registered Nurse (RN)	Registered with the California Board of Registered Nursing (BRN)
Clinical Nurse Specialist (CNS)	An RN with a Master's Degree in an area of specialization and certification by BRN.
Psychiatric /Mental Health Nurse	A CNS with a specialization in Psychiatry/Mental Health, certified by BRN.
Nurse Practitioner (NP)	An RN who has completed a Nurse Practitioner program, certified by BRN.
Licensed Psychiatric Technician (LPT)	Licensed by California Board of Vocational Nursing and Psychiatric Technicians
Physician (MD)	Licensed by the Medical California of California
Medical Assistant	Unlicensed individual with training as a Medical Assistant by a MD, NP, or PA, under supervision of same.
Physician Assistant (PA)	Licensed by California Physician Assistant Board

7.2. WHO CAN PROVIDE WHAT PROCEDURE

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Vocational Nurse, Psych Tech	Trainee enrolled in MFT, PhD program (post BA/BS but pre-MA/MS/PhD)	MHRS (Staff with BA/BS in MH related Field and 4-year exp in MH)	Staff without BA/BS and 4 yrs. exp/or AA & 6 yrs. exp.
Assessment:										
History & Data Collection	Yes	Yes	Yes	Yes	Yes	Yes	Yes+	Yes+	Yes+	Yes+
MSE & Diagnosis	Yes	Yes	Yes	Yes	Yes	No	No	Yes+	No	No
Complete Client Plan	Yes	Yes	Yes	Yes	Yes	Yes+	No	Yes+	Yes+	No
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes++	Yes++	Yes+ ++	Yes++	No
Medication Administration	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Medication Dispensing	Yes	No	No	Yes*	Yes	Yes*	No	No	No	No
Med. Prescribing or Furnishing	Yes	No	No	No	Yes	No	No	No	No	No
Med support svc.	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Psychological Testing	No^	Yes	No^	No	No^	No	No	Yes+	No	No
Psychotherapy	Yes	Yes	Yes	Yes	Yes	No	No	Yes+	No	No
Rehabilitation Counseling	No	Yes	Yes	Yes	No	Yes	No	Yes+	Yes	Yes+
Brokerage	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes+	Yes	Yes+
Therapeutic Behavioral Services	No	Yes	Yes	No	No	No	No	Yes+	Yes	No
Collateral	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+
Plan Development	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+
KTA ICC	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes+
KTA IHBS	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes+

+ Co Signature Required

^ Staff w/ specific training and experience may qualify, upon approval of the MH Director

* RN's may dispense if trained in dispensing and re-certified annually

++ Must have immediate supervision if issues of danger to self or others are present

7.3. UTILIZATION REVIEW

State regulations and BHRS policies specify that all beneficiary health records, regardless of format (electronic or print) go through the utilization review (UR) process. This process is meant to ensure that all planned clinical services are appropriate to address the client's behavioral health needs. It is also meant to make sure that the records comply with all State and Federal regulations as well as BHRS Policies. The Utilization Review includes the evaluation and improvement of services through the following practices:

- Medication Monitoring
- Utilization Review
- Contract Provider Utilization Review
- Inpatient Utilization Review

The role of the Utilization Reviewers is critical as they provide clinical oversight and function as a "check and balance" system. The reviewers are license-eligible, licensed, and/or waived BHRS staff. The reviewers are responsible to ensure the following: all services meet Medical Necessity standards; planned services benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning; all documents are completed within established BHRS standards; and monitor that client plans are written in client-centered language and include client signature as evidence of client involvement. Utilizing a UR tool, the reviewers provide feedback to the Quality Improvement Coordinator who is responsible for tracking any findings and following up on any quality issues and identify items for disallowance.

Programs and individuals may receive information regarding trends identified through the URC process. Notification is through the UR Report. Information on trends will also be used when considering the training needs of individual staff and the organization.

Clients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in client preferences and encourage shared decision making.

Adults, including those receiving behavioral health treatments, have the right to give or refuse consent to medical diagnostic or treatment procedures. California Health and Safety Code § 7185.5(a) states that "the legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care..." California Code of Regulations, Title 22 § 70707(b) (6) provides that a patient has a right to "participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment."

The range of services provided shall be discussed prior to admission with the prospective client or an authorized representative so that the program's services are clearly understood. BHRS has an obligation to inform clients of the risks and benefits of treatment. At the onset of services, we must ensure that clients understand the content of not only the Informed Consent form, but of all of the documents required at the onset of services. This confirmation of understanding should be done prior to the client agreeing to services and signing the forms. This includes ensuring that minors who are able to consent for their own services without a parent are fully educated about the similarities and differences in the types of services they can receive. In addition, although we do not need to have client's re-sign Informed Consent forms when they transfer from program-to-program, it is important we inform them of the specific risks and benefits of each particular services when they initially transfer.

An important part of informed consent is the person's capacity to consent. A person is deemed to have legal capacity to consent to treatment if he/she has the ability to understand the nature and consequences of the proposed health care, including its significant benefits, risks and alternatives (including doing nothing), and can make and communicate a health care decision. A person's lack of mental capacity to consent to medical care may be temporary or it may be permanent, and the provider should determine capacity on a case-by-case basis whenever consent is sought. For example, a client who is clearly under the influence of drugs or alcohol may lack capacity temporarily, but could provide consent at a later time, when not so impaired. If you have any questions regarding a beneficiary's ability to consent, please consult with your supervisor and Quality Improvement.

*Reference: Institute of Medicine Committee on Quality of Health Care in America (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press.
Title 9 Section 532.3*

8.1. MINOR CONSENT

This section provides guidance regarding consent for health care services for minors receiving services from BHRS. The terms *health care* and *medical care* include Assessment, care, services or referral for treatment for general medical conditions, mental health issues, and alcohol and other drug treatment. As with adult clients consenting for their own services, parents or minors who can consent for their own services have the fundamental right to consent to or refuse medical treatment.

Generally speaking, minors need the consent of their parents to receive mental health services unless the minor has the right to consent to care under minor consent laws (see Circumstances that Allow for Minor to Consent to Their Own Services). Only one parent is necessary to provide consent unless we are aware of evidence that the other parent has objected. Adoptive parents have the same rights to consent as natural parents.

In the case of divorced parents, the right to consent rests with the parent who has legal custody. If the parents have "joint legal custody" usually either parent can consent to the treatment unless the court has required both parents to consent. In most situations, we can presume that either parent can consent unless there is evidence to contrary. Some teams prefer to obtain consent from both parents. This is not a legal requirement, but this is acceptable within BHRS as long as it does not pose a significant detriment or cause harmful delay to the treatment of the client.

A parent or guardian who has the legal authority to consent to care for the minor child has the right to delegate this authority to other third parties (aged 18 and older); for example, the parent may delegate authority to consent to medical care to the school, to a coach, to a step-parent, or to a baby-sitter who is temporarily caring for the child while the parent is away or at work. A copy of the written delegation of authority should be scanned into the electronic health records.

In some cases, a "surrogate parent" is raising a minor child. If this adult is a *qualified relative* (often the grandparent, or an aunt or uncle, or older sibling) who has stepped into the role of parent because the biological parents are no longer willing or able to care for the child, he or she should fill out the **Caregiver's Affidavit** form which is used widely throughout California.

These so-called Caregivers who have "unofficially" undertaken the care of the child are authorized by law to consent to most medical and mental health care and to enroll these children in school. Once they have completed the **Caregiver's Affidavit** form (which is then scanned into the electronic health records) they may consent to medical or mental health care for the minor child; however, if the parent(s) returns, the "caregiver's" authority is ended, and once again the parent has authority to consent to or refuse care for the child. A Caregiver's Affidavit does not have to be "renewed" and can remain in effect until the parent returns, or until the child turns 18.

The court has the power to authorize medical and mental health treatment for abandoned minors and for minors who are dependents or wards of the court (for example, youth in foster care or juvenile hall). Furthermore, the court may order that other individuals be given the power to authorize such medical and mental health treatment as may appear necessary, if the parents are unable or unwilling to consent. In some circumstances a court order is not necessary. For example, under certain circumstances, a police officer can consent to medically necessary care for a minor who is in "temporary custody."

In situations where some adult other than the parent or guardian is providing consent, (unless it is an emergency) care must be taken to establish a non-parent's legal authority to consent to care before treatment begins. Often this requires identification of the child's status as well as the ability or inclination of the natural parents to provide consent. A copy of the Court Order delegating this authority (to a Foster Parent, for example) should be scanned into the electronic health records before care is provided. For those treatments for which a minor can legally provide his or her own consent, no court order or other authorization is necessary when treating a dependent or ward.

In rare situations a court may summarily grant consent to medical or mental health treatment upon verified application of a minor aged 16 or older who resides in California if consent for medical care would ordinarily be required of the parent or guardian, but the minor has no parent or guardian available to give the consent. A copy of the court order should be obtained and scanned in the minor's electronic health record before treatment is provided pursuant to the order.

Consent from the parent is not required if the minor is involuntarily held for 72-hour Assessment and treatment pursuant to Welfare and Institutions Code 5585.2 or 5150 et seq.

Circumstances that Allow for Minor to Consent to Their Own Services.

Minors generally need a parent to consent to healthcare services because minors suffer automatic legal incapacity due to their young age. However, there are certain minors who can consent for their own services.

These minors are:

A. Minors who are treated as "adults" under the law for purposes of medical consent. These are:

- 1) Emancipated minors
- 2) Self-sufficient minors

B. Minors seeking *sensitive services*

These minors do not suffer automatic legal incapacity due to their young age but must still display legal capacity. As with adults, legal capacity to consent to services indicate an ability to understand the nature and consequences of the proposed health care, including its significant benefits, risks, and alternatives; make a health care decision; and communicate this health care decision.

Emancipated Minors include:

- A. Minors 14 and older who have been emancipated by court order;
- B. Minors who are serving in the active US military forces; and
- C. Minors who married or who have been married

Before providing services to these minors, we should obtain a copy of their emancipation card or court order, a copy of their military ID card, or a copy of their wedding certificate and scan these documents into their electronic health records.

Self-sufficient minors are defined by law as minors aged 15 and older who are living separate and apart from their parents and who are also managing their own financial affairs regardless of their source of income. Even though self-sufficient minors can consent to outpatient mental health services such as therapy, rehabilitative counseling, and brokerage, the law is not clear whether or not self-sufficient minors can consent to psychotropic medication treatment. Please consult with your supervisor and Quality Improvement if psychotropic medication treatment is part of the services being sought by a self-sufficient minor.

Minors seeking certain sensitive services may be legally authorized to provide their own consent to those services. The minor also controls whether or not the parent will have access to records generated as a result of receiving those services. When minor consent applies, sensitive services should not be provided over the minor's objection; in other words, ***even if the parent provides consent, non-consent by the qualified minor presents ethical issues and provision of care should be delayed until consultation using the chain of command can be obtained on a case-by-case basis.***

Minors 12 or older may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem; since the law deems such minors to be legally competent to consent to such care, parents or guardians have no legal authority to demand drug testing of their minor children who are 12 or older. The law requires providers to involve the patient or legal guardian in the care, unless to do so would be inappropriate. The decision and reasons to involve, or not involve, the parent/legal guardian needs to be recorded in the electronic health records, as well as staff efforts to involve them.

There are two separate California laws that permit minors 12 and older to consent to outpatient mental health counseling services. The first is Family Code 6924(b). It states that minors 12 and older may consent to mental health treatment or counseling on an outpatient basis (and also, to residential shelter services), if both of the following requirements are satisfied:

- 1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services, **and**
- 2) The minor would either present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services or is the alleged victim of incest or child abuse.

The second, more recent law is found at Health and Safety Code section 124260. It removes the requirement that the provider must first determine that the minor 12 and older be "at risk" before services can be provided. Instead, the provider need only determine that the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient mental health services. The attending professional person should

clearly chart that any required “qualifying” criteria have been met if services are provided pursuant to either of these provisions of the law.

When outpatient mental health care or residential shelter services are provided, the laws state that it shall include the involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person must state in the electronic health record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian. (Note: If outpatient mental health services are provided pursuant to Health and Safety Code 124260, the law states that the decision to involve, or not involve, the parents shall be made in collaboration with the minor patient.).

