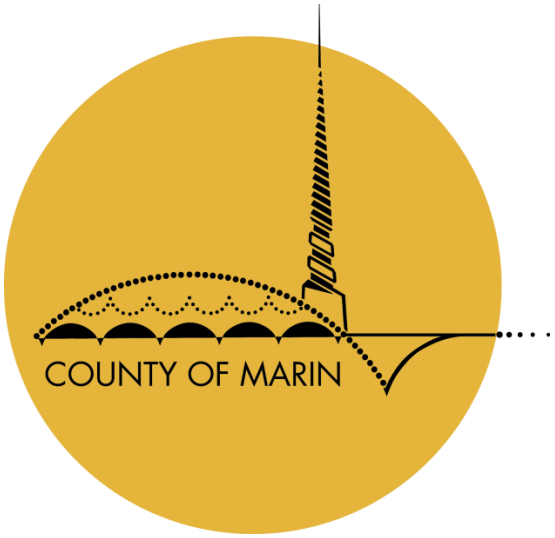

CLINICAL DOCUMENTATION GUIDE

July 2022

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

BEHAVIORAL HEALTH AND RECOVERY SERVICES

BHRS Documentation Manual v 7/11/2022

CONTENTS

APPENDICES

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.

1.1.1. CalAIM

Beginning July 2022, as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, there were significant changes to the documentation standards and requirements. These changes can be found throughout this Manual. The reasons for these changes are to streamline and standardize clinical documentation requirements across systems, and to better align with Centers for Medicare and Medicaid Services' national coding standards and with physical health care documentation practices. The Clinical Documentation Guide published by the California Mental Health Services Authority (CalMHSA) describes these changes in depth and is the source for significant parts of the changes set forth in this guide. The CalMHSA Documentation Guides can be found here.

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, California Mental Health Services Authority (CalMHSA), American Health Information Management Association

(AHIMA), California Advancing and Innovating Medi-Cal (CalAIM) initiative, 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.

Suggestions and Feedback

Suggestions and feedback for enhancements, improvements, or clarifications to this manual are welcome. Please send feedback to BHRSQM@marincounty.org.

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 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.
- Utilization Review disallowances are now focused on Fraud, Waste, and Abuse instead of compliance with documentation standards.

Chapter 2. GENERAL PRINCIPLES OF DOCUMENTATION AND AUTHORIZATION TIMEFRAMES

2.1. General Principles of Documentation

1. All Providers must refer and adhere to BHRS-25, Documentation Requirements for All Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

2. Until the EHR is completely electronic; BHRS 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 BHRS approved forms or an approved electronic health record system for documentation. BHRS Contract Providers must incorporate all BHRS required documentation elements as referenced in this Manual and BHRS 25 policy.

4. Required documents include an accurate Assessment, Problem List and Ongoing 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. Remember the Golden Thread when writing notes. This is the consistent presentation of relevant clinical information throughout all documentation for a client. Each note should lead into the next, creating a comprehensive story of the client's progress through treatment.

8. 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.

9. 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 the actual amount of 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). Medi-Cal billing is per minute. Please do NOT round up.

10. The documentation time that should be included in the total time billed for the service should reflect the actual amount of time spent documenting the service.

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 submitted to a supervisor within 3 business days for review and authorized by the supervisor as soon as possible. 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. Late entry services should include documentation time when claiming.
- Crisis intervention services must be finalized within 24 hours.

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 Adverse Benefit Determination (NOABD), 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.

17. Telehealth Consent: Providers must also inform the client about the use of telehealth and obtain verbal or written consent from the client for the use of telehealth as an acceptable mode of delivering services at least once prior to initiating services via telehealth. Also, it must be explained that clients have the right to access services that may be delivered via telehealth through an in-person, face-to-face visit. Additional details can be found in the Informed Consent section.

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 waivered, 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 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. TIMEFRAMES FOR SUBMISSION OF DOCUMENTATION

As previously stated, staff must open an episode **prior** to providing a service.

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)

ADDITIONAL TREATMENT TEAM PROVIDERS

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

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)

2.4. ASSUMING RESPONSIBILITY OF A HEALTH RECORD

- When new to an ongoing client, assume responsibility for the Mental Health Record.
- Confirm that the client has a finalized Assessment with all required elements.
- Confirm that the client has a problem list.
- Confirm the client record has all compliance items: Consent to Treatment, HIPAA Notification, and ROI (if needed).

Chapter 3. ACCESS CRITERIA AND MEDICAL NECESSITY

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

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.

Standardized Assessment Requirements (Including Timeliness)

a. BHRS requires providers to use an assessment with uniform domains as identified below. For beneficiaries under the age of 21, the required Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

b. The time period for providers to complete an initial assessment and subsequent assessments is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.

d. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.

e. The assessment shall include the provider's recommendation – and determination of medical necessity for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in their scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.

g. BHRS may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals

The Assessment Domain Requirements:

The Assessment is comprised of 7 domains:

- Presenting Problem
- Trauma
- Behavioral Health History
- Medical History
- Psychosocial Factors
- Strengths/Risks
- Clinical Summary

Key elements and information to consider under each domain:

Presenting Problem/Chief Complaint (1)

This domain focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint.

· Presenting Problem (Current and History of) –The person's and collateral sources' descriptions of problem(s), history of the presenting problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.

· Current Mental Status Exam – The person's mental state at the time of the assessment.

· Impairments in Functioning - The person and collateral sources identify the impact/ impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning.

Trauma (2)

This domain involves information on traumatic incidents, the person in care's reactions to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care — it is not necessary in every setting to document the details of traumatic incidents in depth.

· Trauma Exposures – A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.)

· Trauma Reactions – The person's reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.

