San Francisco Health Network
Community Behavioral Health Services

Medi-Cal Specialty Mental Health Services

Outpatient (Non-Hospital) Documentation Manual

Behavioral Health Services
Office of Compliance & Privacy Affairs
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With Appreciation…

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To All DPH Specialty Mental Health Service Providers:

We are pleased to transmit the new *San Francisco Department of Public Health Specialty Mental Health Services Documentation Manual* for Outpatient Mental Health Treatment Services. This manual is intended to be a *living* document that is regularly updated as future guidance is provided by the State on Medi-Cal documentation standards.

The San Francisco Department of Public Health (DPH) Office of Compliance and Privacy Affairs, Behavioral Health Services Compliance Office, has modeled its compliance program after guidance and standards established by the Office of the Inspector General (OIG), U.S. Department of Health and Human Services. In cultivating a culture of compliance, we have embraced the OIG's seven fundamental elements of an effective compliance program for healthcare:

1. Implementing written policies, procedures and standards of conduct;
2. Designating a compliance officer and compliance committee;
3. Conducting effective training and education;
4. Developing effective lines of communication;
5. Conducting internal monitoring and auditing;
6. Enforcing standards through well-publicized disciplinary guidelines; and
7. Responding promptly to detected offenses and undertaking corrective action.

The *San Francisco Department of Public Health Specialty Mental Health Services Documentation Manual* supports implementation of the written documentation policies, practices and standards of the San Francisco Mental Health Plan (SFMHP) and represents an integral part of a comprehensive set of activities focused on promoting compliance with Medi-Cal documentation requirements. This manual is intended to serve as a teaching, training, and documentation resource for the behavioral health workforce across the Child, Youth and Family System of Care (CYF-SOC), the Adult/Older Adult Systems of Care (A/OA-SOC) and the Private Provider Network (PPN). This new manual replaces the 2012 *DPH Community Programs Outpatient Services Documentation Standards and Practices Manual*.

We look forward to working with our behavioral health network in promoting a culture of compliance in San Francisco. For more information, please contact:

The DPH Office of Compliance and Privacy Affairs/Behavioral Health Services Compliance Office
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San Francisco, CA 94103
(415) 255-3400 or visit: www.sfdph.org

Updates and Changes to the 2017 Edition

Some of the changes and updates you will notice in the 2017 Edition of the BHS *Medi-Cal Specialty Mental Health Services Outpatient (Non-Hospital) Documentation Manual* include:

- **Clearly cited sources of authority and guidance**: for clarity and transparency, the manual cites the sources (law, regulation, contract, etc.) and levels (federal, state, local) of authority and guidance for BHS' documentation standards.

- **New guidance on chart documentation from DHCS**: where applicable, DHCS' MHSUDS Information Notice #17-040 guidance has been integrated into BHS' standards, including:

    - Appropriate assessment activities and domains for different types of staff (Section 5);
    - The list of planned vs. unplanned services and service activities (see Sections 6 and 7);
    - Requirements when a client refuses to sign a treatment plan (Section 6);

- **Service definitions from California's State Medicaid Plan**: the definitions from the State Plan are more prominently displayed because they give additional details and insights about the service (in particular, see the definitions of Therapy in Section 10, Medication Support Services in Section 11 and Targeted Case Management in Section 19).

- **SMHS provided in residential settings**: the dual regulations and requirements through the Department of Social Services (DSS) and DHCS for Adult Residential and Crisis Residential are more clearly described.

- **Meds-Only and Urgent Meds**: the updated guidance from DHCS has enabled BHS to update guidelines for "Meds Only" clients as well as the role of Medication Support Services in a clinically urgent scenario (formerly, "one shot medication evaluation").

Documentation Examples & Tools Online: all documentation examples, tools and training materials are centralized online (BHS Quality Management, Clinical Documentation Improvement Program, CDIP[1]). The CDIP "SuperHeroes" icon is used in this manual to highlight tools to can help improve your knowledge and skills!

Remember—this manual is only one of the source documents that providers will use to maintain quality and compliance standards (including, for example, BHS policies, procedures, contract performance objectives and local, state and federal laws and regulations).

[1] https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSQualityMgmt.asp.