It needs to be reiterated that even though a minor 12 or over can provide their own consent for sensitive services related to substance abuse and mental health, mental capacity to provide consent and informed consent is still required. If a minor who otherwise qualifies for minor consent lacks mental capacity, and insists that there not be parental involvement, staff should consult with their supervisor and Quality Improvement so that appropriate steps may be taken.

Note: Psychotropic medication treatment is not one of the sensitive services that a minor can consent for. Parent/guardian consent is required if psychotropic medications are prescribed. Parent/guardian consent is also needed if voluntary inpatient mental health facility services are provided. Further, the minor consent laws do not authorize a minor to consent to convulsive therapy or psychosurgery.

See also http://www.calhospital.org/sites/main/files/file-attachments/qrg_medical_treatment_of_minors.pdf
<http://www.teenhealthlaw.org/>

8.2. MEDICATION CONSENT

A Medication Consent form must be obtained at the time of initiating a new medication and when a new dose is prescribed that is outside of previously consented dosage range. A note indicating discussion about medications and side effects doesn't replace the signed form. It is good practice to document a discussion about risks of not taking as prescribed, what side effects for client to be aware of, and other education about risks and benefits of taking or not taking the recommended medication. As discussed under minor consent, a parent or guardian must sign a consent for a minor for psychotropic medications. The MD/NP is also responsible for providing information to client about the specific medication, preferably in written form, at minimum verbally. This provision of information should be documented in the note.

BHRS Medication Consent form can be completed and signed electronically in the electronic health record. See details in [Medication Clinic Documentation](#) section

8.3. AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION

The confidentiality of medical, psychiatric, and substance abuse information is protected by State and Federal statutes, rules and regulations. These statutes, rules, and regulations require that we protect the client's personal health information (PHI) and that we obtain informed consent from the client in order to disclose any PHI information prior to doing so, except under specific conditions as indicated by the laws. Only staff members who are directly involved in the client's treatment may access the health record for treatment purposes. It is never legal for staff

members to access a client's health record to satisfy a curiosity for their own purpose, even when the client is related to the staff member. The electronic medical record stores information on who has accessed the medical record as part of the audit trail. The audit record is necessary to make efforts to safeguard the client's confidentiality as well as to provide an "account of disclosure" if requested by the client or legal entities via subpoena.

All information and records obtained in the course of providing services shall be confidential. A client or authorized representative who consents to release of any information from their health record must read and sign the "Authorization to Exchange Protected Health Information" (HIPAA Form 03-01) previously referred to as "Release of Information." The Authorization, once signed, is valid for a designated period of time or on an event. The client, or authorized representative must state who the information may be released to, the purpose for which the information may be used, what specific information may be released, and when the authorization will expire. A client may decide to revoke the Authorization, at any time and may do so by submitting the request verbally or in writing to any staff member. The Authorization will at that time be revoked, making it invalid. Information previously released under the Authorization is not affected by this revocation. If the client, at a later time, decides to reactivate the Authorization, a new Authorization must be completed as indicated above.

The client is in control of their health information. A client has a right to view the information in their medical record, but should, if at all possible, complete the designated request of information document (a telephone request for records alone will NOT be accepted). They may initiate a request for their records by visiting or calling the Marin County BHRS Medical Records Office at 250 Bon Air Road, Greenbrae, Tel: 415 4736779 (fax- 415 473-4113) The BHRS Medical Records Supervisor or designee will review the request to ensure a proper and timely response to client's request.

Special Considerations for Minors:

For minors who are eleven (11) years or younger, the authorized representative may authorize the release of information.

For minors who are treated as "adults" under the law for purposes of medical consent (emancipated and self-sufficient minors) and minors seeking *sensitive services* for which they are qualified to provide their own consent under the law, the minor must authorize the release of information even to their own parents or guardians.

Revoking an Authorization

A client may withdraw consent or REVOKE a previously signed Authorization at any time during their course of treatment (9 C.C.R. § 854). In the event the client asks to revoke a release of information, staff must have the client complete the "Revocation of Authorization for Use and Disclosure of Protected Health Information" (MHSUS form 03-02) which must be faxed, mailed or hand delivered to BHRS Medical Records, 250 Bon Air Road, Unit B, Greenbrae, CA 94904

Chapter 9. DOCUMENTATION REQUIREMENTS FOR SPECIFIC PROGRAM TYPES

9.1. Medication Clinic Documentation Guidelines

Assessment: For medication only clients, assessments are required every three years.

Client Plan: As with other planned services, Title 9 Regulations require an annual plan and evidence of client's participation in the plan.

Medication Support Services: Medication Support Services include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness.

CAUTION: Physician services that are not psychiatric services are not the responsibility of the MHP. These would include services that are to address or ameliorate a physical condition that is not related to a mental health condition. Referral to and collaboration with primary care is encouraged. Services to ameliorate physical conditions related to psychotropic medications should be documented in a way that the link to the psychiatric condition is clear.

Time Claiming Limitations for Medication Support: The maximum amount claimable for a client for Medication Support Services in a 24-Hour period is 4 hours. Note that time spent by multiple medication support service staff is combined toward this maximum.

Clinician's GATEWAY (CG)

I. Additional Medication Templates on CG:

1. AIMS (Abnormal Involuntary Movement Scale): Completed Quarterly
2. Metabolic Monitoring Protocol: This is embedded on Adult Medication Support Template and is completed annually.
3. The Patient Health Questionnaire (PHQ-9): is completed by MD/NP Quarterly for clients with MDD or Dysthymia.

II. Procedures in Drop Down:

1. NO SHOW
2. Client Cancellation
3. Medication Assessment
 - There is not a specific form at this time. The elements must all be present including:
 - a. Diagnoses;
 - b. Presenting problem
 - c. Psychiatric history
 - d. Other medical history
 - e. Allergies
 - f. Past and current medications
 - g. Mental Status Exam
 - h. Risk factors
 - i. Substance use and history
 - j. Plan
4. Medication Support is most commonly used procedure. (See definition of Medication Support Services above).
5. Medication Injection
6. Other Non-Billable Chart Note only (ex. Clerical; filling out forms; leaving messages, contact with family after a patient's death).
7. Non-Billable Medication – Only when clients are in lock-out facilities for Medi Cal such as an IMD, PHF, Inpatient Psych Hospital, jail or juvenile hall.
8. Brokerage - Use for activities/services that are not medication related (used by prescribers infrequently).

III. Location:

1. Important to use correct location i.e. Phone, office, jail, field.
 - a. Office: when service is face to face with client
 - b. Phone: filling prescriptions
 - c. Jail/Juvenile Hall is Service Location when a client is incarcerated regardless of where provider is. This includes conversations on the phone when providers speak to family, other staff, treatment conferences, or fill prescription, etc.

IV. Prescription Refill Notes & Consents:

1. All prescriptions should have an accompanying note.
2. If using RxNT- can activate automatic note to CG at time of writing RxNT prescription. If this feature isn't activated, will need to write prescription specifics into note at time of visit or when refilling Rx.
3. If client isn't present- mark box "Refill/Admin/Non Face to Face"
4. Notes must reflect reason/rationale a nurse practitioner or doctor is refilling prescription. Can write "refilled RX to address sxs of no change in dosage or changed dose to...".
5. Never write only "faxed RX".
6. Medication consent form- must be obtained for every new medication or an increase in dose from previous consent. A note indicating discussion about medications and side effects doesn't replace the signed form. It is good practice to document a discussion about risks of not taking as prescribed, what side effects for client to be aware of, and other education about risks and benefits of taking or not taking the recommended medication.
7. BHRS Medication Consent form can be completed and signed electronically in the electronic health record (CG). To access the consent on CG from your Home page:
 - a. Select "document" under type of service:
 - b. Select Medication Consent (English) (Spanish) or (Vietnamese) under Note Template:
 - c. Start Document:
 - d. Complete medication consent including name of medication and dosage range
 - e. To get client signature- use "save and sign" button
 - f. Capture signature with electronic signature pad
 - g. The medication consent can then be printed for client and given along with the medication information sheets.
 - There are medication information sheets have been provided in your offices for 95% of the BHRS prescriptions. For those medications that are not included or for Spanish or other language info sheets, you can use the below link and click Spanish/other language once you open to the chosen medication: <https://medlineplus.gov/druginformation.html>
 - h. Giving out the information sheets is required. Giving out a copy of the consent is client's choice.

V. Medical Record & Notes:

1. Must sufficiently describe the specific services furnished to the specific patient on the specific date and document medical necessity.
2. Interventions must be related to the mental health diagnosis and symptoms
3. Include a plan of care.
4. Include allergies.
 - CG will carry over any allergies to each new note.
 - If No has already been documented previously, on subsequent notes mark "No New Allergies".
5. Important to focus on Mental Health symptoms even when reviewing physical health symptoms. Write physical health care issues under Medical Section of note.
6. If writing a reference to a note in the hard copy chart, always include the date of the form, note, etc.
7. Standardized abbreviations are the only abbreviations that should be used. If in doubt, refer to JCAHO.

VI. Medication Injections:

1. Medication Injection notes includes documentation time and the time required to prepare and administer the injection.
2. The note should include the client's diagnosis and/or primary psychiatric symptomatology and the location of the injection.

VII. Disallowances will be taken when:

1. Note does not address client's mental health condition and does not document evidence of a medication support service.
2. Note reflects a solely clerical activity.
3. Client participation not evident.

VIII. Financial issues:

1. Clients are required to complete annual financial forms. If they ask for the reason, they can be told that this will help ensure that they don't receive bill for whole service since their insurance and financial circumstances can be considered before they receive a bill.

9.2. FULL-SERVICE PARTNERSHIP (FSP)

Mental Health Service Act funds programs including Full-Service Partnerships (FSP) The intent of these programs is that mental health service providers work in partnership with clients, their family, caregivers, other providers, and community to provide a full range of services. These services include planning, policy development, service delivery and evaluation in areas such as drop-in centers, peer support centers, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services while taking into consideration the individual's goals, strengths, needs, race, culture, concerns, and motivations.

Each FSP site is responsible for maintaining outcome measurements and data collection based on the four age-groupings as specified in the Community Services and Supports (CSS) Plans:

- Youth (ages 0-15)
- Transitional Age Youth (ages 16-25)
- Adults (ages 26-59)
- Older Adults (ages 60+)

The following forms are required for this program:

- Outcome Measurements Application Baseline (Partnership Assessment Form - PAF)
- KET (Key Event Tracking)
- 3M forms (Quarterly Assessment)

Outcome Measurements Application Baseline (Partnership Assessment Form- PAF):

A baseline Assessment should be completed within the first 30 days after starting the FSP. The PAF to establish baseline is done at time of entry into an FSP program. A PAF is valid until the consumer has been disenrolled from a program **AND** a lapse of 365 days has occurred since the PAF was discharged. If the program receives a consumer with an existing PAF, meaning that no lapse of 365 or greater has occurred between events, then the program must enter a KET for admission into the program.

Key Event Tracking Changes (KET):

This form is used to enter key events. A program only needs to complete the section of the KET for which a change is being reported, with three exceptions: disenrolling a client, transferring a client, or receiving a transferred client.

When a consumer changes from one program to another, the **Referring** program must complete a KET document indicated the transfer. The **Receiving** program must immediately complete a KET document to complete the transfer process.

If a program opens a consumer for FSP services after the consumer has been closed to another FSP program, but less than 365 days have lapsed since the discharge from the previous FSP program, the new program must complete a KET document—a PAF should not be completed, unless more than 365-day lapse has occurred.

Note: The changing of an apartment but staying within the same complex does not constitute a need to complete a new form.

3M Forms:

The three-month Assessment (3M) is due on every three-month anniversary of the start date [Baseline Partnership Date – the date FSP services were first provided, not outreach and engagement; there must be an episode opening in the Integrated System (IS)]. There is a 15-day window prior to the three-month anniversary and 30 days after to complete it.

Chapter 10. SPECIAL POPULATIONS

10.1. KATIE A. SUBCLASS

As set forth in the Katie A. Settlement Agreement: There are children and youth who have more intensive needs to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to facilitate reunification and to meet their needs for safety, permanence and well-being.