· Trauma Screening- The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}), indicating elevated risk for development of a mental health condition.

· Systems Involvement – The person's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.

Behavioral Health History (3)

This domain focuses on history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/ abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

· Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.

· Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.

· Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addiction Treatment [MAT]), length of treatment, and efficacy/ response to interventions.

Medical History and Medications (4)

In this domain, medical and medication items are integrated into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides important context for understanding the needs of the people we serve.

· Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.

· Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.

· Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger)

Psychosocial Factors (5)

This domain supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

· Family - Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)
· Social and Life Circumstances – Current living situation, daily activities, social supports/ networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community

· Cultural Considerations – Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) and/or Black, Indigenous and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practice

Strengths, Risk and Protective Factors (6)

This domain explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing.

· Strengths and Protective Factors – personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships

· Risk Factors and Behaviors – behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/ planning/intent, aggression, inability to care for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used

· Safety Planning –specific safety plans to be used should risk behaviors arise, including actions to take and trusted individuals to call during crisis.

Clinical Summary, Treatment Recommendations and Level of Care determination (7)

The clinical summary domain provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

· Clinical Impression – summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below)

· Diagnostic Impression – clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified)

· Treatment Recommendations – recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care.

While each of the domains are required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the person's current and historical need is accurately documented. Include the perspective of the person in care and, whenever possible, use their quotes within the document.

Also, It is considered a "best practice" to note the name of the Primary Care Physician (PCP) on the assessment.

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.

3.2. ACCESS CRITERIA for Specialty Mental Health Services (SMHS)

DHCS has issued the following age specific descriptions of Access Criteria for Specialty Mental Health Services (SMHS)

3.2.1. Criteria for Beneficiaries 21+

Beneficiary meets both of the following criteria, (1) and (2) below:

1. The beneficiary has one or both of the following:
    a. •Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

    b. A reasonable probability of significant deterioration in an important area of life functioning AND

2. The condition is due to either of the following:
    a. •A diagnosed mental health disorder, according to the criteria of the DSM and the ICD.

    Or

    b. •A suspected mental disorder not yet diagnosed.

3.2.2. Access Assurances for Beneficiaries under 21

For enrolled beneficiaries under 21 years of age, BHRS shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code.

Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2)

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

Or

(2) The beneficiary meets **both** of the following requirements in a) and b), below

a) The beneficiary has **at least one** of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

And

b) The beneficiary's condition as described above is due to **one of the following**:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems

ii. A suspected mental health disorder that has not yet been diagnosed

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria for SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

Definitions: Involvement in Child Welfare

The beneficiary has an open child welfare services case, which means that the child welfare agency has opened a child welfare or prevention services case with the family to monitor and provide services.

A child has an open child welfare or prevention services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance and/or prevention services case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement.

A child can have involvement in child welfare whether the child remains in the home or is placed out of the home. Involvement in child welfare also includes a child whose adoption occurred through the child welfare system.

Definitions: Homelessness

The federal Department of Housing and Urban Development's most recent definition of homelessness includes four categories:

1. Literally homeless
2. Imminent risk of homelessness
3. Homeless under other Federal statutes
4. Fleeing/attempting to flee domestic violence

Definitions: Juvenile Justice Involvement

The beneficiary: has ever been detained or committed to a juvenile justice facility, or

is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency
Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition.
Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

The assessment is critical for establishing the diagnosis and identifying problems or illnesses to be included in the problem list. The problem list takes the information gathered during the assessment process and directs the focus of services. The problem list also links the interventions to specific problems. The Progress Notes describe the specific service provided and establish that the service is meant to address a problem on the problem list.

3.3. Medical Necessity in Context of Access Criteria.

The California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to improve health outcomes by ensuring that beneficiaries have access to the right care in the right place at the right time. A part of improving this access is by redesigning the medical necessity criteria for Specialty Mental Health Services for children and adults. These changes supersede the previous medical necessity criteria described in Title 9 that are based on ameliorating symptoms and functional impairments brought about by an included diagnosis and are aimed at lessening the burden on beneficiaries to get through the door for treatment.

All Medi-Cal services provided to persons in care continue to need to meet the standard of being “medically necessary”. However, under the CalAIM revision, medical necessity criteria will now be more closely aligned with W&I Code definitions for adults[1], and Title 42[2] for children.

For persons 21 years of age or older, a service is generally “medically necessary” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. This is in addition to the following criteria.

- The person has a significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in an important area of life functioning
- AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

For individuals under 21 years of age a service is “medically necessary” if needed to correct and ameliorate a mental illness or condition. This would include services that sustain, support, improve, or make more tolerable a mental health condition. This is in addition to the following criteria.

- The person is experiencing homelessness, and/or is interacting with the child welfare or criminal justice system
- OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder.
- OR, the person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment
- AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

This deemphasis on diagnosis to establish medical necessity is meant to allow more flexibility in the provision of services but is not meant to eliminate diagnoses in clinical practice as a focus for treatment.

Note: Although W & I and CFR sections state that a mental health diagnosis is not a prerequisite for access to covered SMHS, this does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted previously, there are applicable ICD-10 codes. These include “Other specified” and “Unspecified” disorders. Additionally, Z-codes for “Factors influencing health status and contact with health services” and DHCS’ established list of priority Social Determinants of Health (SDOH) should be used where appropriate.

[1] Welfare and Institutions Code section 14184.402(a)

[2] Section 1396d(r)(5) of Title 42 of the United States Code

3.4. 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. THE PROBLEM LIST

The use of the Problem List in behavioral health has largely replaced the use of treatment plans except where federal requirements mandate that treatment plans be maintained.

The Problem List is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the Problem List. The providers responsible for the client's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by non-LPHA staff.

