County of Marin

Behavioral Health and Recovery Services

Documentation Manual for Fee for Service Providers

FY 20-21

August 2020 revision

County of Marin
www.co.marin.ca.us

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

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Introduction

Marin County Behavioral Health and Recovery Services (BHRS) is a county mental 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. 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. Although some clients receive services that are funded through grants, as a policy we do not reduce or alter documentation standards because of the client's funding source.

Marin County has adopted a Compliance Program based on guidance and standards established by the Office of Inspector General, U.S. Department of Health and Human Services. The intent of the compliance plan is to prevent fraud and abuse at all levels. The compliance plan particularly supports the integrity of all health data submissions, as evidenced by accuracy, reliability, validity, and timeliness. The plan applies to staff, volunteers, trainees, and contractors working in county owned or operated sites. As part of this plan we must work to ensure that all services submitted for reimbursement are based on accurate, complete, and timely documentation (for Reasons for Recoupment from DHCS, see Appendix D). It is the responsibility of every provider to submit a complete and accurate record of the services they provide and to document services in compliance 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)) and serves as the basis for all documentation and claiming in the County of Marin, regardless of payer source. All staff, whether directly operated by the County or Contracted Network "Providers" are expected to abide by the information found in this guide.

Quality Improvement may issue updates and/or clarifications to information found in this manual via Provider meetings, emails, or acceptable modes of communication. The updates and/or clarifications are considered to be official BHRS requirements and will be incorporated into this guide as appropriate.

Why We Document

- Legal and Revenue purposes: Charts are legal records and assist in protecting legal interests of client, and provider.
- Client picture and history: Charts provide documented evidence of the client's current situations, progress and obstacles toward achieving goals.
- Communication and collaboration with other service providers and improved quality of care: Coordinate and provide continuity of care.

Remember: Clients have the right to access their medical records.

Medical Necessity and Functional Impairments

Medical necessity is established through the assessment process. Diagnosis and impairments further strengthen and reaffirm the need for mental health services that support the client/family's road to recovery. Although we establish medical necessity at assessment, **it does not end here**. Medical necessity permeates every service that is offered and delivered to the client/family; therefore, it requires ongoing re-assessment throughout the client/family's course of treatment provided through Marin County of Marin Mental Health and Substance Use Services.

To be eligible for Medi-Cal reimbursement for Outpatient/Specialty Mental Health Services, a service must ***meet all 3 criteria for medical necessity***

- Diagnostic Criteria
- Impairment Criteria
- Intervention Related Criteria

Diagnostic Criteria:

An included diagnosis (see Appendix A for DHCS approved diagnoses)

Impairment Criteria:

An impairment as a result of a mental disorder

A functional impairment is a dysfunction in social, developmental and/or occupational spheres of life.

- Occupational/Educational
- ADLs (Activities of Daily Living)
- Family and Social Relationships
- Housing
- Health
- Symptoms
- History of Psychiatric Hospitalizations
- Probability of Deterioration in An Area of Life Functioning

Determining the level of severity is a clinical judgment.

Medical Necessity continued page 6

Intervention Criteria:

The focus of intervention addresses mental health condition(s). (The condition would not be responsive to physical health care based treatment)

The expectation that proposed interventions will:

- Significantly diminish the impairment
- Prevent significant deterioration in important area of life functioning
- Allow child to progress developmentally as individually appropriate

ALL SERVICES AND INTERVENTIONS FOR WHICH MEDI-CAL REIMBURSEMENTS ARE REQUESTED MUST ACCOMPLISH ONE OF THE FOLLOWING:

- Diminish impairment
- Prevent significant deterioration
- Allow a child to progress developmentally as individually appropriate

Connection Between the Assessment, Case Formulation, Client Plan and Progress Notes