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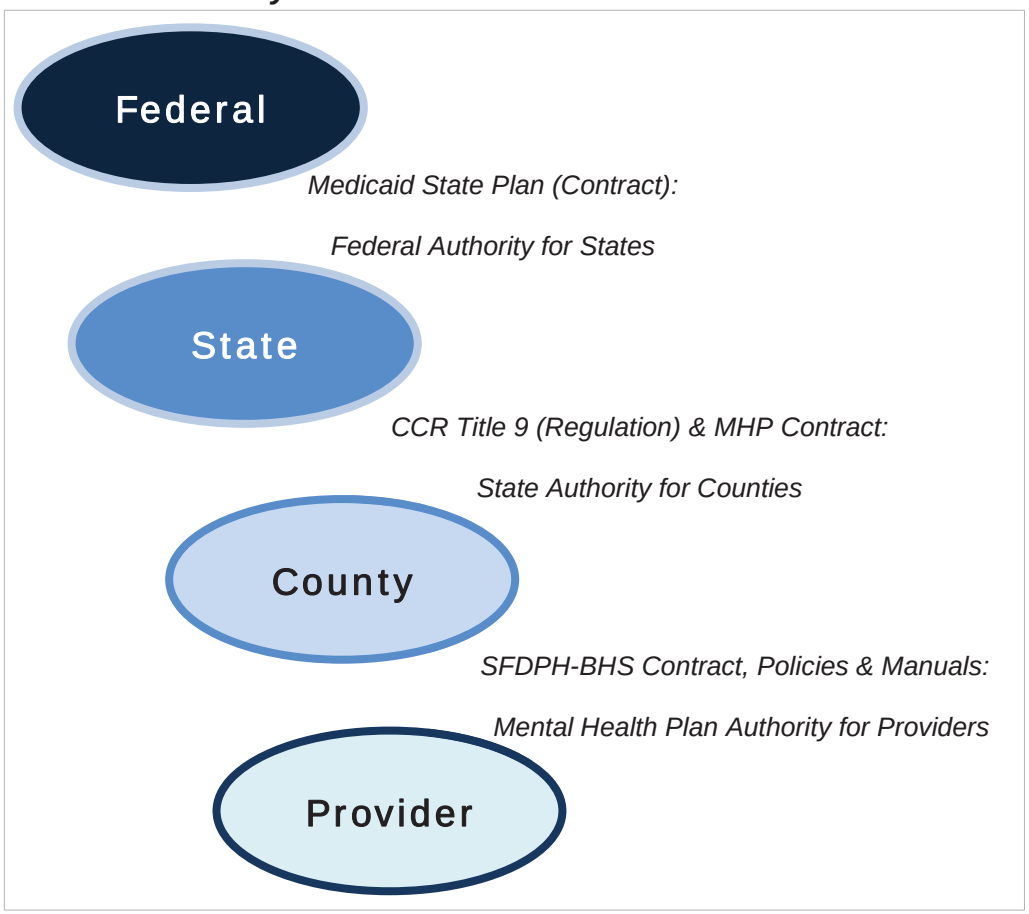
Section 1: Source of SMHS Chart Documentation Guidance

San Francisco Specialty Mental Health Services (SMHS) are funded through Medi-Cal and County General Fund. To claim Medi-Cal for reimbursement of qualifying services, counties must meet contractual requirements between the California Department of Health Care Services (DHCS) and the City and County of San Francisco, Department of Public Health, Behavioral Health Services (SFDPH-BHS). That contract is called the "Mental Health Plan Contract" (MHP Contract) and it conforms to the state regulations that implement SMHS (CCR Title 9, Chapter 11).

The MHP Contract also aligns with the contract between DHCS and the federal Centers for Medicare and Medicaid Services (CMS). That contract and its amendments are referred to as the California's Medicaid State Plan and State Plan Amendments (see figure below).

Compliant documentation of services in a client's record is one of many requirements counties must meet to receive Medi-Cal SMHS funding for billable services. When contractual requirements for documentation are not met, such as incomplete or non-compliant documentation of client services, it can result in increased State oversight of a county and/or the return of Medi-Cal funds to the State (see Reference J for the Reasons for Recoupment by DHCS in FY17-18).

Levels of Authority & Sources of Guidance for Medi-Cal SMHS



Section 2: The Role of the DPH Office of Compliance and Privacy Affairs (OCPA), Behavioral Health Services Compliance Office (BHSCO)

The DPH OCPA BHSCO is an independent office within DPH that is responsible for monitoring local compliance with Medi-Cal SMHS requirements and promoting compliant client medical record keeping in partnership with DPH administrators and the behavioral health network.

The *San Francisco Department of Public Health Specialty Mental Health Services Documentation Manual* is a resource developed by DPH OCPA BHSCO to support behavioral health providers in meeting documentation compliance standards. The *Documentation Manual* includes client service documentation requirements for the following services:

1. Rehabilitative Mental Health Services including:
    - Outpatient Mental Health Services
    - Medication Support Services
    - Evaluation & Management Services
    - Day Treatment Intensive
    - Day Rehabilitation
    - Crisis Intervention
    - Crisis Stabilization
    - Specialty Mental Health Services in Adult Residential Treatment
    - Psychiatric Health Facility Services
2. Targeted Case Management
3. Intensive Case Coordination, Intensive Home-Based Services & Therapeutic Foster Care
4. Therapeutic Behavioral Services

Compliant documentation is more than just a contractual requirement or the subject of a triennial audit; it's an important record of an individual's behavioral health journey. Whether a provider has worked in the behavioral health system for many years or just started a career at a community clinic, reviewing this manual and visiting the DPH website for documentation updates and tools are both essential parts of good clinical practice.