Children/youth (up to age 21) are considered to be a member of the Katie A. Subclass if they meet the following criteria:

- Are full scope Medi-Cal (Title XIX) eligible;
- Have an open child welfare services case {means any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court-ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made}; and
- Meet the Medical Necessity criteria for Specialty Mental Health Services (SMHS) as set forth in CCR, Title 9, Section 1830.205 or section 1830.210

In addition to:

- Currently being considered for: Wraparound, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to therapeutic behavioral services or crisis stabilization/intervention (see definitions listed in glossary); OR
- Currently in or being considered for group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs.

KATIE A. SERVICE PROCEDURES

Note: membership in the *Katie A.* subclass is no longer a prerequisite to receiving medically necessary ICC and IHBS services.

• INTENSIVE CARE COORDINATION (ICC)

Intensive Care Coordination (ICC) is similar to the activities that are routinely provided to our clients as Brokerage. ICC must be delivered using a Child/Youth/Client and Family Team (CFT) to develop and guide the planning and service delivery process. The difference between this service and traditional Brokerage is that ICC must be used to facilitate implementation of the cross-system/multi-agency collaborative services approach. ICC also differs from Brokerage in that it typically requires more frequent and active participation by the ICC Coordinator to ensure that the needs of the child/youth are being met.

- **INTENSIVE HOME BASED SERVICES (IHBS)**

Intensive Home Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the Child/Youth/Client and their significant support persons to help the child/youth develop skills and achieve the goals and objective of the plan. These are not traditional therapeutic services.

This service differs from rehabilitation services in that it is expected to be of significant intensity to address the intensive mental health needs of the child/youth and is predominantly delivered outside of the office setting such as at the client's home, school or another community location.

Katie-A: Certain restrictions apply to the ICC & IHBS procedure.

- ICC services are locked out for youth in hospitals, psychiatric health facilities, or psychiatric nursing facilities except for the purposes of coordinating placement of the youth transitioning from those facilities for a maximum of 30 days -for no more than 3 non-consecutive 30 day periods. As of 7/1/17, ICC services are no longer locked out in group homes.
- As of 7/1/17, IHBS may be provided to youth in group home facilities. IHBS can be provided in the community (homes, schools, recreational settings, etc.). IHBS services are not permitted during the same hours of the same day as: day treatment, group therapy, or TBS.

10.2. THERAPEUTIC BEHAVIORAL SERVICES (TBS) CLASS

As stated in the *Emily Q* Settlement document, children and youth under the age of 21 who, in addition to having full cope Medi-Cal and meeting Medical Necessity criteria, also meet the class criteria for TBS if:

- Child/Youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs; or
- Child/Youth is being considered by the county for placement in a facility described above; or
- Child/Youth has undergone at least one emergency psychiatric hospitalization related to current presenting mental health diagnosis within the preceding 24 months; or
- Child/Youth has previously received TBS while a member of the certified class; or
- Child/Youth is at risk of psychiatric hospitalization.

TBS Services

Therapeutic behavioral service (TBS) is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health service. TBS is an intensive one-to-one, short-term outpatient treatment intervention. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility, or to enable a transition from any of those levels to a lower level of residential care.

Therapeutic behavioral services are intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or planned transition to a to a lower level of placement. The purpose of providing TBS is to further the child/youth's overall treatment goals by providing additional TBS during a short-term period.

TBS Service Procedures

TBS INTERVENTION: A TBS intervention is defined as an individualized *one-to-one* behavioral assistance intervention to accomplish outcomes specifically outlined in the written TBS treatment plan.

A TBS intervention can be provided either through face-to-face interaction or by telephone; however, a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time.

TBS COLLATERAL: A TBS collateral service activity is an activity provided to significant support persons in the child/youth's life, rather than to the child/youth. The documentation of collateral service activities must indicate clearly that the overall goal of collateral service activities is to help improve, maintain, and restore the child/youth's mental health status through interaction with the significant support person.

TBS ASSESSMENT: A TBS assessment service activity is an activity conducted by a provider to assess a child/youth's current problem presentation, maladaptive at risk behaviors that require TBS, member class inclusion criteria, and clinical need for TBS services. Periodic re-assessments for continued medical necessity and clinical need for TBS should also be recorded under this service function.

TBS PLANS: TBS Plans of Care/Client Plan service activities include the preparation and development of a TBS care plan. Activities that would qualify under this service function code include, but are not limited to:

- Preparing Client Plans

- Reviewing Client Plan (Reimbursable only if review results in documented modifications to the Client Plan)

- Updating Client Plan

- Discussion with others to coordinate development of a child/youth's Client Plan (excludes supervision). (Reimbursable only if discussion results in documented modifications to the Client Plan.)

11.1. EXAMPLES OF STRENGTHS

Strengths refer to individual and environmental factors that increase the likelihood of success. Therefore, it is not only important to recognize individual and family strengths, but to *use* these strengths to help them reach their full potential and life goals.

- Motivated to change
- Has a support system –friends, family, etc.
- Employed/does volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Has insight into symptoms/impairments
- Sees value in taking medications
- Has a spiritual program/connected to church
- Good physical health
- Adaptive coping skills
- Capable of independent living
- Interested in restoring relationships

11.2. EXAMPLES OF INTERVENTION WORDS

Assess	Support
Refer	Arrange
Explore	Analyze
Identify	Develop
Clarify	Interpret
List	Reframe
Discuss	Facilitate
Reinforce	Practice
Evaluate	Connect
Utilize	Educate
Encourage	

11.3. EXAMPLES OF INTERVENTIONS PHRASES FOR SPECIFIC PSYCHIATRIC SYMPTOMS, CONDITIONS.

ANXIETY

- Assess reasons for symptoms of anxiety
- Explore triggers/situations
- Refer for medication evaluation to address
- Encourage reading on subject of anxiety
- Discuss how medication is helping
- Explore benefits/changes in symptoms
- Teach relaxation skills
- Utilize relaxation homework to reinforced skills learned
- Analyze fears, in logical manner
- Develop insight into worry/avoidance
- Identify source of distorted thoughts
- Encourage use of self-talk exercises
- Teach thought stopping techniques
- Identify situations that are anxiety provoking
- Teach/practice problem-solving strategies
- Encourage routine use of strategies
- Identify coping skills that have helped in the past
- Validate/reinforce use of coping skills
- Identify unresolved conflicts and how they play out

BORDERLINE PERSONALITY

- Assess behaviors and thoughts
- Explore interpersonal skills
- Explore trauma/abuse
- Validate distress and difficulties
- Explore how DBT may be helpful
- Encourage outside reading on BPD
- Explore risky behaviors
- Explore self-injurious behaviors
- Improve insight into self-injurious behaviors
- Assess suicidal behaviors
- Encourage and practice use of coping skills
- Identify and work through therapy interfering behaviors
- Discuss benefits/effectiveness of medication
- Educate on skills training
- Encourage use of skills training skills
- Explore all self-talk
- Reinforce use of positive self-talk
- Explore and identify triggers
- Review homework
- Review Diary Card
- Reinforce completion of homework/diary card
- Reinforce use of DBT skills
- Encourage/reinforce trust in own responses

SUBSTANCE USE/ABUSE (within context of mental health treatment and within practitioner's scope of practice)

- Explore drug/alcohol history
- Refer for physical exam to primary care physician
- Encourage follow up with physician
- Support and encourage evaluation for psychotropic medication
- Discuss benefits/effectiveness of medication
- Encourage participation in appointments with psychiatrist
- List/identify negative consequences of substance use/abuse
- Educate on consequences of substance use on mental health
- Encourage to remain open to discussion around denial/acceptance
- Encourage participation in AA/NA
- Support participation of AA/NA
- Refer to inpatient/outpatient program
- Support/reinforce client's participation in substance abuse treatment
- Facilitate/explore understanding of risk factors
- List positive aspects of sobriety
- Reinforce development of substance free relationships
- Review effects of negative peer influences
- Encourage exercise and social activities that do not include substances
- Encourage positive change in living situation
- Identify positive aspects of sobriety on family unit/social support system
- Reinforce working on sobriety
- Explore effects of self-talk
- Reframe negative self-talk
- Assess stress management skills
- Teach stress management skills
- Reinforce use of stress management skills
- Explore effective after-Client Plan

TRAUMA

- Work together on building trust
- Explore issues around trust
- Teach/explore trust in others
- Research family dynamics and how they play out
- Explore effects of childhood experiences
- Encourage healthy expression of feelings
- Encourage use of journaling
- Encourage outside reading on trauma
- Explore how trauma impacts parenting patterns
- Educate on dissociation as a coping response
- Explore history of dissociative experiences
- Support confronting of perpetrator
- Utilize empty-chair exercise to work through trauma
- Explore/identify benefits of forgiveness
- Explore roles of victim and survivor and how they are playing out

DEPENDENCY

- Explore history of dependency on others

- Identify how fear of disappointing others affects functioning
- List positive aspects of self
- Assign positive affirmations
- Identify how distorted thoughts affect understanding
- Explore fears of independence
- Identify ways to increase independence
- Teach and reinforce positive self-talk
- Explore effects of sensitivity to criticism
- Educate on co-dependency
- Explore issues around co-dependency
- Educate on benefits of assertiveness skills
- Teach/practice assertiveness skills
- Reinforce/encourage assertiveness
- Encourage use of “No”
- Identify and list steps toward independence
- Identify ways of giving without receiving
- Teach about healthy boundaries
- Practice/reinforce/model use of healthy boundaries
- Encourage decision making

DEPRESSION

- Assess history of depressed mood
- Identify symptoms of depression
- Identify what behaviors associated with depression
- Explore/assess level of risk
- Assess/monitor suicide potential and risk
- Teach and identify coping skills to decrease suicide risks
- Identify patterns of depression
- Encourage journaling feelings as coping skill
- Identify support system
- Develop WRAP plan
- Encourage use of WRAP plan
- Encourage/reinforce positive self-talk
- Explore issues of unresolved grief/loss
- Teach/identify coping skills to manage interpersonal problems
- Reinforce/recommend physical activity
- Monitor and encourage self-care (hygiene/grooming)
- Normalize feelings of sadness and responses
- Explore potential reasons for sadness/pain
- Connect anger/guilt with depression

FAMILY CONFLICT

- Explore patterns of conflict within the family
- Teach conflict resolution
- Explore familial communication patterns
- Facilitate family communication
- Identify how family patterns of conflict and communication are played out
- Facilitate healthy expression of feelings/concerns
- Reinforce use of healthy expression of feelings
- Identify/reinforce family strengths
- List ways family may participate in healthy activities in community

- Define roles in the family
- Identify areas of strength that may be used to parent
- Teach/practice/model parenting techniques
- Identify patterns of dependency on family members
- Identify feelings of fear/guilt/disappointment
- Explore/identify patterns of dependency within family unit

BIPOLAR DISORDER

- Explore symptoms concerning bipolar disorder
- Educate on mania and depression
- Use reflection to identify mania/depression behaviors
- Educate on risky behaviors associated with mania
- Explore behaviors associated with mania
- Identify coping skills
- Identify early warning signs and energy levels
- Explore grandiosity
- Encourage/discuss effectiveness of medication
- Encourage participation in appointments with psychiatrist
- Identify effects of stress on psychiatric symptoms
- Identify/discuss issues of impulsivity
- Discuss consequences of impulsivity
- Model/reinforce effective communication
- Utilize cognitive reframe
- Encourage education on bipolar disorder

MEDICAL ISSUES

- Gather information regarding medical history
- Identify who is primary care physician
- Encourage follow through with medical recommendations
- Identify/explore negative consequences of not following through
- Educate on grief/loss issues and impact on openness to medical treatment
- Explore denial around recommended medical treatment/follow up
- Process feelings of fear/ambivalence/anxiety
- Normalize feelings of fear/ambivalence/anxiety
- Teach relaxation exercises
- Monitor/encourage compliance with medical recommendations
- Reinforce use of coping skills during medical appointments
- Reinforce communication skills to ask for clarity
- Reinforce assertiveness skills
- Encourage use of social support system

11.4. EXAMPLES OF PROGRESS NOTES

EXAMPLE BROKERAGE SERVICE

- S: Client with history of impulsivity and mood swings, which have resulted in situational and legal problems. Client has received 30-day notice to vacate due to non-compliance with rules.
- I: Case Manager evaluated housing options due to client receiving a notice to vacate current residence. Explored housing alternatives, including local shelters. Case Manager contacted staff at facilities to assess vacancies and whether facilities would accept client or be a good fit. Advocated on client's behalf. Scheduled visits to two facilities.
- R: Case manager unable to identify social support system for temporary housing, although was able to find possible openings at other board and care settings.
- P: Case Manager will follow-up with contact board and care setting. Will continue to inquire regarding availability and to advocate on client's behalf, in order to assist client with finding new place to live. Case Manger will contact client for the board and care interview and will provide assistance and support to client during interview.