4.1.1. Problem List Requirements

The Problem List needs to include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any. Include diagnostic specifiers from the DSM if applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the beneficiary and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Problem List Example						
Number	Code	Description	Begin Date	End Date	Identified by	Provider Type
1	Z65.9	Problem related to Unspecified psychosocial circumstances	7/1/2022	7/19/2022	Name	MH Rehab Specialist
2	Z59.02	Unsheltered homelessness	7/1/2022	Current	Name	Peer Support Specialist
3	Z59.7	Insufficient insurance and social welfare support	7/1/2022	Current	Name	Peer Support Specialist
4	F33.3	Major Depressive Disorder recurrent, severe with psychotic features	7/19/2022	Current	Name	Psychiatrist
5	F10.99	9 Alcohol Use Disorder, unspecified	7/19/2022	Current	Name	Clinical Social Worker
6	I10	Hypertension	7/25/2022	Current	Name	Primary Care Physician
7	Z62.819	History of unspecified abuse in childhood	8/16/2022	Current	Name	Clinical Social Worker

Note that ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate.

4.1.2. Problem List Timelines

DHCS does not require the Problem List to be updated within a specific time frame or have a requirement about how frequently the Problem List should be updated after a problem has initially been added. However, providers should update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

Providers should add to or remove problems from the Problem List when there is a relevant change to a beneficiary's condition.

The basic requirement for the Problem List is that it should be updated on an ongoing basis to reflect the current presentation of the person in care.

4.2. Services Still Requiring a Treatment Plan.

4.2.1. Targeted Case Management (TCM)/Brokerage

Targeted Case Management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment.

The TCM plan:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary;
- Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

A plan with these required elements must be provided in a narrative format in a client's progress note and do not require a client/caregiver signature. This plan should be included at the initiation of TCM/Brokerage services and updated as appropriate in the narrative of subsequent TCM/Brokerage services.

4.2.2. Peer Support Services (PSS)

Peer Support Services (PSS) must be based on approved plan of care.

The plan of care shall be documented within the progress notes in the beneficiary's clinical record and must be based on a plan of care approved by any treating provider who can render reimbursable Medi-Cal Services.

4.2.3. Other Service types: ICC, IHBS, TFC, TBS

These service types require a separate care plan with specified goals and **do require** client/caregiver signature. This care plan is in addition to the Problem List. See service description for additional information.

Intensive Care Coordination (ICC)

Intensive Home Based Services (IHBS)

Therapeutic Foster Care (TFC)

Therapeutic Behavioral Services (TBS)

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. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment.

Good progress notes should be:

Clear,
Consistent,
Descriptive,
Reliable,
Accurate/Precise
Timely

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 are also used to communicate with other care providers. Progress notes should clearly indicate the type of service provided and how the service is necessary to address an identified problem.

In order to meet regulatory and compliance standards, Progress Notes must contain the following

- The type of service rendered
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location of the beneficiary at the time of receiving the service.
- A typed or legibly printed name, signature of the service provider and date of signature.

- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

The following are also required to be incorporated within progress notes in order to meet regulatory requirements. However, they are provided "in the background" by the EHR system.

- ICD 10 code.
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

5.1. PROGRESS NOTE FORMAT

BHRS is not requiring that progress notes be written in a specific format. However, it may be helpful for providers to use a format that will make sure that the notes are readable, as well as make sure that the required elements listed above are included.

Purpose	**The Purpose:** In order to meet the requirement that the note describes how the service addresses the client's behavioral health need, (e.g., symptom, condition, diagnosis, risk factor), purpose of the intervention should be clear. • Include keywords from the Problem List to clearly identify the issue(s) being addressed. • Indicate the status of the problem – that it is still an active need. • Be clear that the focus of the intervention is to address the identified problem.
Intervention	**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. 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
Plan	**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. If this is a Brokerage or Peer Support service, the treatment plan could go here. • Are there new problems for the problem list? • Document that the problems on the problem list remain appropriate or revise as needed • If lack of improvement, get consultation 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 (or three business days) documentation time frame utilized in BHRS.

Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

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 falls 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 addressing the consumer/ family's needs and must be consistent with the current Problem List.

These services include:

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

6.1 Descriptions of Specific Service Procedures:

6.1.1. ASSESSMENT

This procedure is used to document the evaluation of the current status of the individual's mental, emotional, or behavioral health. It can include mental status exam, establishing a diagnosis, appraisal of the individual's functioning in the community such as living situation, daily activities, social support systems, relevant cultural issues and history, and health history and status. Assessment includes screening for substance use/abuse and may include the use of testing procedures. The diagnosis, MSE, medication history, and assessment of relevant conditions and psychosocial factors are assessment activities which must be provided by a licensed and/or licensed waived practitioner consistent with their scope of practice. However, other qualified providers may provide assessment activities such as gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

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 or revision of Problem Lists or, for those services that need them, treatment plans. Services whose plans are included in the narrative of the service, like TCM Linkage would not use Plan Development. Plan Development may be claimed by any practitioner. For example, when the client's status changes (i.e., a new issue is identified there may be a need to update the problem list. Documentation of Plan Development should include a description of the revision, or update made to the problem list, or a statement that the Problem List was reviewed and found to remain appropriate in addressing client's needs

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.

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.

When a group service is rendered, a list of participants is required to be documented and maintained by the practitioner. Should more than one practitioner render a group service, one progress note may be completed for a group session and signed by one practitioner. While one progress note with one practitioner signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. A good group note includes specific interventions and specific responses/observations for each client in the group. 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.

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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 (Targeted Case Management)

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, they must have a brokerage/TCM specific treatment plan, which should be imbedded within the narrative of a brokerage progress note.

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.

Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

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.

6.1.11. 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. Requires a separate Treatment Plan.

Lockouts for ICC Services

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. ICC services are not locked out in group homes.

6.1.12. 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.

Lockouts for IHBS

IHBS services are not permitted during the same hours of the same day as day treatment, group therapy, or TBS.

6.1.13. THERAPEUTIC BEHAVIORAL SERVICES (TBS)

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 Services may be provided to children and youth under the age of 21 who, in addition to having full cope Medi-Cal and meeting Medical Necessity criteria, also meet TBS class criteria under any of the following:

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

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.

Notes can be disallowed if a non-billable service is included anywhere in the note, no matter how short that portion of the service may have been. If you need to include a non-billable service in a billable note, please indicate, "(Time not billed to Medi-Cal)" after the description of the non-billable service in the note. That way auditors will know that the non-billable service is not being included in the billed time.

The following services are not Medi-Cal claimable:

1. Purely clerical activities (faxing, copying, emailing, texting, leaving a voicemail, scheduling an appointment between the client and yourself, 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. Personal care services provided to individuals including grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals.
13. Childcare/babysitting.
14. 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
15. Utilization management, peer review, or other quality improvement activities.
16. Interpretation/Translation; however, an *intervention* in another language may be claimed.
17. 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.

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 service types.

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. Juvenile Hall lockout exceptions (services are billable only if):

A dependent minor in Juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary is medi-cal eligible, or

After adjudication for release into the community.

In these instances, choose location of "other location" and clearly document the above reasons and that minor is in Juvenile Hall in body of note

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. Other services, such as Collateral, use the non-billable form of the service.

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., Assessment, Plan Development, 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.

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 waivered 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).

Note that with the advent of CalAIM, the use of ICD-10 diagnosis codes for “Persons with potential health hazards related to socioeconomic and psychosocial circumstances” is considered within the scope of practice for both licensed and non-licensed staff. These codes are Z55 through Z65. The complete list can be found here.

"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.

Prior to providing services, “waivered” clinicians must provide the following to the BHRSCredentialingPublic <BHRSCredentialingPub@marincounty.org>

- 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 BHRSCredentialingPublic <BHRSCredentialingPub@marincounty.org>

- 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)	Possesses a bachelor's degree (BS or BA) in a mental health related field *and* 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. *Or* an associate arts degree *and* a minimum of six (6) years of experience in a mental health setting. *Or* 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.
Other, Unlicensed	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.

Graduate School (pre-Master's or pre-Doctoral)	
Title	**Definitions/Characteristics**
Psychologist Intern (pre-Doctoral)	Completed academic courses but have not been awarded their doctoral degree. 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. Intern status requires a formal agreement between the student's school and the licensed psychologist that is providing supervision.
Psychologist Trainee (pre-Doctoral)	In the process of completing a qualifying doctoral degree. Often called "Practicum Students." Receiving academic credit while acquiring "hands-on" experience in psychology by working within a variety of community agencies, institutions, businesses, and industrial settings. Supervised by a licensed psychologist.
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 *registration* certificate (which contains a valid BBS *registration* 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 *registration* certificate (which contains a valid BBS *registration* 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 *registration* certificate (which contains a valid BBS *registration* number)

Licensed	
Title	**Definitions/Characteristics**
Psychologist (Licensed)	Licensed by the CA Board of Psychology Possesses a current CA Board of Psychology *license* certificate (which contains a valid *license* 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 *license* certificate (which contains a valid BBS *license* number)
LMFT or MFT (Licensed Marriage and Family Therapist)	Licensed by the CA Board of Behavioral Sciences (BBS) Possesses a current BBS *license* certificate (which contains a valid BBS *license* number)
LPCC (Licensed Professional Clinical Counselor)	Licensed by the CA Board of Behavioral Sciences (BBS) Possesses a current BBS *license* certificate (which contains a valid BBS *license* 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)	Certified Peer Specialist (Pending)	Staff without BA/BS and 4 yrs. exp/or AA & 6 yrs. exp.
Assessment: MH + medical history, SU+ exposure, strengths, risks, barriers to achieving goals	Yes	Yes	Yes	Yes	Yes	Yes	Yes+	Yes+	Yes+	No	Yes+
Assessment: Dx, MSE, medication hx, assessment of relevant conditions and psychosocial factors affecting the individual's physical and MH	Yes	Yes	Yes	Yes	Yes	No	No	Yes+	No	No	No
Behavioral Health Prevention Education Service	No	No	No	No	No	No	No	No	No	Yes	No
Collateral	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes+
Care/ Client/treatment Plan	Yes	Yes	Yes	Yes	Yes	Yes+	No	Yes+	Yes+	Yes	No
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes++	Yes++	Yes+ ++	Yes++	No	No
Intensive Care Coordination (ICC)	No	Yes	Yes	No	No	No	No	Yes	Yes	No	Yes+
Intensive Home-Based Services (IHBS)	No	Yes	Yes	No	No	No	No	Yes	Yes	No	Yes+
Medication Administration	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Medication Dispensing	Yes	No	No	Yes*	Yes	Yes*	No	No	No	No	No
Med. Prescribing or Furnishing	Yes	No	No	No	Yes	No	No	No	No	No	No
Med support svc.	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Psychological Testing	No^	Yes	No^	No	No^	No	No	Yes+	No	No	No

Psychotherapy	Yes	Yes	Yes	Yes	Yes	No	No	Yes+	No	No	No
Plan Development	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes+
Problem List	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rehabilitation Counseling	No	Yes	Yes	Yes	No	Yes	No	Yes+	Yes	No	Yes+
Self Help/Peer Services	No	No	No	No	No	No	No	No	No	Yes	No
Targeted Case Management/Brokerage	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes+	Yes	No	Yes+
Therapeutic Behavioral Services	No	Yes	Yes	No	No	No	No	Yes+	Yes	No	No

+ 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. Utilization Review includes the evaluation and improvement of services through the following practices:

- Medication Monitoring
- Outpatient Programs 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. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote quality and compliance. The reviewers are license-eligible, licensed, and/or waivered BHRS staff. 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 that may indicate Fraud, Waste, or Abuse.