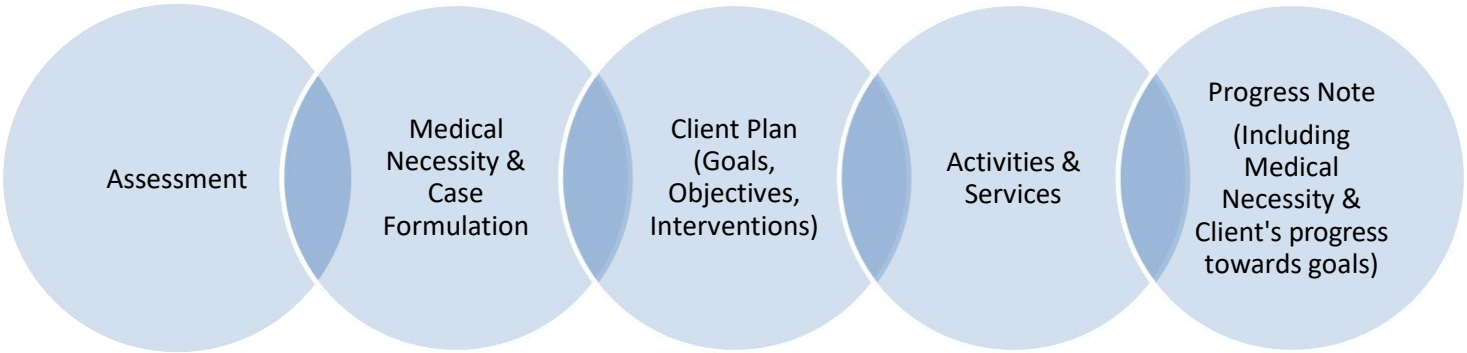
Definitions:

Assessment: A service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis and the use of use of testing procedures

Case Formulation: Describes the person's presenting problems, describes factors that may be contributing to the person's problems (both if they were present at the beginning of the problem and/or if they contribute to the person maintaining their current level of functioning), describes the client's strengths. Case formulations should also describe the disposition with frequency (e.g. weekly therapy to assist with symptom management)

Client Plan: A client plan is an agreement between the treating staff and the client regarding the client's goals, objectives to reach in order to meet the goal and the interventions that the staff will use to assist the client in meeting his/her objectives (and ultimately the goal).

Progress Notes: A part of the medical record in which the staff describes interactions with clients, ***medical necessity at the time of service***, progress towards goals, and any services done on the client's behalf. Services done to assist client in coordinating treatment need to include why the client needs assistance (must include medical necessity). BHRS and Network Providers are required to write progress notes using SIRP format.



COUNTY OF MARIN

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

How to Strengthen Your Assessments

- Describe the client's strengths and weaknesses in behaviorally specific language.
- Perform a thorough assessment including these elements:
    - Reason for Assessment
    - History of the Present Illness or Difficulty
    - Mental Health History
    - Substance Use History
    - Medical History
    - Work History
    - Family History
    - Review of Physical Systems
    - Mental Status Examination
    - DSM-5 Diagnosis
- Before making a diagnosis, make sure the diagnosis is supported by behaviors, symptoms, and functional impairments documented in the assessment. DHCS is clear that if the assessment does not support the diagnosis, the entire treatment episode is subject to disallowance.
- If your assessment consists of several interviews with the client, think twice before assigning an "Unspecified" diagnosis. Although there are cases in which the behaviors and symptoms presented by the client do not fit one of the specific DSM diagnoses, assigning an "Unspecified diagnosis should be done sparingly and not just because the person performing the assessment neglected to obtain the information, which would have made further diagnostic specificity possible.

Remember: There is a relationship between the diagnosis and the treatment

The relationship between diagnosis and (1) type of treatment, (2) manner of approach, (3) choice of specific therapeutic techniques, (4) treatment frequency, and (5) length of treatment is equally important in the case of psychological treatments.

Client Plans

Client Plans should contain the client's goals, the objectives the client will reach in order to achieve the goal and the intervention staff will take to assist the client in meeting the objectives and achieving the goal.

Goals:

A Goal represents client's/family's long-term dreams or desires - "the big picture."

Goals are meaningful when the client is involved in the development of the plan.