EXAMPLE BROKERAGE SERVICE # 2

- S: Client needs support for getting through vocational program. Client's ideas of reference and social anxiety continue to impair ability to follow through with either getting into or remaining in the program. Successfully completing the program is an objective on the client plan.
- I: CM met with client re getting into voc program. Provided problem resolution to assist in overcoming anxiety related barrier to getting into or staying with program. Discussed his thoughts that staff don't like him and anxiety related to this. Provided reality check re voc staff opinion of him. Assisted client to focus on goal of getting through program so can get a decent job, per client plan.
- R: Client stated was less anxious after getting reassurance that there's no reason for program staff to not like him. Stated will try to continue with program.
- P: Will follow up and practice role play of possible scenarios to facilitate ability to stay in program. Will continue to monitor and assist client in achieving the objective.

EXAMPLE COLLATERAL SERVICE

- S: Case manager met with client and the client's family (biological mother and aunt) at the office to discuss ways to help support client in attaining goal of re-entering the workforce. Client continues to exhibit referential thinking due to thought disorder and anxiety when interacting with people, especially family. Client was engaged although affect was guarded.
- I: Case Manager met with the client's family and modeled healthy communication and boundary setting. Case Manager educated the client's family on healthy ways to help client attain goals by taking time to listen to the client and family's concerns without interruption or providing unsolicited feedback. Case Manager encouraged the client to use the phrase "I just need you to listen" when starting a conversation with family. Client's family was encouraged to continue participation in monthly family support group for further development of skills.

- R: Client's family was able to identify communication patterns that may be helpful in order to improve support with communication. For example, the family was open to listening for a "key phrase" during interactions with client. Client was able to identify a "key phrase" as well as being opened to using the skill when communicating with her family. Client was opened to listening how this skill may also be useful for overall communication with others, including employers. Family reported being open to trying to attend a monthly family support group.
- P: Clinician will continue to utilize social support system to help address client's needs. Clinician will also continue to work with client to identify and practice healthy coping skills in order to support client with returning to the workforce.

EXAMPLE INDIVIDUAL REHABILITATION

- S: Clinician met with client in in the community for a one-on-one session to improve client's relaxation skills. Client continues to exhibit impaired judgment, low frustration tolerance, and highly reactive when faced with frustrating situations. Appeared somewhat subdued, although anxious.
- I: In order to help client decrease angry outbursts, clinician encouraged the client to utilize coping skills such as deep breathing relaxation exercises and taking quick time-outs instead of reacting to situations. Practiced coping skills to manage anger, clinician and client role-played a recent situation where client reacted to the situation in angry manner. Clinician and client practiced different responses the client could have had. Client was encouraged to use relaxation exercises at least 2x during the following week.
- R: Client reports feelings frustrated when people "don't understand me.... they ask me the same question over and over.... they make me mad." During role-play, client was able to identify a couple of areas where taking a breath and a quick time-out may have been helpful. Client reported participation in role-play was beneficial and agreed to practice coping skill at least 2 times during the next week, if the situation arises.
- P: Clinician to meet with client in one week and process if the use of the practiced coping skills was helpful or not helpful during stressful situations.

EXAMPLE MENTAL HEALTH SERVICE –FAMILY THERAPY

- S: Clinician traveled to client's home to meet with the client and his maternal grandparents. Client and family are experiencing high level of stress and need support with helping the client manage anxiety, threats of self-harm and feeling overwhelmed. Client and family were open to process feelings/concerns.
- I: Clinician facilitated communication between family members and allowed time for all the express self and concerns. Reinforced use of healthy communication and modeled such when interacting with all individuals present. Clinician used gently confrontation, active listening, support, and encouragement when an individual struggled with expressing their feelings and assisting them with communicating in a positive manner. Clinician educated the client's grandparents about parenting techniques and ways to set consistent and healthy boundaries for client. Identified previous adaptive coping skill used by each family member in the past. Clinician wrapped up the meeting by identifying the family's strengths to encourage future participation in family therapy sessions and encouraged the family to contact the clinician should they need assistance with addressing their frustration.
- R: Client tried to control the family session, interrupting conversations and displaying his temperament. Client responded to redirection by clinician. Client identified a difficult day at school, as he was unable to participate in field trip, due to previous behavioral issues. Grandparents reported desire to help client feel better, however, when client does not listen to directives or do chores, it is difficult to get along. Grandmother was open to allowing clinician to confront her responses to client's behaviors. Grandmother had some difficulty with staying on topic and wanting to continue to discuss her frustration, instead of focusing on coping skills and interventions. Family in agreement to take time out, when feeling frustrated in order to avoid conflict and also

agreed to contact the clinician should they need assistance with managing frustration related to communicating with the client.

- P: Clinician will continue to work with client and family to assist them with improving communication, parenting skills, and coping skills to help client attain goal of managing anxiety, decreasing threats of self-harm and managing feelings of overwhelm.

EXAMPLE GROUP REHABILITATION

- S: Client participated in group session with 5 peers. The purpose of the group was to provide emotional support, encourage the use of positive coping strategies, reinforce interpersonal skills and use of peer support in a safe environment.
- I: Facilitator led check-in by asking client to report on his week. Facilitator gave positive reinforcement to client for identifying use of positive strategy in dealing with a difficult situation. Facilitator also provided positive feedback for client's listening to suggestions by other group members. Facilitator provided redirection as necessary to facilitate group process.
- R: Client participated in well in group, able to report on difficult situation and listen to suggestions from peers. Client responded well to receiving redirection when straying off topic. Client reported feeling good about being able to use strategy.
- P: Continue to provide safe and encouraging environment for group members. Continue to encourage use of peer supports and practice of coping strategies.

EXAMPLE PLAN DEVELOPMENT

- S: Client with significant history of thought disorder, including auditory hallucinations and paranoid delusions continues to be symptomatic, although relatively stable for the last three months. Affect is blunted, insight is limited, although has recently been more medication adherent than in the past. Continues to need support to remain on meds, remain in stable structured housing, and maintain adequate health.
- I: Spoke with client to revise and renew annual client plan. Reviewed previous objectives for relevance. Suggested changes based on his more stable situation. Supported his remaining compliant with medication, and we agreed that we should keep an objective related to this important area. Discussed whether having objective relating to obtaining stable housing was still relevant, or whether we should revise as "maintain stable housing", given that he has remained at current place for most of year. Also discussed whether we need to meet as frequently during the upcoming year as we have been.
- R: Client was engaged in revising objectives on plan. Agreed that focus on maintain housing was more appropriate than obtaining housing. Continued to express some ambivalence re meds but acknowledges that they have benefitted him. Agreed that keeping an objective re this is appropriate. Appeared to have mixed feelings about possible decreased frequency of contact. Was more comfortable with compromise language that we would "explore" decreased frequency of contact.
- P: Will write up renewed Client Plan based on our discussion and present to him for approval/signature.

EXAMPLE CRISIS INTERVENTION

- S: Received a call from manager of client's residence. Manager reported that client was yelling repeatedly, although not at any particular person. Manager stated that client's behavior is frightening other residents,

although she was unsure whether there was any direct threat. Client has a history of stopping meds and substance use, which have resulted in decompensation and hospitalization due to similar behavior in past.

- I. Visited client at his residence and spoke with manager. Client was extremely agitated, with considerable delusional content expressed. Appeared to be responding to internal stimuli. Client admitted that he has not been taking meds – states that they are poison. Was only able to redirect to coherent interaction from brief periods before client would return to somewhat incoherent rambling speech, containing ideas of reference and delusional material. Manager stated that she can't keep him in the residence in his current state, although said that she would accept him back if he gets back on his medication and his behavior stabilizes. Writer initiated 5150 based on grave disability, as does not meet danger to self or others criteria but cannot provide for shelter in current state. Called for transport and police for assistance in 5150 to CSU for evaluation and stabilization. Provided reassurance to client while waiting for police and transport, and after their arrival.
- R. Client became slightly more subdued when officers arrived and when told that he was going to hospital. Was reassured that he was not being arrested, only being taken to hospital on a hold to help him get restabilized. Was not resisting assistance into ambulance.
- P. Will check with CSU after they have evaluated to see whether they will admit to inpatient, or restart meds and discharge back to residence. Will inform CSU that unless client clears considerably, residence will not accept back. Will keep residence manager informed of client's state in terms of discharge.

EXAMPLE IHBS SERVICE

- S: Clinician met with the client at his home in order to assist the client with continuing to learn and utilize coping skills to effectively manage feelings related to depression and isolation. The client appeared to be in low spirits as evidenced by his hushed tone of voice and stating that "there is nothing anyone can do to help me".
- I: Clinician greeted client and modeled pro social communication skills by engaging the client in a discussion about how his weekend had gone and if he was able to get out of the house at least once as planned. To determine the client's current level of depression this clinician asked the client to rate his depression on a scale of 1 to 10 (ten being "very depressed"). This clinician encouraged the client to process what coping skills have and have not worked with regard to managing sadness and encouraged the client to verbalize if he would be interested in attending a support group for individuals who have lost a child as a means to address the sadness related to the death of his daughter. This clinician encouraged the client to review his safety plan to ensure that the client is clear regarding steps he can take if he feels he needs assistance between sessions and reviewed the various coping skills that can decrease depressive symptoms such as going for a walk, attending his psychiatry appointments regularly and asking for support when it is needed.
- R: Client reported that his weekend was "okay" but stated that he did not really go anywhere as planned because he "just did not feel like it". The client reported that his depression was currently at a 5 and that he just wishes that people could understand him. Clinician struggled to verbalize what coping skills help him and continued to state that all he needed was "time" to get over his sadness. Client reported that he would be willing to attend a support group for people who have lost a child and stated that he planned to attend next week. The client reviewed his safety plan and agreed to follow the steps necessary to request support if needed.
- P: Clinician will continue to meet with the client 2x per week to assist him with developing and utilizing coping strategies to assist him with decreasing depressive symptoms and isolation.

EXAMPLE ICC SERVICE

- S: Care Coordinator (CC) met with the Client Family Team (CFT) which consisted of the client, the client's foster parents, Child Welfare Services social worker and the client's County Behavioral Health Aide.
- I: CC thanked all individuals for attending today's meeting for the purpose of review the progress that the client has made thus far with regard to managing angry feelings in a more constructive manner and decreasing threats of self-harm. The CC encouraged the client and each individual present to speak to the progress that the client has made and encouraged each individual to provide input regarding "next steps" in the treatment process to ensure the client's continued success. The CC noted several community resources that were discussed and reported that he would follow up on these resources for the client and report back to the team when additional information is gathered. The CC reported that based on the client's progress toward his treatment goals that the treatment plan would be updated to reflect current baselines and would be presented to the client and the team next week. The CC provided positive feedback to the client for his hard work toward addressing his goals and encouraged the client to continue to verbalize his needs to his support persons as necessary.
- R: The client was actively engaged in the CFT as evidenced by his eye contact and remaining seated at the table. He was able to report that the extra support he has been receiving from his foster parents over the past month has been helpful and that sometimes he needs to be reminded of his goals. Each individual present reported that the client has been better able to manage his feelings of frustration in the school and home setting and discussed community resources they feel may be of additional support to the client. All present agree to review the updated treatment plan at the CFT scheduled next week.
- P: The CC will review and update the client's current treatment plan to reflect current needs and baselines and will present the updated plan to the CFT during next week's scheduled meeting.