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse within the service provision and claiming system. Disallowances in audits will only occur when there is evidence of fraud, waste, and abuse. These are generally defined as follows:

Waste is an unintentional overutilization, under utilization, or misuse of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically

necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Programs and individuals may receive information regarding quality improvement items identified through the UR process. Notification is through the UR Report and these items will require a plan of correction. 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, Title22 § 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."

- Telehealth

In addition, providers must also inform the client about the use of telehealth and obtain verbal or written consent from the client for the use of telehealth as an acceptable mode of delivering services at least once prior to initiating services via telehealth. Also, it must be explained that clients have the right to access services that may be delivered via telehealth through an in-person, face-to-face visit. Additionally, it must be explained that the use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the client without affecting their ability to access services in the future; explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the medical record the provision of this information and the client's verbal or written acknowledgment that the information was received.

If a provider maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services, then this is sufficient for documentation of client consent and should be kept in the client's medical record.

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:
   - Emancipated minors
   - 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:

- Minors 14 and older who have been emancipated by court order.
- Minors who are serving in the active US military forces; and
- 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 and retained at the time of initiating a new medication and when a new dose is prescribed that is outside of previously consented dosage range for each medication prescribed and administered under the direction of BHRS. 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. Medication consent forms must be completed in accordance with documentation standards in BHRS 20 Informed Consent for Medications policy.

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 statues, 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, an initial assessment is required and assessment updates should be completed as clinically indicated.

Problem List Should be updated on an ongoing basis to reflect the current presentation. Include diagnostic specifiers from the DSM if applicable.

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.** Presenting problem/ chief complaint
     - **b.** Trauma
     - **c.** Behavioral Health history
     - **d.** Medical history and medications
     - **e.** Psychosocial Factors Strengths, Risk and Protective Factors Clinical Summary, Treatment Recommendations, Level of Care Determination
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 provides 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.
2. Interventions must be related to the problem list.
3. 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".
4. Important to focus on Mental Health symptoms even when reviewing physical health symptoms. Write physical health care issues under Medical Section of note.
5. If writing a reference to a note in the hard copy chart, always include the date of the form, note, etc.
6. 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. 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. EXAMPLES

10.1. 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

10.2. EXAMPLES OF INTERVENTION WORDS

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

10.3. 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 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 tress 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 no 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

10.4. EXAMPLES OF PROGRESS NOTES

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EXAMPLE BROKERAGE SERVICE

This staff provided the following case management intervention to address the client's inability to manage emotions due to their anxiety. This staff contacted Group Intervention Center and spoke with intake counselor (Susan) to obtain information about the appropriateness of their Healing Heart Program to meet client's needs. Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Healing Hearts indicated client seemed appropriate for their program group and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend this support group.
Treatment Plan:
Client's goal(s) in their own words: "I need a referral to get into the Healing Hearts Program"
To meet this goal, client participated actively in the development of this plan and will receive case management/peer support services to address the below concerns: Access to Healing Hearts Program.

EXAMPLE COLLATERAL SERVICE

Client's father and grandmother report that on most days, client closes herself off in her bedroom as soon as she comes home on visits and only leaves her room to meet basic physical needs. These behaviors resulting from client's depression are creating challenges in family relationship, per father. This clinician provided empathic and validating statements, acknowledging caregiver's frustration and concern. Clinician provided psychoeducation around the various ways that anxiety can manifest behaviorally, especially in adolescents. Clinician discussed common challenges amongst families when there are notable differences in the expression of respect between the generations within household. Clinician solicited feedback from caregivers about whether or not the experience of generational differences resonated with them. Client's caregivers were forthcoming in expressing their challenges to understand how to best support client. They were receptive to information and expressed willingness to try new approaches with client. This clinician will continue to work with client's family in identifying new methods to respond to client's isolative behavior

EXAMPLE INDIVIDUAL REHABILITATION

In effort to monitor client's moods and emotions, I engaged her in an open-ended conversation about her day and how she has been feeling. I praised her for her reported positive day. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (i.e., reading, listening to music, etc.). I normalized her need to take a break from difficult situations and reminded her to take time outside. Assisted client in practicing how to let others know that she needs to use her safety plan by engaging in a role play. Client was verbal and engaged throughout the session. I will meet with client next week for an individual rehabilitation session to support her with developing and utilizing coping skills.

EXAMPLE PLAN DEVELOPMENT

I collaborated with client to develop his initial problem list. I prompted client to share his life goal and brainstormed how it would be incorporated into his problem list. I reviewed the needs and strengths identified during the assessment and worked with client to determine how to leverage his strengths to support his areas of need. Client was engaged throughout the session, though he struggled to identify strengths. Client was in agreement with the problem list developed. This clinician will begin individual and family therapy sessions later this week.

APPENDICES

GLOSSARY

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.

CalAIM-California Advancing and Innovating Medi-Cal initiative. is a population health approach that prioritizes prevention and whole person care. In Behavioral Health, it will promote better integration with physical health care. It will streamline policies to improve access to behavioral health services, simplify how these services are funded, and support administrative integration of mental illness and substance use disorder treatment.

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.

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.

Problem List – is a list of diagnoses, identified concerns, and issues to identify person's care needs.

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, includes parents, legal guardians, other family members, or other unrelated individuals, 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.