Objectives:

Objectives are the practical steps to move toward the Goal and drive the interventions/ services.

Client Plan Objectives need to be **specific**, **measurable**, and **observable**.

3 Ways to Measure Goals:

1. COUNTING (at least 1 trigger)
2. PERCENTAGE (use coping strategies 75% of the time)
3. SCALING (rate self at no more than a 5 on a scale of 1-10 for anxiety with 10 being very anxious and 0 being not anxious at all)

Example: Client will learn to identify at least two triggers that precede an aggressive incident. Client will learn three tools to decrease agitation from a baseline of one as measured by client report and collaboration with staff at client's housing.

Interventions:

Interventions are the actions by the staff that assist the client in accomplishing the objectives. Interventions need to include the frequency and duration of the intervention.

Example: Staff will use psychoeducation to assist client with learning two strategies to effectively manage auditory hallucinations. Staff will offer client feedback for recognizing at least two triggers that precede an aggressive incident during weekly meetings with client for the next 6 months.

Note: Interventions or services that address impairments resulting from non-covered diagnoses are not reimbursable.

How to Strengthen Your Client Plans

Be clear about WHAT you are treating

Describe the behaviors, symptoms, and functional impairments that are the direct result of the included diagnosis or diagnoses in behaviorally specific terms.

Describe the behaviors, symptoms and functional impairments that are the goals of your interventions in specific language and quantify them whenever possible (e.g. by using self-reports of severity using a simple 1 to 10 scales with defined anchor points).

Be clear about HOW you are treating what you are treating

Identify the proposed type(s) of interventions and modalities you will be using, including detailed descriptions of the interventions. Avoid general terms such as “therapy” and instead describe what the interventions will actually involve. (e.g., identify self-defeating strategies and this basis by exploring and analyzing the client’s typical self-statements and use cognitive restructuring to modify these beliefs.)

All interventions should include frequencies and durations. How frequently and for how long do you plan to continue intervening in this particular way before re-evaluating and modifying your interventions?

Remember:

- Documented interventions must have as their focus the condition/impairments resulting directly from the included diagnosis(es) in order to establish medical necessity.
- Documented interventions must have reasonable expectation of significantly diminishing impairments, preventing significant deterioration, or allowing a child to progress developmentally as appropriate.

Progress Notes

BHRS and Network Providers are required to write notes in the SIRP format.

Situation: *Sets the stage. Gives reader an idea of why the service is occurring, what symptoms or behaviors are the focus of the service.*

- Use descriptive sentences
- State the purpose of the contact
- Include statements about client's appearance, mood, behaviors, symptoms, functioning.

Intervention: Identifies what you did during the interaction with or for the client to address the situation. Use verbs to describe your actions: (see Appendix B for more suggestions)

- Identified skills used to cope/adapt/respond/problem solve.
- Reinforced new behaviors, strengths (name)
- Taught/modeled/practiced skill (specify)
- Redirected

Response: Response from the client following your intervention. Describe verbal and non-verbal response from client.

- Client sat back in her chair, breathed deeply and appeared less anxious
- Client stated she would contact her primary doctor
- Client agreed to practice skill/behavior on his own

Plan: Indicate what next steps will be. "P" relates to the objectives on the Client Plan. Specifies action items as a result of the contact and service provided. For example:

- Contacts to be made on behalf of the client
- Skills client will be learning
- Follow up on homework assignments

For Sample Phrasing of Interventions and Client Response, see Appendix B.

How to Strengthen Your Progress Notes

- Remember that in order to be reimbursable; the progress note for each service must include documentation of an intervention that meets the intervention criteria identified in the client plan.

- Progress notes that describe sessions involving nothing more than a report of what the client said are not reimbursable. Passive listening without intervening in some way does not move the client closer to his/her goals. This is one of the most frequently encountered problems in progress notes, especially those written by novice therapists and case managers.

- When looking back on a session, if you find that you did not intervene in some way that was consistent with the Client Plan, you should consider not billing for the time.