APPENDICES

GLOSSARY

Annual Plan is the documentation that must be completed on an annual basis. This includes the Assessments, treatment plan and all consents. "Client Plan" means a plan for the provision of specialty mental health services to an individual client who meets the Medical Necessity criteria in Sections 1830.205 or 1830.210.

ANSA-Adult Needs and Strengths Assessment (ANSA) is an instrument that may be used to help identify the client and family strengths and needs. The results are useful when identifying treatment goals.

CANS-Child and Adolescent Needs and Strengths (CANS) is an instrument used to help identify the client and family strengths and needs. These results are useful when identifying and addressing treatment goals.

HIPAA- Health Insurance Portability and Accountability Act: includes the protection of the privacy of individually identifiable health information. As part of this protection, release of information is required to share any information pertaining to client's care/services.

Included Diagnosis Refers to those diagnosis, in DSM-5, which will be the focus of the clinical interventions for which we can receive reimbursement ([see section for list](#)).

Interventions refer to what the practitioner will do in order to assist client with meeting their objective and life goals. These are what drive reimbursements.

Medi-Cal refers to Medicaid program in California from which reimbursements for medically necessary services are received.

Mental Health Service Procedure refers to program-specific procedure used in progress notes to inform what services were provided by practitioner. The services include individual, group, family therapies, and interventions. These procedures are used to determine reimbursements from payer source.

Notice of Adverse Beneficiary Determination (NOABD) is a written notice that gives Medi-Cal Beneficiaries an explanation when a denial or only a limited authorization is made in response to a request for services.

Objectives refer to the smaller accomplishments/steps the *client* makes in order to achieve their life goals.

Practitioner-Licensed/Associate/Licensed-Waived/Trainee provider of MH services.

PHI-Protected Health Information

Authorization to Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information refers to a document signed by client and provider that permits specified information to be shared among designated persons and/or agencies regarding client's services and or treatment plan, for a designated period of time.

"Significant Support Person" means persons, in the opinion of the client or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to a parent, legal guardian, other family member, or other unrelated individual of a client who is a minor, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client.

Stage of Change or Stage of Recovery refers to practitioner's impression of where the client is; Client's stage of readiness to make changes to improve their quality of life; stage of change will inform treatment plan goals and interventions.

Appendix B.

COVERED DSM-5 DIAGNOSES FOR SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES

ICD-10 Code	DSM-5 Disorder
F20.81	Schizophreniform disorder
F20.9	Schizophrenia
F21	Schizotypal personality disorder
F22	Delusional disorder
F23	Brief psychotic disorder
F25.0	Schizoaffective disorder, Bipolar type
F25.1	Schizoaffective disorder, Depressive type
F28	Other specified schizophrenia spectrum and other psychotic disorder
F29	Unspecified schizophrenia spectrum and other psychotic disorder
F31.0	Bipolar I disorder, Current or most recent episode hypomanic
F31.11	Bipolar I disorder, Current or most recent episode manic, Mild
F31.12	Bipolar I disorder, Current or most recent episode manic, Moderate
F31.13	Bipolar I disorder, Current or most recent episode manic, Severe
F31.2	Bipolar I disorder, Current or most recent episode manic, With psychotic features
F31.31	Bipolar I disorder, Current or most recent episode depressed, Mild
F31.32	Bipolar I disorder, Current or most recent episode depressed, Moderate
F31.4	Bipolar I disorder, Current or most recent episode depressed, Severe
F31.5	Bipolar I disorder, Current or most recent episode depressed, With psychotic features
F31.71	Bipolar I disorder, Current or most recent episode hypomanic, In partial remission
F31.72	Bipolar I disorder, Current or most recent episode hypomanic, In full remission
F31.73	Bipolar I disorder, Current or most recent episode manic, In partial remission
F31.74	Bipolar I disorder, Current or most recent episode manic, In full remission
F31.75	Bipolar I disorder, Current or most recent episode depressed, In partial remission
F31.76	Bipolar I disorder, Current or most recent episode depressed, In full remission
F31.81	Bipolar II disorder
F31.89	Other specified bipolar and related disorder
F31.9	Bipolar I disorder, Current or most recent episode depressed, Unspecified
F31.9	Bipolar I disorder, Current or most recent episode hypomanic, Unspecified
F31.9	Bipolar I disorder, Current or most recent episode manic, Unspecified
F31.9	Bipolar I disorder, Current or most recent episode unspecified
F31.9	Unspecified bipolar and related disorder
F32.0	Major depressive disorder, Single episode, Mild
F32.1	Major depressive disorder, Single episode, Moderate
F32.2	Major depressive disorder, Single episode, Severe
F32.3	Major depressive disorder, Single episode, With psychotic features
F32.4	Major depressive disorder, Single episode, In partial remission
F32.5	Major depressive disorder, Single episode, In full remission
F32.81	Premenstrual dysphoric disorder
F32.89	Other specified depressive disorder
F32.9	Major depressive disorder, Single episode, Unspecified

F32.9	Unspecified depressive disorder
F33.0	Major depressive disorder, Recurrent episode, Mild
F33.1	Major depressive disorder, Recurrent episode, Moderate
F33.2	Major depressive disorder, Recurrent episode, Severe
F33.3	Major depressive disorder, Recurrent episode, With psychotic features
F33.41	Major depressive disorder, Recurrent episode, In partial remission
F33.42	Major depressive disorder, Recurrent episode, In full remission
F33.9	Major depressive disorder, Recurrent episode, Unspecified
F34.0	Cyclothymic disorder
F34.1	Persistent depressive disorder (dysthymia)
F34.81	Disruptive mood dysregulation disorder
F40.00	Agoraphobia
F40.10	Social anxiety disorder (social phobia)
F40.218	Specific phobia, Animal
F40.228	Specific phobia, Natural environment
F40.230	Specific phobia, Fear of blood
F40.231	Specific phobia, Fear of injections and transfusions
F40.232	Specific phobia, Fear of other medical care
F40.233	Specific phobia, Fear of injury
F40.248	Specific phobia, Situational
F40.298	Specific phobia, Other
F41.0	Panic disorder
F41.1	Generalized anxiety disorder
F41.8	Other specified anxiety disorder
F41.9	Unspecified anxiety disorder
F42.2	Obsessive-compulsive disorder
F42.3	Hoarding disorder
F42.4	Excoriation (skin-picking) disorder
F42.8	Other specified obsessive-compulsive and related disorder
F42.9	Unspecified obsessive-compulsive and related disorder
F43.0	Acute stress disorder
F43.10	Posttraumatic stress disorder
F43.20	Adjustment disorder, Unspecified
F43.21	Adjustment disorder, With depressed mood
F43.22	Adjustment disorder, With anxiety
F43.23	Adjustment disorder, With mixed anxiety and depressed mood
F43.24	Adjustment disorder, With disturbance of conduct
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
F43.8	Other specified trauma- and stressor-related disorder
F43.9	Unspecified trauma- and stressor-related disorder
F44.0	Dissociative amnesia
F44.1	Dissociative amnesia, with dissociative fugue
F44.4	Conversion disorder (functional neurological symptom disorder), With abnormal movement
F44.4	Conversion disorder (functional neurological symptom disorder), With speech symptoms

F44.4	Conversion disorder (functional neurological symptom disorder), With swallowing symptoms
F44.4	Conversion disorder (functional neurological symptom disorder), With weakness/paralysis
F44.5	Conversion disorder (functional neurological symptom disorder), With attacks or seizures
F44.6	Conversion disorder (functional neurological symptom disorder), With anesthesia or sensory loss
F44.6	Conversion disorder (functional neurological symptom disorder), With special sensory symptoms
F44.7	Conversion disorder (functional neurological symptom disorder), With mixed symptoms
F44.81	Dissociative identity disorder
F44.89	Other specified dissociative disorder
F44.9	Unspecified dissociative disorder
F45.1	Somatic symptom disorder
F45.21	Illness anxiety disorder
F45.22	Body dysmorphic disorder
F45.8	Other specified somatic symptom and related disorder
F45.9	Unspecified somatic symptom and related disorder
F48.1	Depersonalization/derealization disorder
F50.01	Anorexia nervosa, Restricting type
F50.02	Anorexia nervosa, Binge-eating/purging type
F50.2	Bulimia nervosa
F50.81	Binge-eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified feeding or eating disorder
F50.89	Pica, In adults
F50.9	Unspecified feeding or eating disorder
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.9	Unspecified personality disorder
F63.0	Gambling disorder
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania (hair-pulling disorder)
F63.81	Intermittent explosive disorder
F64.2	Gender dysphoria in children
F64.8	Other specified gender dysphoria
F64.9	Unspecified gender dysphoria
F65.0	Fetishistic disorder
F65.1	Transvestic disorder

F65.2	Exhibitionistic disorder
F65.3	Voyeuristic disorder
F65.4	Pedophilic disorder
F65.51	Sexual masochism disorder
F65.52	Sexual sadism disorder
F65.81	Frotteuristic disorder
F65.89	Other specified paraphilic disorder
F65.9	Unspecified paraphilic disorder
F68.10	Factitious disorder
F68.A	Factitious Disorder Imposed on Another
F80.82	Social (pragmatic) communication disorder
F80.9	Language disorder
F80.9	Unspecified communication disorder
F84.0	Autism spectrum disorder
F90.0	Attention-deficit/hyperactivity disorder, Predominantly inattentive presentation
F90.1	Attention-deficit/hyperactivity disorder, Predominantly hyperactive/impulsive presentation
F90.2	Attention-deficit/hyperactivity disorder, Combined presentation
F90.8	Other specified attention-deficit/hyperactivity disorder
F90.9	Unspecified attention-deficit/hyperactivity disorder
F91.1	Conduct disorder, Childhood-onset type
F91.2	Conduct disorder, Adolescent-onset type
F91.3	Oppositional defiant disorder
F91.8	Other specified disruptive, impulse-control, and conduct disorder
F91.9	Conduct disorder, Unspecified onset
F91.9	Unspecified disruptive, impulse-control, and conduct disorder
F93.0	Separation anxiety disorder
F94.0	Selective mutism
F94.1	Reactive attachment disorder
F94.2	Disinhibited Social Engagement Disorder
F95.0	Provisional tic disorder
F95.1	Persistent (chronic) motor or vocal tic disorder
F95.2	Tourette's Disorder
F95.8	Other specified tic disorder
F95.9	Unspecified tic disorder
G21.0	Malignant neuroleptic syndrome
Z03.89	No Diagnosis or Condition*

* Only when providing crisis intervention, crisis stabilization, or during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

Appendix C.

TITLE 9 Service Definitions

**TITLE 9.
CALIFORNIA CODE OF REGULATIONS
Chapter 11.
Medi-Cal Specialty Mental Health Services**

Assessment (§1810.204)

“Assessment” means a service activity which may include a clinical analysis of the history and current status of a beneficiary’s mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

Plan Development (§1810.232)

“Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.

Mental Health Services (§1810.227)

“Mental Health Services” means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

Therapy (1810.250)

“Therapy” means a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

Rehabilitation (§1810.243)

“Rehabilitation” means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

Collateral (§1810.206)

“Collateral” means a service activity to a significant support person in a beneficiary’s life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

Medication Support Services (§1810.225)

“Medication Support Services” means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis Intervention (§1810.209)

“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible but deliver the service at a site other than a provider site that has been certified by the department or a Mental Health Plan to provide crisis stabilization.

Case Management (§1810.249)

“Targeted Case Management” (Case Management/ Brokerage/Linkage/Placement) means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development.

TITLE 9 DEFINITION (§1810.227) ~ SPECIALTY MENTAL HEALTH SERVICE

“Mental Health Services” mean those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of Adult Residential Services, Crisis Residential Treatment Services, Crisis Intervention, Crisis Stabilization, Day Rehabilitation, or Day Treatment Intensive Services. Mental Health Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: For seriously emotionally disturbed children and adolescents, Mental Health Services provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration.

Appendix D

Coordinated Client Plan (C.P.) Guideline

The C.P. is both a client treatment plan and a service authorization form. If it is not renewed on time annually, all ability to finalize notes and to bill for services will STOP and may result in a loss of revenue.