Treatment Plan – requirement for some specific types of services. In some instances may be imbedded within a progress note.

Appendix B.

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 C.

DHCS Priority Social Determinants of Health (SDOH) Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Appendix D

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 *Note: Several forms are available in English, Spanish and Vietnamese.*	**Where is the form located within the BHRS System**	**Where form should GO once Completed**
❑	ADMISSION FORM (This form can be used to open, update a treating clinician's name.) *Note: forms are available for Youth, Adult, Katie A, CSU, Casa Rene, etc.*	Marin County BHRS Clinical Forms	E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician sends original to Medical Records in the bldg. of program
❑	CLIENT PROFILE FORM *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.*	Marin County BHRS Clinical Forms	Copy E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician sends original to Medical Records in the bldg. of program
❑	CONSENT FOR TREATMENT	PDF Consent - English	Signed copy sent to Medical Records in the bldg. of program
❑	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
❑	NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT	MHS Contractor Resources	Original to Medical Records in the bldg. of program Copy given to Client
❑	ADVANCE HEALTHCARE DIRECTIVE INFORMATION *Note: For anyone over 18 years of age.*	MHS Contractor Resources	To Client
❑	AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)	Frequently Used ROI's	Clinician sends original to Medical Records in the bldg. of program
❑	MEDICATION CONSENT FORM (If appropriate)	Clinician's Gateway	Clinician sends original to Medical Records in the bldg. of program

Due at Opening, Every 6 months, and at Discharge

❑	BEHAVIOR CHECKLISTS if applicable (CBCL/YSR) For children	YFS: in the Paper Temple	Clinician sends original to Medical Records in the bldg. of program
❑	CANS, for youth aged 3-18.	Clinician's Gateway	Entered into KIDNet by provider
❑	PSC 35 for children aged 3-18.	YFS: in the Paper Temple	Clinician sends original to Medical Records in the bldg. of program Copy to supervisor.

Due on the ANNUAL:

❑	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
❑	CLIENT PERIODIC DATA UPDATE FORM (CSI)	Marin County BHRS Clinical Forms	E-mail to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician sends original to Medical Records in the bldg. of program
❑	AUTHORIZATION FOR RELEASE OF INFORMATION (ROI) *Note: Check to see if dates and names on ROI are current.*	Frequently Used ROI's	Clinician sends original to Medical Records in the bldg. of program

To CLOSE a Client:

❑	DISCHARGE FORM (This form can be used to close or change a clinician's name.)	Marin County BHRS Clinical Forms *Note: forms are available for Adult, Youth, Katie A, CSU, Casa Rene, etc.*	E-mail to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician sends original to Medical Records in the bldg. of program

To UPDATE a Client:

❑	Diagnosis Change Form	Marin County BHRS Clinical Forms	E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician sends original to Medical Records in the bldg. of program
❑	Provider Change Form	Marin County BHRS Clinical Forms	E-mailed to: Vherrera@marincounty.org Fax: 415-473-5850 Clinician sends original to Medical Records in the bldg. of program

Appendix E.

Abbreviations, Acronyms, & Symbols

Abbreviations and Acronyms

A/O	Alert and oriented
AAOX 1-4	Alert and oriented times 1,2,3,4,
ACE	Adverse Childhood Experience
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
BHIN	Behavioral Health Information Notice
BIB	Brought in by
bio	biological
BIPOC	Black, Indigenous and People of Color
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
CalAIM	California Advancing and Innovating Medi-Cal
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
CMS	Centers for Medicare & Medicaid Services
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
DHCS	Department of Health Care Services
disc w/	discussed with
div	divorced
DM	Diabetes Mellitus
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery Services
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
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
FFS	Fee-for-Service
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_2O	water
HA	headache
halluc.	hallucination
HBP	High Blood Pressure
HCPCS	Healthcare Common Procedure Code System
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
LAI	Long acting injectable
LGBTQ+	: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and others
LOC	Level of Care

L.M.	Left message
lb	pound
LD	Learning Disabled
lg	large
LiCO3	Lithium Carbonate
LPHA	Licensed Practitioner of the Healing Arts
LPS	Lanterman, Petris, Short
m	male
M/C	Medi-Cal
MAOI	Mono-amine oxidase inhibitor (class of anti-depressants)
MAT	Medication for Addiction Treatment
max.	maximum
MCP	Managed Care Plans (Physical Health)
MCO	Managed Care Organization
MDO	Mentally Disordered Offender
med.	medicine
Med. Hx	Medical History
Meds	Medications
meth.	methamphetamines
mg.	milligram
Mgmt.	Management
mgs	message
MHP	Mental Health Pan
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
SMHS	Specialty Mental Health Services
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
TCM	Targeted Case Management
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 = waivered
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^{o}	secondary to
↑	increase	1^{o}	primary
Ø	zero or no	~	about, approximately
c̄	with	>	greater than
s̄	without	<	less than
♂	male	☺	happy
♀	female		

Official Joint Commission "Do Not Use" List[1]		
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"
MSO4 and MgSO4	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 F.

Lockout Guidelines for Facilities where BHRS Clients are Frequently Located

I. Facilities <u>with</u> 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
Creekside Santa Rosa
Crestwood Idylwood Care Center (Helio's)
Crestwood Modesto
Crestwood Stockton
Crestwood Vallejo
Medical Hill Oakland
Merced Behavioral Health
Sequoia Treatment Center – Willow Glen
Telecare Garfield
Telecare Morton Baker

Psychiatric Healing Facility (PHF)

Crestwood Healing Center PHF Santa Rosa

Other Lockout Facilities – All Services Locked-Out*

Jail/Juvenile Hall

* Juvenile Hall lockout exceptions (services are billable only if):

A dependent minor in Juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary is medi-cal eligible, OR

After adjudication for release into the community.