- Remember that so-called "therapeutic non-specifics" (e.g., empathic listening, "being open to what the client says") are not really interventions—at least in the sense which would make them Medi-Cal reimbursable.

- When you write your progress notes, ask yourself whether the session moved the client closer to achieving the goals that are on his/her Client Plan. If your answer is "no," you need to determine why this was the case and formulate a plan for avoiding this during future sessions. This plan should be made part of the progress note for this session.

How to Strengthen Your Overall Treatment Strategy

In addition to evaluating the effectiveness of your interventions on a regular basis (and documenting these evaluations in the progress notes and in revisions of the Client Plan), **you should periodically review the appropriateness of your treatment strategy as a whole.**

This would include an evaluation of

- The appropriateness of the array of services being provided.
- The frequency with which the services are provided
- The intensity with which the services are provided (i.e. session length)

It is especially important that service providers be able to determine when a client is receiving too few services, too many services, inadequate service, excessive service, or duplicate services by multiple providers.

When documentation is reviewed for medical necessity, there is a strong correlation between the percentage of services that are disallowed due to documentation that does not meet medical necessity criteria for Specialty Mental Health Services and the number of hours being claimed per day or per week for that beneficiary. There is no prohibition against providing intensive services, but the documentation for intensive services must meet medical necessity criteria.

Reauthorizations

The following are requirements for Reauthorizations:

Documentation:

- Reauthorization Requests must have all components to meet Medical Necessity.
- Review Diagnosis and update as necessary
- Symptoms and Functional Impairments that demonstrated that the client is Seriously Mentally Ill. If the client's functional impairments are mild to moderate, this client will be referred UNLESS the clinician clearly documents that services are needed to maintain current level of functioning.
- Treatment Goals that are ***Specific, Measurable, and Observable.***
- Interventions MUST be what staff will do to help decrease client's mental health symptoms and address functional impairments.
- Clinical formulation is where you bring it together to justify why the client needs services.

Reauthorizations MUST include the most recent assessment and treatment plan. Client plan MUST be signed by the client, the clinician, and the supervisor (if applicable)

Procedure:

- Reauthorizations need to be submitted a minimum of 10 working days prior to the expiration of authorized services to ensure no interruption of services.
- **Please include start date of the reauthorization on the form**.

For Reauthorization and Change of Service Modality Request form, see Appendix C.

Appendix A.

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*
* Covered 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.	

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Appendix B:
Sample Phrases for Interventions

Clinicians' Interventions

Acknowledged	Discussed	Inquired	Questioned
Addressed	Empathized	Interpreted	Reality-tested
Advocated	Encouraged	Interrupted	Recommended
Analyzed	Engaged	Joined	Reflected
Assisted	Established	Labeled	Reframed
Assured	Examined	Listened	Role-modeled
Called	Expanded	Made eye contact	Role-played
Challenged	Explained	Mirrored	Set limits
Clarified	Explored	Modeled	Shifted
Confronted	Facilitated	Monitored	Supported
Constructed	Figured Out	Noted	Urged
Consulted	Focused	Observed	Validated
Created	Guided	Offered feedback	Wondered
Defined	Helped	Played	Etc.
Demonstrated	Identified	Processed	
Developed	Informed	Provided	

Clients' Responses

- Agreed
- Affirmed
- Attempted
- Became (anxious, sad etc.)
- Calmed
- Complained
- Contradicted
- Cried
- Denied
- Disagreed
- Dissociated
- Explained
- Expressed
- Fell Asleep
- Frowned
- Looked (away, towards the ground, etc.)
- Made eye contact
- Nodded
- Played
- Quieted
- Relaxed
- Remained
- Said
- Shouted
- Smiled
- Yawned

Examples of Phrasing

I listened empathically as he…	We reframed…	I validated…	I clarified…
She used sessions as a reality check….	I challenged her perception….	Together we reviewed….	I reinforced his decision to….
I offered optional parenting interventions	I inquired	We constructed a (time line, genogram, set of goals, etc.)	I helped her identify….
I observed silently as she….	I wondered aloud….		