Action Button Definitions:

Renew — Extends the date of authorization by one year from the date the plan is finalized. All notes are connected to a Client Plan so if a C.P. is not renewed by the annual due date, you will not be able to finalize and bill for your notes. Can be used up to 45 days prior to due date. Know the due dates for all your clients' C.P.s; and if RENEW is an option under the Action button –choose it!

County Staff and FSPs are responsible for renewing the annual C.P. and are considered the primary “author” and coordinator of the plan.

Revise — To be used to make content changes on interventions and/or objectives. For example, when there is a significant change in your client's status a change in the C.P. needs to be made. Other reasons may include updating a provider or staff name or adding achievement dates. Using revise allows you to make changes and to “edit” to the entire C.P.

Remember:

- RENEW starts a new authorization for one year.
- REVISE changes/updates the existing C.P. *without* changing the end dates or re-authorizing.

Add Objective /Intervention — To add objective(s)/intervention(s) to an existing finalized plan. Every program must have an intervention(s) that corresponds to one or more objectives, and the provider/program name in the intervention must match the provider/program name on your service notes or else you will not be able to finalize or bill for them. When adding an obj. /int., changes/edits in content can be made only in your program.

Submit for Authorization — Use this action to submit the CP to your Supervisor for review and authorization. In the “Authorization” section of the plan you must scroll down the list of names to identify and forward the plan to your Supervisor. The C.P. is not renewed/revise/added onto until your Supervisor authorizes it and it has been finalized by you or your Supervisor.

- Medication Prescribers can “self-authorize” their C.P.s and need to choose their own name in the drop-down list under the “Authorization” section.

Finalize — Once the C.P. has been authorized by a Supervisor, you must finalize the C.P. in order to bill for services.

Edit — When Revising/Renewing/Adding Objective or Intervention to a C.P., and have saved it as a draft, “edit” allows changes to content before sending it to Supervisor and finalizing it. The “edit” action also allows adding an achievement date to an intervention without creating a new C.P. number.

New Plan — (Button can be found at the top center of C.P. screen.) Only use the “New” button IF there is no active plan existing for the client in the system. A good practice is to first look in C.G. for a “finalized” plan that you can add onto before you start a new C.P.

Electronic Signature—To obtain a signature on the C.P. using a signature pad, press “Save and Sign” and then press the “Capture” button to obtain client autograph on the electronic signature pad. The signature is not captured until the finalize button is pressed.

Appendix E

BHRS Checklist for Documentation

All of the following documents must be completed on indicated schedule:

(Please note: This is a general guideline. Your individual program may use forms in addition to the ones listed here and they may be located in alternative Drives or files specific to your program workflow. Please check with your Supervisor if you have questions.)

To OPEN a Client to Program

	Form Name <i>Note: Several forms are available in English, Spanish and Vietnamese.</i>	Where is the form located within the BHRS System	Where form should GO once Completed
<input type="checkbox"/>	ADMISSION FORM (This form can be used to open, update a treating clinician's name.) <i>Note: forms are available for Youth, Adult, Katie A, CSU, Casa Rene, etc.</i>	Marin County BHRS Clinical Forms	E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician send original to <u>Medical Records</u> in the bldg. of program
<input type="checkbox"/>	CLIENT PROFILE FORM <i>Note: Submit this form to register brand new clients in the system; and if needed, to update client demographic information on a previously registered client.</i>	Marin County BHRS Clinical Forms	Copy E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician send original to <u>Medical Records</u> in the bldg. of program
<input type="checkbox"/>	CONSENT FOR TREATMENT	PDF Consent - English	Signed copy sent to <u>Medical Records</u> in the bldg. of program
<input type="checkbox"/>	FINANCIAL RESPONSIBILITY FORM (FRF)	Financial and Billing Forms	Send all original forms via inter-office mail to: Billing 20 N. San Pedro Rd. Ste. 2025A Tele Contact X 6816
<input type="checkbox"/>	NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT	MHS Contractor Resources	Original to <u>Medical Records</u> in the bldg. of program Copy given to Client
<input type="checkbox"/>	ADVANCE HEALTHCARE DIRECTIVE INFORMATION <i>Note: For anyone over 18 years of age.</i>	MHS Contractor Resources	To Client
<input type="checkbox"/>	AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)	Frequently Used ROI's	Clinician send original to <u>Medical Records</u> in the bldg. of program
<input type="checkbox"/>	MEDICATION CONSENT FORM (if appropriate)	Clinician's Gateway	Clinician send original to <u>Medical Records</u> in the bldg. of program

Due at Opening, Every 6 months, and at Discharge

<input type="checkbox"/>	BEHAVIOR CHECKLISTS if applicable (CBCL/YSR) For children	YFS: in the Paper Temple	Clinician send original to <u>Medical Records</u> in the bldg. of program
<input type="checkbox"/>	CANS, for youth aged 3-18.	YFS- check with Supervisor	Entered into KIDNet by provider
<input type="checkbox"/>	PSC 35 for children age 3-18.	YFS: in the Paper Temple	Clinician send original to <u>Medical Records</u> in the bldg. of program Copy to supervisor.

Due Within 60 days of opening:

<input type="checkbox"/>	ASSESSMENT CA-Adults/CA-Child	Template found in Clinician's Gateway	Send to Supervisor (if required) and then Finalize
<input type="checkbox"/>	CLIENT PLAN	Template found in Clinician's Gateway	Send to Supervisor to authorize and then Finalize

Due on the ANNUAL:

<input type="checkbox"/>	ANNUAL RE-ASSESSMENT CA-Adults/CA-Child	Clinician's Gateway	Send to Supervisor (if required) and then Finalize
<input type="checkbox"/>	CLIENT PLAN	Clinician's Gateway	Send to Supervisor and then Finalize
<input type="checkbox"/>	CLIENT PLAN SIGNATURE ADDENDUM	Client Plan Addendum PDF	Clinician send original to <u>Medical Records</u> in the bldg. of program
<input type="checkbox"/>	FINANCIAL RESPONSIBILITY FORM	Financial and Billing Forms	Send all original forms via inter-office mail to: Billing 20 N. San Pedro Rd. Ste. 2025A Tele Contact X 6816
<input type="checkbox"/>	CLIENT PERIODIC DATA UPDATE FORM (CSI)	Marin County BHRS Clinical Forms	E-mail to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician send original to Medical Records in the bldg. of program
<input type="checkbox"/>	AUTHORIZATION FOR RELEASE OF INFORMATION (ROI) <i>Note: Check to see if dates and names on ROI are current.</i>	Frequently Used ROI's	Clinician send original to Medical Records in the bldg. of program

To CLOSE a Client:

<input type="checkbox"/>	DISCHARGE FORM (This form can be used to close or change a clinician's name.)	Marin County BHRS Clinical Forms <i>Note: forms are available for Adult, Youth, Katie A, CSU, Casa Rene, etc.</i>	E-mail to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician send original to Medical Records in the bldg. of program
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To UPDATE a Client:

<input type="checkbox"/>	Diagnosis Change Form	Marin County BHRS Clinical Forms	E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician send original to <u>Medical Records</u> in the bldg. of program
<input type="checkbox"/>	Provider Change Form	Marin County BHRS Clinical Forms	E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician send original to <u>Medical Records</u> in the bldg. of program

Appendix F.

Abbreviations, Acronyms, & Symbols

Abbreviations and Acronyms

A/O	Alert and oriented
AAOX 1-4	Alert and oriented times 1,2,3,4,
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL's	Activities of Daily Living
ADV. Dir.	Advanced Directive
AH	Auditory hallucinations
AIDS	Acquired Immune Deficiency Syndrome
AIMS	Abnormal Involuntary Muscle Scale
aka	also known as
AMA	Against Medical advice
AOD	Alcohol and other drugs
approx	approximately
Appt	Appointment
ARBD	Alcohol Related Birth Defects
ASAP	As soon as possible
ASPD	Anti-Social Personality Disorder
avg.	average
AVH	auditory or visual hallucinations
AWOL	absent without leave
B.A.L.	blood alcohol level
B.I.D.	2 times a day
b/c	because
b/f	boyfriend
BCP's	birth control pills
BDD	Body Dysmorphic Disorder
BIB	Brought in by
bio	biological
BM	bowel movement
BMR	Basal metabolic rate
BO	body odor
BP	blood pressure
BPD	Borderline Personality Disorder
bro.	brother
BS	Blood Sugar
Btw	by the way
Bx	behavior
c/o	compliant of/complaining of
CA	Carcinoma or cancer
CANS	child adolescent needs and strengths
Cauc.	Caucasian

CBC	Complete blood count
CBT	Cognitive Behavioral Therapy
cc	cubic centimeter
CD	Chemical Dependency
CFS	Chronic Fatigue Syndrome
CFT	Child family Team
cigs	cigarettes
CISD	Critical Incident Stress Debriefing
clt.	Client
CNS	Central nervous system
conc.	concentrate
cont.	continued
COPD	Chronic Obstructive Pulmonary Disease
CP	Client Plan
CPR	cardiopulmonary resuscitation
CPT	Current Procedural Terminology (billing codes)
CSU	Crisis Stabilization Unit
CVA	cerebrovascular accident
CVD	cardiovascular disease
CXR	chest x-ray
D/C or d/c	Discontinue
DBT	Dialectical Behavior Therapy
DD	Developmental Disability
DDNOS	Dissociative Disorder Not Otherwise Specified
Dec.	Decanoate
disc w/	discussed with
div	divorced
DM	Diabetes Mellitus
DNR	Do not resuscitate
DOB	date of birth
DS	discharge summary
DSM IV TR	Diagnostic & Statistical Manual of Mental Disease, 4th Ed, Text Revision
DSM-5	Diagnostic & Statistical Manual of Mental Disease, Fifth Edition
DTO	danger to others
DTS	danger to self
DT's	Delirium Tremens
dui	driving under the influence (alcohol)
DV	Domestic Violence
dwi	driving while intoxicated

Dx	Diagnosis
e.g.	for example
ECG or EKG	electrocardiogram
ECT	Electroconvulsive Therapy
EEG	electro encephalogram
EMDR	Eye Movement Desensitization Reintegration
enc	encourage
EPS	Extrapyramidal Syndrome of Side Effects
EPSDT	Early & Periodic Screening, Diagnosis and Treatment
ER	emergency room
est	estimate
Et al.	An Others
EtOH	Ethyl Alcohol
eval	evaluation
F/T	full time
F/U or f/u	Follow up
Fa	Father
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
Fdbk	Feedback
FFP	Federal Financial Participation
FM	Fibromyalgia
FMS	False Memory Syndrome
FSP	Full Service Partnership
FY	fiscal year
GAD	Generalized Anxiety Disorder
GAF	Global Assessment of Functioning Scale
GD	Gravely Disabled; Grave Disability
gf or g/f	girlfriend
GI	gastrointestinal
gm	gram
group tx	group therapy
H & P	History & Physical
H.S.	Hour of sleep or p.m.
H/O	history of
H ₂ O	water
HA	headache
halluc.	hallucination
HBP	High Blood Pressure
Hct	hematocrit
HEP A, B, or C	Hepatitis A, B or C
Hep Lock	Heparin Lock
HI	Homicidal ideation

HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HOH	Hard of Hearing
hosp	hospital
HPI	History of present illness
HTN	Hypertension
husb	husband
HV	home visit
Hx	History
I & O	intake and output
i.e.	In other words
IBS	Irritable Bowel Syndrome
ICD-10	International Classification of Diseases, Tenth revision
ICU	Intensive care unit
ID	identification
ID	Identification
IEP	Individualized Education Plan
IM	intramuscular
IMD	Institute of Mental Disease
inc.	increase
info.	information
inj.	injection
Inpt.	Inpatient
int	internal
IOR	ideas of reference
IP	Internal preoccupation
IQ	Intelligence Quotient
IV	intravenously
juv.	juvenile
Kg	Kilogram
L.M.	Left message
lb	pound
LD	Learning Disabled
lg	large
LiCO ₃	Lithium Carbonate
LPS	Lanternman, Petris, Short
m	male
M/C	Medi-Cal
MAOI	Mono-amine oxidase inhibitor (class of anti-depressants)
max.	maximum
MDO	Mentally Disordered Offender
med.	medicine
Med. Hx	Medical History