In these instances, choose location of "other location" and clearly document above reasons and that minor is in Juvenile Hall in body of note

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 <u>after</u> CSU Admission. Crisis Intervention and other Mental Health Services allowed on the same day as admission to CSU but only <u>prior</u> to admission, not to be used <u>after</u> admission.

III. Acute Psychiatric Inpatient Units (partial list)

<u>Can provide:</u>

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

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

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

IV. Crisis Residential Facilities: <u>Brokerage services</u> allowed only. **<u>Medication Services</u>** are allowed if within scope of practice.

Casa Rene (Drake House)

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

Transitional Residential Facilities:

Crestwood Healing Ctr Transitional Residential Treatment Program (San Rafael)

Medical Skilled Nursing Facilities – <u>without</u> Special Treatment Program (STP)

<u>Can provide any Medi-Cal Mental Health Services</u>

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)

<u>Can provide any Medi-Cal Mental Health Services</u>

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 G.

Revision History

Changes in the July 2022 version

Revised introduction to include CalAIM changes

Revised Assessment related section and language to reflect CalAIM Standardized domains

Provided link to CalAIM Clinical Documentation Manuals

Revised Medical Necessity section

Revised Scope of Practice section including table

Removed sections pertaining to Client Plan

Replaced references to Client Plan with Problem List

Removed section regarding Service Authorization Period

Added section pertaining to Problem List, with example

Included section pertaining to treatment plan for select services

Added section pertaining to Telehealth Consent

Updated language regarding required note format

Updated sections pertaining to time frames, timeliness and maximum time for documentation

Updated Utilization Review Section, including definitions of Fraud, Waste, and Abuse

Updated abbreviation and acronym list

Updated Lockout section

Added Appendix of SDOH ICD-10 codes

Added revised policy BHRS-25 to Appendix H

Changes in the January 2022 version

Added CalAIM as a source of information in the Introduction section

Updated General Principles of Documentation and Compliance sections

Removed or revised references to diagnosis related medical necessity throughout guide

Added CalAIM language throughout guide

Amended assessment requirements re: “not yet diagnosed” status and use of Z codes

Revised Medical Necessity section in keeping with CalAIM criteria changes, i.e., replaced Diagnostic, Impairment, and Intervention Title 9 language with CalAIM language

Revised Components of Medical Necessity section

Removed “included diagnosis” references in Client Plan section

Revised Progress Notes section to included expanded medical necessity description and to remove “covered diagnosis” language.

Removed “Planned vs Unplanned” reference from Lockouts and Limitations section

Removed Appendix listing “Covered Diagnoses”

Removed Appendix including BHRS 25 Documentation Standards Policy pending revisions

Reordered revision history

Renumbered Appendices

Changes in the May 2021 version

Clarified scope of practice for assessment service

Added statement of 15 minute maximum for documentation time for ongoing care notes

Added section on assuming the record of an ongoing client

Expanded Planned vs Unplanned services and added graphic

Removed Special Populations Chapter: Katie A Subclass section & Therapeutic Behavioral Services class section

Renumbered Chapters

Removed Katie A Service Procedures section

Moved ICC, IHBS, TBS from Katie A Services Procedures section to Descriptions of Specific Services chapter

Incorporated TBS Class requirement into TBS Service description

Expanded Medication Consent

Changes in the August 2020 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

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

Appendix H

Policy BHRS-25: Documentation Requirements for All Specialty Mental Health Services (SMHS), Drug Medi-Cal, (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

County of Marin **Behavioral Health and Recovery Services (BHRS)**	POLICY NO. BHRS-25 Next Review Date: July 1, 2025
POLICY: **DOCUMENTATION REQUIREMENTS FOR ALL SPECIALITY MENTAL HEALTH SERVICES (SMHS), DRUG MEDI-CAL (DMC), AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) SERVICES**	Date Approved: July 1, 2022 Date Reviewed/Approved: By: _____ Jei Africa, PsyD Director of Behavioral Health and Recovery Services

POLICY: DOCUMENTATION REQUIREMENTS FOR ALL SPECIALITY MENTAL HEALTH SERVICES (SMHS), DRUG MEDI-CAL (DMC), AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) SERVICES

I. PURPOSE:

This policy and procedure outlines new guidelines and requirements that streamline clinical documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. The information in this policy and procedure supersedes guidance from the Department of Health Care Services' (DHCS) Information Notice 17-040.

II. BACKGROUND:

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to reform behavioral health documentation requirements to improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective beneficiary care; address equity and disparities; and ensure quality and program integrity.

To achieve this aim, DHCS is streamlining and standardizing clinical documentation requirements across Medi-Cal SMHS, DMC, and DMC-ODS services. These updated documentation requirements better align with Centers for Medicare and Medicaid Services' (CMS) national coding standards and physical health care documentation practices.

BHIN 22-019 supersedes state regulations as noted in Attachment 2, BHIN 21-046 in part (related to client plan and signature requirements), MHSUDS IN 17-040 in full, and BHINs or other guidance in existence as of the date of publishing BHIN 22-019 regarding documentation requirements for SMHS, DMC, and DMC-ODS services except as outlined in Attachment 1. To the extent that there is conflict between the MHP contract, DMC contract, or the DMC-ODS Intergovernmental Agreement terms and

BHIN 22-019, BHIN 22-019 supersedes the contract terms.