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Appendix C:

MMHP Child/Adult Medi-Cal
Reauthorization and Change of Service Modality Request Form

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BHRS CHILD/ADULT MEDI-CAL REAUTHORIZATION AND CHANGE OF SERVICE MODALITY REQUEST FORM

Fax To: 415 473-2353

Reauthorization request must be received 10 business days before expiration of prior authorization

Date:		Clinician:		
Provider/Agency:		Telephone:		Ext.
		Supervisor:		

Client Data:

Client Name:		Date of Birth:	
SS#:		or Medi-Cal#:	

Diagnosis:

Diagnoses: DSM5 code and written description		
	DSM 5 code	**Description**
Primary Dx		
Secondary Dx		
Tertiary Dx		
Substance Abuse/Dependence: Yes ☐ No ☐		

Diagnosis has been changed from the initial Access Team Referral (if applicable): Yes ☐ No ☐

Date of initial Access Team (or MMHP) referral _____

Treatment Info:

Requested Start Date of the reauthorization	
Date of most recent assessment	
Date of most recent treatment plan (signed by the client)	
# of sessions requesting	
Type of treatment modality (i.e.: family, PCIT, PPP, trauma, group, individual)	

1. Current Mental Health symptoms and rationale for requesting additional sessions/change of modality:

2. Progress toward meeting objectives from previous treatment plan:

3. **Impairment in functioning** (Include all that apply. ***Provide an explanation in box below.)***

☐ Occupational/Educational ☐ ADLs Activities of Daily Living ☐ Family and Social Relationships

☐ Housing ☐ Health ☐ Severity of Symptoms

☐ History of Psychiatric Hospitalizations ☐ Probability of Deterioration in an Area of Life Functioning

4. Psychiatric medications and Medical/ Health Issues, if any:

Remember: You must submit an assessment with a client plan to obtain approval for reauthorization.

- **The client plan MUST include objectives which are specific, measurable, and observable.**
- **The interventions on the client plan MUST include frequency and duration.**
- **The client plan must be SIGNED by the client.**
- **Supervisor Signature is required for all intern staff.**

Clinician	Supervisor
Date	Date

Appendix D:

Reasons for Recoupment from DHCS

www.dhcs.ca.govDocuments/Enclosure-4-Reasons-for-Recoupment-FY-2019-20

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES REASONS FOR RECOUPMENT FISCAL YEAR 2019/2020
NON-HOSPITAL SERVICES

MEDICAL NECESSITY/ASSESSMENT

1. The Mental Health Plan (MHP) did not submit documentation substantiating it complied following requirements:

A) The MHP uses the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as the clinical tool to make diagnostic determinations. (MHP Contract, Exhibit A, Attachment 3)

B) Once a DSM-V diagnosis is determined, the MHP shall determine the corresponding mental health diagnosis, in the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) and use the ICD-10 diagnosis code(s) to submit a claim for specialty mental health services (SMHS) to receive reimbursement of Federal Financial Participation (FFP) in accordance with the covered diagnoses for reimbursement of outpatient and inpatient SMHS.

MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations § 1830.205(b)(1) and 1830.210; and, Mental Health and Substance Use Disorder Services Information Notices

Please note: The applicable ICD-10 diagnoses are subject to change. If applicable, changes in covered ICD-10 diagnosis codes will be detailed in MHSUDS Information Notices.

2. Services, except for Crisis Intervention and/or services needed to establish medical necessity criteria, shall be provided, in accordance with the State Plan, to beneficiaries who meet medical necessity criteria, based on the beneficiary's need for services established by an Assessment. The MHP did not submit documentation substantiating the beneficiary's need for services was established by an Assessment.