Meds	Medications
meth.	methamphetamines
mg.	milligram
Mgmt.	Management
mgs	message
MI	Motivational Interviewing
min	minimum
MJ	marijuana
ml	milliliter
mm	millimeter
Mo	Mother
Mos.	Months
MRI	Magnetic Resonance Imaging
MSE	Mental Status Exam
MTBI	Mild Traumatic Brain Injury
MVA	motor vehicle accident
N/A	Not Applicable
N/V	nausea and/or vomiting
narc	narcotics
neg	negative
neuro	neurological
NKA	No Known Allergy
NKDA	No Known Drug Allergies
NLP	Neurolinguistic Programming
NOABD	Notice of Adverse Benefit Determination
NOA's	Notice of Action (ABCD & E) (Obsolete forms)
noc	night
NOPP	Notice of Privacy Practices
NOS	Not otherwise specified
NPO	nothing by mouth
NRR	Normal rate and rhythm
NS	No show
NSG	nursing
NTE	Not to exceed (usually given as part of PRN RX)
O/N	overnight
OCD	Obsessive-Compulsive Disorder
OD	overdose
ODD	Oppositional Defiant Disorder
OP	Outpatient
oriented X3	oriented in all spheres: person, place & date/time
OT	occupational therapy
OTC	over the counter
oz	ounce
P.C.	penal code
P.O.	By mouth

p.r.n.	Prescribed to be taken as needed or as required
P/T	part time
P/u	Pick up
PC	Phone call
PCP	Primary Care Physician
PDR	Physicians' Desk Reference
PE	physical examination
Per	In Accordance With
perp	Perpetrator
PERRLA	Pupils equal, round, reactive to light & accommodation
PHF	Psychiatric Health Facility
PI	present illness
PID	Pelvic inflammatory disease
PM	afternoon
PMS	Premenstrual Syndrome
pre	before
PSC-35	Pediatric Symptom Checklist
pt.	Patient
PTSD	Post-Traumatic Stress Disorder
Q 1 hr	every hour
Q NOC	every night
q.2 h	every second hour
Q.A.M.	Every morning
q.h.s.	At hour of sleep
q.i.d.	4 times a day
q.s.	as much as will suffice
qt	quart
R	Right
R	respiration
R X 1	repeat times one
R/O	rule out
R/S	reschedule
RE/ re:	Regarding or Concerning
reg	regular
ret'd	returned
ROI	Release of Information
ROM	range of motion
RTC	return to clinic
RTIS	responding to internal stimuli
RX	Prescription or written order by a doctor
S/R	Seclusion & Restraints
SA	substance abuse
SE	Side effects
SI	Suicidal ideation
SIB	Self-Injurious Behavior

SIP	Situation, Intervention, and Plan
SIRP	Situation, Intervention, Response, and Plan
sis	sister
SLE	Sober Living Environment
SMI	Seriously Mentally Ill
SOB	shortness of breath
SOC	Share of Cost/System of Care
SPMI	Seriously and Persistently Mentally Ill
SSDI	Social Security Disability Insurance
SSI	Symptom Severity Index/ Social Sec Insurance
SSRI	Selective Serotonin Reuptake Inhibitor
stat	immediately
STD	Sexually Transmitted Disease
Sub Q	subcutaneous
SUD	Substance Use disorder(s)
SW	Social Worker
SWF	single, white, female (marital status, race, gender)
SX /sx	Symptom
T	temperature
T.I.D.	3 times a day
T.O.	telephone order
tab	tablet
TAR	Treatment Authorization Request
TAT	Thematic Apperception Test
TC	Telephone call
T-Con	Temporary Conservatorship
temp	temperature

TIA	Transient Ischemic Attack
TIR	Traumatic Incident Reduction
TPC	Treatment planning conference
TPR	temperature, pulse, respiration
TRO	Temporary Restraining Order
Tx	Treatment/Therapy
UA	urinalysis
unk	unknown
V.O.	Verbal Order
V/S/ v.s.	vital signs
VD	Venereal disease
VH	Visual hallucinations
VKD	Visual Kinesthetic Dissociation
VM	Voicemail
Voc	Vocational Services/Vocation Rehabilitation
Vol.	voluntary
vs	Versus
w/	With
w/c	wheelchair
w/in	within
w/o	Without
WBC	White blood count
WCB	Will call back
wk	week
WNL	Within normal limits
wt	weight
X	Times (as in 2 times per week)

Roles and Positions			
ACM	Adult case Manager	MFT	Marriage and Family Therapist
Case Mgr.	Case manager	MHRS	Mental Health Rehab Specialist
CM	Case manager	PHD	Doctor of Philosophy (Psychologist)
CMHC	Community Mental Health Counselor	P. A.	Program Assistant
EMT	Emergency Medical Technician	PD	Police Department
FNP	Family Nurse Practitioner	PO	Probation Officer
Hse Mgr	House manager	PRT	Placement Return Team
Int.	Intern	QIC	Quality Improvement Coordinator, Quality Improvement Committee
LCSW	Licensed Clinical Social Worker	W	when used after a discipline = waived
LPHA	Licensed Practitioner of the Healing Arts	Super	Supervisor
MD	Physician	Psy.D	Doctor of Psychology

Agencies and Organizations			
AA	Alcoholics Anonymous	MCS	Marin County Sheriff
ACA	Adult Children of Alcoholics	MCSD	Marin County Sheriff Dept.
AFDC	Aid to Families with Dependent Children	MGH	Marin General Hospital
APS	Adult Protective Service	MHA	Marin Housing Authority
ARF	Adult Residential Facility	MHB	Mental Health Board
BES	Buckelew Employment Services	MMHP	Marin Mental Health Plan
BHRS	Behavioral Health and Recovery Services	MSW	Marin Services for Women
CAM	Community Action Marin	MTC	Marin Treatment Center
CHP	California Highway Patrol	NA	Narcotics Anonymous
CIP	Center for Individual Psychotherapy	NAMI	National Alliance for Mentally Ill
CMHS	County Mental Health Services	NPD	Novato Police Department
CMSP	County Medical Service Program	OA	Overeaters Anonymous
CPMC	California Pacific Medical Center	PES	Psychiatric Emergency Services (CSU)
CPS	Child Protective Services	PGO	Public Guardian's Office
CSOC	Children's System of Care	PHF	Psychiatric Hospital Facility
DHCS	California Department of Healthcare Services	PSG	Personal Support Group
DOR	Department of Rehab	R to R	Road to Recovery
EAP	Employee Assistance Program	RSS	Residential Support Services
ERC	Enterprise Resource Center	SAPD	San Anselmo Police Department
FPD	Fairfax Police Dept.	Shelter +	Shelter Plus
FSA	Family Service Association	SNF	Skilled Nursing Facility
GEM	Growing Excellence in Marin	Sr. Acc.	Senior Access
GGRC	Golden Gate Regional Center	SRPD	San Rafael Police Dept
HHS	Health and Human Services	TBS	Therapeutic Behavioral Services
HICAP	Health Insurance Counseling Advocacy Program	TCPD	Twin Cities Police Dept.
HMO	Health Maintenance Organization	UCSF	University of Calif. San Francisco Medical Center
IMD	Institute for Mental Disease	Unit A	MGH inpatient psychiatric unit
JFCS	Jewish Family and Children Services	Unit B	CMHS CSU unit
LPPI	Langley Porter Psychiatric Institute	WMSC	West Marin Service Center
MW	MarinWorks	YES	Youth Empowerment Services
MAIL	Buckelew Marin Assisted Independent Living	YFS	Youth & Family Services
MCC	Marin Community Clinic		
Symbols			
@	At	Ⓜ	Mother
Δ	change	Ⓣ	Father
∴	therefore, consequently	Ⓟ	Brother
Ψ	Psychologist, Psychiatrist or psychotherapy	Ⓢ	Sister
↓	decrease	2°	secondary to
↑	increase	1°	primary
∅	zero or no	~	about, approximately
c̄	with	>	greater than
s̄	without	<	less than
♂	male	☺	happy
♀	female		

**Official Joint Commission
"Do Not Use" List¹**

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)*	Decimal point is missed	Write X mg
Lack of leading zero (.X mg)	Decimal point is missed	Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate"
M _{SO4} and MgSO ₄	Confused for one another	Write "magnesium sulfate"

¹ Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Appendix G.

**Lockout Guidelines for
Facilities where BHRS Clients are Frequently Located**

I. Facilities with lockouts/restrictions- CCR Title 9, Chapter 11, § 1810.221.1

Type of facility: IMDs (Institution for Mental Disease) – MHRCs (Mental Health Rehabilitation Centers) and Skilled Nursing Facilities (SNF) with Special Treatment Program (STP)

All Services Locked-Out (Medi-Cal Mental Health (MH)/Case Management (CM) services not allowed):

California Psychiatric Transitions (CPT)
Canyon Manor Residential
Crestwood Modesto
Crestwood Stockton
Crestwood Idylwood Care Center (Helio's)

Crestwood Vallejo
Medical Hill Oakland
Merced Behavioral Health
Sequoia Treatment Center – Willow Glen
Telecare Garfield
Telecare Morton Baker

Other Lockout Facilities – All Services Locked-Out

Jail/Juvenile Hall
State Hospitals – Napa

II: Crisis Stabilization Unit (CSU, aka PES): Can provide: Case Management - Brokerage is after admission to CSU. No other specialty mental health service allowed after CSU Admission. Crisis Intervention and other Mental Health Services allowed on the same day as admission to CSU but only prior to admission, not to be used after admission.

III. Acute Psychiatric Inpatient Units (partial list)

Can provide:

**Case Management – Brokerage related to Discharge Planning and Placement only*, or
Medication Support Unbillable.**

Marin General Hospital
San Francisco General Hospital
St. Francis Hospital
Mills Peninsula Health Services
John Muir Behavioral Health Center
Aurora Hospital

** Within 30 days of discharge for up to 3 non-consecutive 30-day periods.*

IV. Crisis Residential Facilities: Brokerage services allowed only. Medication Services are allowed if within scope of practice.

Casa Rene (Drake House)

V. Facilities without any lockouts/restrictions of Mental Health and Case Management/Brokerage services

Medical Skilled Nursing Facilities – without Special Treatment Program (STP)

Can provide any Medi-Cal Mental Health Services

Crestwood Idylwood (“The Gardens”)
Kindred Nursing and Transitional Care (Greenbrae)
Northgate Post-Acute Care
Novato Healthcare Center
The Oaks-Petaluma
Pineridge Healthcare Center
Professional Post-Acute Center
Rafael Convalescent Hospital
San Rafael Healthcare & Wellness

Residential Care Facilities (aka RCF or Board & Care/B&C)

Can provide any Medi-Cal Mental Health Services

All Saints	Everwell (Delta at the Sherwoods)
Crestwood Our House (Vallejo)	St. Anne’s
Crestwood American River	Psynergy
Good Shepard Vista (Assisted Living)	Ruby’s Valley Care Home
Golden Home Extended Care	St. Michael’s
Davis Guest Home	Willow Glen
Everwell (Enclave at the Delta)	

Appendix H

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-25
	Next Review Date: October 2022
POLICY: <u>DOCUMENTATION STANDARDS FOR OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES</u> SUPERSEDES – 211-09	Date Reviewed/Approved: October 22, 2019 By:  Jei Africa, PsyD Director of Behavioral Health and Recovery Services

POLICY: DOCUMENTATION STANDARDS FOR OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES

I. PURPOSE:

Marin County Behavioral Health and Recovery Services (BHRS) is committed to providing quality mental health services that are documented to meet Federal and State regulations and consistent with community standards. Consistent and complete treatment records are an essential component of quality client care.

The purpose of the treatment record is to communicate the client’s clinical history, past and current mental health status, treatment, interventions, and plans for future clinical care.

Clear documentation and documentation standards promote quality of care in the following ways:

- Comprehensive clinical documentation facilitates complete and appropriate assessments, efficient and effective treatment planning and delivery, consumer involvement in goal development and service delivery, peer review, medication monitoring, training and supervision.
- Liability issues can be minimized when documentation in the medical record follows applicable regulations, professional practice standards and legal standards.
- Clear documentation creates a written communication to aid in the continuity of care provided by all members of the mental health team.
- Medi-Cal, Medicare and other funding streams can be utilized for maximum revenues to support ongoing client services.