III. POLICY:

Effective July 1, 2022, the chart documentation requirements for all SMHS, DMC, and DMC-ODS services are as established in the procedure below. Deviations from compliance with documentation standards outlined below will require corrective action plans. Recoupment shall be focused on fraud, waste, and abuse.[1]

DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, with the exception of continued requirements specifically noted in Attachment 1 and replaced them with these new behavioral health documentation requirements, including problem list and progress notes requirements. The specific forms utilized for the assessment domains, problem list, or progress notes are up to the county's discretion.

Services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency

IV. PROCEDURE:

I. Standardized Assessment Requirements

A. SMHS

a. The MHP requires providers to use the uniform assessment domains as identified below. For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

b. The time period for providers to complete an initial assessment and subsequent assessments for SMHS are up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether Non-Specialty Mental Health Services (NSMHS) or SMHS access criteria are met

[1] Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual.

are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.[2]

d. The assessment shall include a typed or legibly printed name and signature of the service provider and date of signature.

e. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.

g. The MHP may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.[3]

B. DMC and DMC-ODS

a. Counties shall require providers to use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC and DMC-ODS beneficiaries.

b. The assessment shall include a typed or legibly printed name and signature of the service provider and date of signature.

c. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

d. Covered and clinically appropriate DMC and DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis for

[2] For more detailed information on this policy refer to the No Wrong Door BHIN 22-011.

[3] Cal. Code Regs., tit. 9, § 1840.344; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3, pp. 2m-p; California State Plan Section 3, Att.3.1-B, Supp. 2, pp. 15-17

Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment.

e. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes.[4]

II. SMHS Assessment Domain Requirements

The SMHS assessment shall include the following seven required domains. Providers shall document the domains in the SMHS assessment in the beneficiary's medical record. Providers shall complete the assessment within a reasonable time and in accordance with generally accepted standards of practice.

Domain 1:

- Presenting Problem(s)
- Current Mental Status
- History of Presenting Problem(s)
- Beneficiary-Identified Impairment(s)

Domain 2:

- Trauma

Domain 3:

- Behavioral Health History
- Comorbidity

Domain 4:

- Medical History
- Current Medications
- Comorbidity with Behavioral Health

[4] Additional information on assessment requirements can be found in BHIN 21-071 (DMC) and BHIN 21-075 (DMC-ODS).

Domain 5:

- Social and Life Circumstances
- Culture/Religion/Spirituality

Domain 6:

- Strengths, Risk Behaviors, and Safety Factors

Domain 7:

- Clinical Summary and Recommendations
- Diagnostic Impression
- Medical Necessity Determination/Level of Care/Access Criteria

III. SMHS, DMC, and DMC-ODS Problem List

A. The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.

B. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

C. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list.

D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.

E. The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any.
    - Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the beneficiary and/or significant support person, if any.

- The name and title of the provider who identified, added, or removed the problem, and the date the problem was identified/added or removed.

F. Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

G. DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

IV. SMHS, DMC, and DMC-ODS Progress Notes

A. Providers shall create progress notes for the provision of all SMHS, DMC and DMC-ODS services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

B. Progress notes shall include:

- The type of service rendered.
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location of the beneficiary at the time of receiving the service.
- A typed or legibly printed name and signature of the service provider and date of signature.
- ICD 10 code.[5]
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code as consistent with current guidance.
- Next steps including, but not limited to, planned action steps by the

[5] For valid Medi-Cal claims, appropriate ICD-10 and HCPCS/CPT codes must appear in the clinical record, associated with each encounter and consistent with the description in the progress note. For further guidance on coding during the assessment process, refer to the Code Selection Prior to Diagnosis BHIN.

provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

C. Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

D. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). Weekly summaries are no longer be required for day rehabilitation and day treatment intensive.

E. When a group service is rendered, a list of participants is required to be documented and maintained by the Plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements listed above shall also be met.

V. Treatment and Care Planning Requirements

DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, with the exception of the continued requirements specifically noted in Attachment 1. Several of these care plan requirements remain in effect due to applicable federal regulations or guidance.

A. Targeted Case Management

Targeted case management services within SMHS additionally require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment.[6] The TCM care plan:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary;
- Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals; • Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

These required elements shall be provided in a narrative format in the beneficiary's progress notes.

B. Peer Support Services

Peer support services must be based on an approved plan of care.[7] The plan of care shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

C. Additional Treatment and Care Plan Requirements

Requirements for treatment and care planning for additional service types are found in Attachment 1.

[6] See the California State Plan, Sec. 3, Att. 3.1-A, Supp. 1, pp. 8-17; 42 C.F.R. § 440.169(d)(2) and 42 C.F.R. § 441.18 for more specific guidance.
[7] State Medicaid Director Letter #07-011; California State Plan, Supp. 3 to Att. 3.1-A, pp. 4, 5, 6h, 6i (substance use disorder); p. 2m.1 (SMHS).

VI. Telehealth Consent

If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the medical record the provision of this information and the client's verbal or written acknowledgment that the information was received.

DEFINITIONS

Drug Medi-Cal (DMC): Drug Medi-Cal is a treatment funding source for eligible Medi-Cal members. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment.

Drug Medi-Cal Organized Delivery System (DMC-ODS): The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received

approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).

Fee-For-Service (FFS) Medi-Cal Delivery System: Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal beneficiaries. FFS providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.

Managed Care Plan (MCP): MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services (NSMHS) to children under the age of 21. MCPs refer to and coordinate with county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

Non-Specialty Mental Health Services (NSMHS): NSMHS are delivered via MCP and FFS delivery systems and are provided to recipients 21 years and over with mild-to- moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.

Specialty Mental Health Services (SMHS): SMHS include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). All the MHPs are part of county mental health or behavioral

health departments and the MHP can provide services through its own employees or through contract providers.

FORMS/ATTACHMENTS

Attachment 1: Requirements that Remain in Effect
Attachment 2: Superseded Regulations