MHP Contract, Exhibit A, Attachment 2

3. The MHP did not submit documentation substantiating that, as a result of an included ICD-10 diagnosis, the beneficiary has, at least, one of the following impairments:

a) A significant impairment in an important area of life functioning;

b) A probability of significant deterioration in an important area of life functioning;
c) A probability the child will not progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, title 9, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

CLIENT PLAN

4. Services shall be provided, in accordance with the State Plan, based on the beneficiary's need for services established by an Assessment and documented in the Client Plan. Services were claimed:

A) Prior to the initial Client Plan being in place; or
B) During the period where there was a gap or lapse between client plans; or,
C) When the planned service intervention was not on the current client plan.

An approved client plan must be in place prior to service delivery for the following SMHS:

- *Mental health services (except assessment, client plan development)*
- *Intensive Home Based Services (IHBS)*
- *Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs*
- *Therapeutic Behavioral Services (TBS)*
- *Day treatment intensive*
- *Day rehabilitation*
- *Adult residential treatment services*
- *Crisis residential treatment services*
- *Medication Support (non-assessment/evaluation, non-plan development and non-urgent)*
- *Psychiatric Health Facility Services (Cal. Code Regs., tit. 22, § 77073.)*
- *Psychiatric Inpatient Services (Code Fed. Regs., tit. 42, § 456.180(a); Cal. Code Regs tit. 9 §§ 1820.230 (b), 1820.220 (l)(i))*

MHP Contract.; State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025), page 2c; MHSUDS Information Notice 17-040

PROGRESS NOTES

5. The MHP did not submit documentation substantiating that the focus of the intervention is to address the beneficiary's included mental health condition.

a) A significant impairment in an important area of life functioning;
b) A probability of significant deterioration in an important area of life functioning;
c) A probability the child will not progress developmentally as individually appropriate; and
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

6. The MHP did not submit documentation substantiating the expectation that the intervention will do, at least, one of the following:

a) Significantly diminish the impairment;
b) Prevent significant deterioration in an important area of life functioning;
c) Allow the child to progress developmentally as individually appropriate; or
d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

7. The progress note does not describe how services provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.

8. The MHP did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:

a) No progress note submitted

b) The progress note provided by the MHP does not match the claim submitted to DHCS for reimbursement in terms of the following:
1) Specialty Mental Health Service claimed.
2) Date of service, and/or
3) Units of time.

CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), CCR, title 22, section 51458.1(a)(3)(4); MHP Contract; CCR, title 9, section 1840.112(b)(3)

9. The service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation (e.g., Institution for Mental Disease [IMD], jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11).

NOTE: When a beneficiary who resides in a setting in which s/he would normally be ineligible for Medi-Cal is moved off grounds to an acute psychiatric inpatient hospital or PHF, that individual again becomes Medi-Cal eligible (unless the hospital is free-standing with more than 16 beds and is thus considered an IMD and the beneficiary is between the ages of 21-64).

CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, part 435, *sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d*

10. The service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (A dependent minor in a juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary, is Medi-Cal eligible. See CCR, title 22, section 50273(c)(5) A delinquent minor is only Medi-Cal eligible after adjudication for release into community. See CCR, title 22, section 50273(c)(1))

Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5)

11. The service provided was solely for one of the following:

a) Academic educational service
b) Vocational service that has work or work training as its actual purpose
c) Recreation
d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors
e) Transportation
f) Clerical
g) Payee Related

CCR, title 9, sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); title 22, chapter 3, section 51458.1(a)(5),(7);

12. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present, and resulted in excess time claimed.

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

13. For service activities involving one (1) or more providers, progress notes, or other relevant documentation in the medical record, did not clearly include the following:

a) The total number of providers and their specific involvement r in the context of the mental health needs of the beneficiary; **or**
b) The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable; ***or***
c) The total number of beneficiaries participating in the service activity.

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

14. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

MHP Contract; MHSUDS Information Notice 17-040

15. The MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:

a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a “no show’), or
b) Service provided did not meet the applicable definition of a SMHS.

CCR, title 9, section 1840.112(b)(3); title 22, section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1

16. The service provided was not within the scope of practice of the person delivering the service.

CCR, title 9, section 1840.314(d); MHSUDS Information Notice 17-040