The purpose of this policy is to:

- Describe expectations for documentation standards and practices based on cited authorities.
- Determine that Medi-Cal documentation standards shall apply to all BHRS clients.
- Recognize that grant funded programs, Mental Health Service Act (MHSA) Full Service Partnerships (FSP), Crisis Stabilization Unit (CSU), Therapeutic Behavioral Services (TBS), Crisis Residential Units (CRU), CAM peer providers and other staff or programs may have additional and/or different specific documentation requirements.
- Identify that the BHRS Clinical Documentation Guide is the resource manual for documentation standards for county and contractor programs.

II. REFERENCES:

California Code of Regulations (CCR) Title 9, Chapter 11
Code of Federal Regulations (CFR) 42 part 438
DHCS County Contract, Attachment C
Welfare and Institutions Code, Section 14680 & 5778.
MHSUDS Info Notices 17-040 & 17-052

III. POLICY:

BHRS requires that each service provider document all services provided to clients in accordance with State and Federal regulations and professional standards.

It is the policy of BHRS that service claims submitted for reimbursement to any Federal, State, or private source shall be based on complete and timely documentation filed in the client's behavioral health record. Any services provided which do not meet standards and regulations shall not be submitted for reimbursement.

It is also the policy that staff will use the Electronic Health Records (EHR) to document services whenever possible.

All staff will be expected to complete and protect all documentation of a client's medical record in compliance with State and Federal regulations including Health Insurance Portability and Accountability Act (HIPAA), Marin County Health and Human Services Policies, and BHRS Policies and Procedures.

This policy is applicable to all BHRS staff, trainees, volunteers, contractor staff co-located with county teams, and contract agencies who provide services for BHRS clients.

IV. AUTHORITY/RESPONSIBILITY:

Quality Management/Compliance
Division Directors
Program Managers
Supervisors
BHRS Service Providers
Contractors

V. PROCEDURE:

Documentation of Outpatient Services by County and Contract Providers shall be as follows:

- A. Assessment
 - 1) Requirement
 - Assessment is to be completed and finalized with the Electronic Health Record (EHR), Clinician's Gateway (CG).
 - Assessment should establish the foundation for medical necessity for ongoing services.
 - 2) Frequency and Timeliness of Documenting
 - Assessments are to be completed and finalized within 60 calendar days of opening episode.

- Annual assessments are to be completed and finalized within 30 calendar days prior to the end of the established/current authorization period.
 - Medical Assessments are to be completed at least every three years from episode opening.
- 3) Scope of Practice
- Historical Information and Client Data may be completed by any staff.
 - Diagnosis, Mental Status, and Case Formulation sections can only be formulated by a licensed/registered/waivered staff and/or by trainees under the supervision and with a co-signature of a licensed/waivered staff.
 - An assessment can only be finalized by the author after the Diagnosis, Mental Status, and Case Formulation sections are completed by appropriate staff as listed above.
- 4) Additional Assessment Tools
- Children and youth seen by BHRS providers must be administered a Child and Adolescents Needs and Strengths (CANS) Core 50 and the PSC35 (Pediatric Symptom Checklist) at the beginning of treatment, every six months following the first administration, and at the end of treatment. Parents/caregivers will complete the PSC-35 for children and youth ages 3 up to age 18. Certified providers will complete the California CANS (form dated October 3, 2016) through a collaborative process which includes children and youth ages 6 up to age 20 and their caregivers (at a minimum).

B. Client Plan

- 1) Requirement
- Client Plans are required for all clients determined to meet medical necessity and open for services for more than sixty (60) days.
- 2) Frequency and Timeliness of Client Plans
- The Initial Client Plan must be completed within sixty (60) days of an admission for both Adult and Children's System of Care providers or for an episode in which the client was completely closed to the facility program for over 180 days (6 months) and is being re-opened to services.
 - Client Plans must be reviewed and renewed on an annual basis to reflect progress and updated goals and objectives.
- 3) Scope of Practice
- Client plans may be completed by all staff unless excluded on scope of practice grid
 - Co-signatures by licensed/registered/waivered staff are required on Client Plans for trainees and all non-licensed/non-registered/non-waivered staff. Co-signatures by Program Supervisors shall also serve as authorizations.
- 4) Authorization
- All BHRS county Client Plans must be authorized by Program Supervisor or designated contractor supervisor.
- 5) Service limitations prior to Client Plan finalization.
- Only Assessment, Plan Development, Brokerage (related to Linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services) and Medication Support Services (for assessment, evaluation, or plan development, or if there is an urgent need, which must be documented) can be claimed prior to Plan finalization. These limitations apply to lapses between plans as well. In the event of a client crisis, Crisis Intervention may be claimed.
- 6) Revisions to the Client Plan
- Client Plan may be revised at any time during the authorization period.
 - Client Plan should be revised any time there is a significant development or change in the focus of treatment.

- Client Plan revisions can include the addition of goals/objectives to address a new issue or to add a different treatment modality.
- 7) Revisions to Client Plans require a client signature unless the revision is purely administrative (i.e., no change in the modality or goal of treatment). Administrative revisions should be noted as such and documented as described below.
 - 8) Client Participation and Signature
 - Client participation shall be documented by obtaining the signature of the client/parent/guardian on the Client Plan Signature Addendum or by electronic signature on the plan.
 - If a client/parent/guardian refuses or is unavailable to sign, the clinician will document the reason that the client/parent/guardian signature was not obtained. Clinicians should continue to attempt to obtain a signature and document all attempts in subsequent progress notes.
 - If a signature is not required due to an administrative update, this should be stated in the section of the Client Plan designated to describe why the client's signature was not obtained.

C. Progress Notes

- 1) General Requirement
 - All staff must complete progress notes for all Specialty Mental Health Services provided.
 - Progress notes should document relevant aspects of client care.
 - Focus of intervention should address impairment that established medical necessity, i.e., diminish impairment or prevent deterioration.
- 2) Required Elements
 - The date the service was provided.
 - Location where the service was provided.
 - The amount of time taken to provide services.
 - Description of encounters, staff provided interventions, client response, plan for follow-up, relevant clinical decisions when made, and referrals made when appropriate.
 - The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.
- 3) Format
 - Progress Notes should be written using the Situation-Intervention-Response-Plan (SIRP) format, except in programs not required to follow this format.
 - All county staff and contractors shall document progress notes in the Clinician's Gateway electronic health record, unless approved by contract and/or with the approval of the Contract Manager/Division Director.
 - Note that Clinician's Gateway EHR enforces most, but not all of the required elements listed above.
 - Staff should only use abbreviations from the approved abbreviations list from the most current BHRS Clinical Documentation Manual. Other acronyms should be spelled out on first use.
- 4) Timeliness
 - Documentation of services should be completed as soon as possible after the service is performed and within the following time frames.
 - All documentation of services not requiring a co-signature must be entered and finalized in the client EHR within 72-business hours or 3 business days from when the service was provided.
 - Documentation that requires a co-signature should be completed by the author within 72-business hours or 3 business days, co-signed by supervisor and

finalized within 10 business days.

- Documentation completed later than 72-business hours or 3 business days from when the service was provided is considered late and should be labeled “Late Entry” at the beginning of the note. Late entry services should **not** include documentation time when claiming.

5) Co-signatures

- Co-signatures are required for trainees and staff who do not meet Mental Health Rehabilitation Specialist (MHRS) qualifications.
- Co-signatures may be required for any staff as determined to be necessary by the program supervisor or Quality Management for supervisory purposes.

6) Scope of Practice

Staff will only provide services allowed by licensure status, or other privileged status such as Mental Health Rehabilitation Staff (MHRS), per the following table.

	Physician	Licensed or Waived Psychologist (post PhD)	Licensed or Registered LCSW, MFT, LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	MH Nurse Practitioner	Registered Nurse	Licensed Vocational Nurse, Psych Tech	Trainee enrolled in MFT, PhD program (post BA/BS but pre MA/MS/PhD)	MHRS (Staff with BA/BS in MH related Field and 4 year exp in MH)	Staff without BA/BS and 4 yrs. exp/or AA & 6 yrs. exp.
Assessment:										
History & Data Collection	Yes	Yes	Yes	Yes	Yes	Yes	Yes+	Yes+	Yes+	Yes+
MSE & Diagnosis	Yes	Yes	Yes	Yes	Yes	No	No	Yes+	No	No
Complete Client Plan	Yes	Yes	Yes	Yes	Yes	Yes+	No	Yes+	Yes+	No
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes++	Yes++	Yes+ ++	Yes++	No
Medication Administration	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Medication Dispensing	Yes	No	No	Yes*	Yes	Yes*	No	No	No	No
Med. Prescribing or Furnishing	Yes	No	No	No	Yes	No	No	No	No	No
Med support svc.	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Psychological Testing	No^	Yes	No^	No	No^	No	No	Yes+	No	No
Psychotherapy	Yes	Yes	Yes	Yes	Yes	No	No	Yes+	No	No
Rehabilitation Counseling	No	Yes	Yes	Yes	No	Yes	No	Yes+	Yes	Yes+
Brokerage	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes+	Yes	Yes+
Therapeutic Behavioral Services	No	Yes	Yes	No	No	No	No	Yes+	Yes	No
Collateral	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+
Plan Development	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+
KTA ICC	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes+
KTA IHBS	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes+

+ Co Signature Required

^ Staff w/ specific training and experience may qualify, upon approval of the MH Director

* RN's may dispense if trained in dispensing and re-certified annually

++ Must have immediate supervision if issues of danger to self or others are present

7) Service Language

- For consumers whose language needs are other than English, staff must document at the beginning of starting services, how the services will be delivered in order to meet the language needs of the client. All following on-going care notes must also include language in which service was delivered.
- Documentation of each service for non-English speaking consumers must indicate whether the service was provided through an interpreter, by a bilingual clinician or other modality,

8) Multiple Service Providers

In the event that an individual or group service is provided by more than one clinician, the progress note(s) also must clearly document the specific involvement and amount of time of each provider.

D. Program Specific Requirements

Grant funded programs, Mental Health Service Act (MHSA) Full Service Partnerships (FSP), Crisis Stabilization Unit (CSU), Therapeutic Behavioral Services (TBS), Crisis Residential Units and other programs may establish additional and/or different specific documentation requirements, although these requirements should be consistent with the standards described in this policy.

E. Training

- The BHRS Clinical Documentation Guide is the resource manual for documentation standards for county and contractor programs.
- New staff must receive documentation training no later than 6 months from start date.
- Additionally, staff may be required to receive training upon request of their supervisor or Quality Management.

Appendix I

Changes in the January 2020 version

- Clarified timeliness section, aligned with desk reference.
- Eliminated unverified Medicare requirement
- Revised and relocated section regarding services billable prior to completion of plan, during plan gaps
- Clarified confusing language regarding supervision
- Replaced introduction to non-billable services section
- Eliminated references to “No M/C” procedures and revised references to Non-Billable procedures.
- Replaced “intern” with Associate or trainee, as applicable, regarding staff references per regulatory change.
- Updated medical necessity language relating to diagnosis.
- Updated covered diagnosis table – Appendix B
- Eliminated ICD-9 references throughout.
- Updated abbreviations tables – Appendix F
- Updated Lockout and Limitations section and aligned with Appendix G
- Updated examples throughout
- Updated Clinician’s Gateway version reference
- Eliminated section regarding not claiming services documented more than 30 days late.
- Added section pertaining to Combining Multiple Service Types
- Updated links to Forms
- Included Documentation Standards Policy BHRS 25 - Appendix H

Changes in the August 2020 2.0 version

- Eliminated references to “No M/C” procedures and revised references to Non-Billable procedures.
- Updated Medical Necessity Section relating to use of DSM-5. Describes changes related to inclusion of Autism Spectrum Disorder as a covered diagnosis and elimination of the use of DSM-IV to allow for differential between previously covered and non-covered related diagnoses. Lists DSM-IV related diagnoses eliminated from covered diagnosis table.
- Updated covered diagnosis table – Appendix B