Section 3: Provider's Scope of Practice, Credentialing & Privileges

Since 1993, California has implemented its Medicaid-funded Specialty Mental Health Services (also known as Medi-Cal SMHS) program through the "Rehabilitation Services Option" rather than the "Clinic Services Option."

The switch from "Clinic" to "Rehabilitation" allowed California to broaden the array of services, provider types and service settings. The table below compares the two models across domains (with bold/italicized print to highlight key differences).[2]

Domain	Clinic Services Option	Rehabilitation Service Option
Definition from Federal Social Security Act	§1905(a)(9): "Clinic services [are those] ***furnished by or under the direction of a physician***, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address"	§1905(a)(13): "Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) ***recommended by a physician or other licensed practitioner of the healing arts [LPHA]*** within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level"
Treatment Model	***Medical*** model	***Recovery*** model
Focus	***Stabilization***	Active ***treatment and participation***
Locations	***Clinic***-based	***Community***-based
Type of Staff	***Licensed; higher degree*** professionals	Professionals, ***mental health technicians and peer specialists***
Organizational Model	Organized ***clinics***	***Organizations*** that provide one or more covered services

As you can see, the switch to a "Rehabilitation Services Option" brought flexibility on the one hand (e.g., in terms of staffing and service provision) as well as complexity on the other hand (e.g., in terms of determining scope of practice, credentialing and service privileges for a broader and more diverse workforce and scopes of practice).

Background: Scope of Practice

"Scope of practice" is terminology used by state licensing boards "for various healthcare-related fields that defines the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that

[2] US Dept. of Health & Human Services (January, 2005). *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*. Retrieved from https://aspe.hhs.gov/system/files/pdf/74111/handbook.pdf

which the individual has *received education and clinical experience*, and in which *he/she has demonstrated competency*" (Wise, 2008[3]).

The California Department of Consumer Affairs (DCA) is the regulatory body that licenses professionals, educates consumers and enforces consumer laws (http://www.dca.ca.gov/about_dca/major_functions.shtml). There are 42 licensing Boards within DCA, including the Boards of:

- Behavioral Sciences
- Medical Board
- Osteopathic Physicians
- Pharmacy
- Psychiatric Technicians
- Psychology
- Registered Nursing.

California's laws (statutes) are grouped by issues/topics (codes) and the laws that govern health care services and professional licensure can be found in Business & Professions Code, Health & Safety Code, Insurance Code, Welfare & Institutions Code, etc. (http://leginfo.legislature.ca.gov/faces/codes.xhtml).

Background: Credentialing
When a mental health provider joins the network of a managed care organization, the provider receives privileges to provide and bill for services—those privileges are based on an analysis and review of the providers license, education and scope of practice and health care laws (the analysis and review of a provider's documentation is called *credentialing*).[4]

The credentialing process is completed by BHS' Office of Compliance & Privacy Affairs and that office also publishes the "*Service and Staff Billing Privileges Matrix* (see Reference D)—that Matrix shows the services you are allowed (privileged) to provide, given the credentialing process (the review of your materials, scope of practice and health care laws).

The *Service and Staff Billing Privileges Matrix* identifies six categories of credentialed staff. The following pages focus on these categories:

1. Licensed Practitioner of the Healing Arts (LPHA)
2. Waivered/Registered LPHA
3. Non-LPHA Nurses, Psychiatric Technicians & Pharmacists
4. Mental Health Rehabilitation Specialist (MHRS)
5. Mental Health Worker (MHW)
6. Graduate Student (Enrolled in School; Unlicensed).

Licensed Practitioner of the Healing Arts (LPHA)
The Federal Medicaid rules introduced the term "Licensed Practitioner of the Healing Arts" (LPHA), but did not provide a definition. Generally, LPHA is taken to mean "any health practitioner …who is licensed in the State to diagnose and treat individuals

[3] Wise, E.W. (2008). Competence & Scope of Practice: Ethics & Professional Development. *Journal of Clinical Psychology: In session*, *64*(5), 626-637.
[4] Kongstvedt, P.R. (2013). *The Essentials of Managed Care* (6th Ed). Jones & Bartlett, Burlington, MA.

with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law."[5]

LPHA staff have broad privileges (within their specific scope of practice) and BHS providers follow the guidance in the SFDPH-BHS *Service and Staff Billing Privileges Matrix* (Reference D) which identifies the following as a LPHA staff:

1. Licensed Physician (MD/DO)
2. Licensed Nurse Practitioner (NP)
3. Licensed Clinical Nurse Specialist (CNS)
4. Licensed Clinical Social Worker (LCSW)
5. Licensed Marriage and Family Therapy (LMFT)
6. Licensed Professional Clinical Counselor (LPPC)
7. Licensed Psychologist (PhD/PsyD).

These seven categories of licensed mental health staff are also referred to as "Licensed Mental Health Professionals" (LMHP) in DHCS' recent MHSUDS Information Notice #17-040.

Waivered/Registered Licensed Practitioner of the Healing Arts (LPHA)
§1810.254 of CCR Title 9 defines "Waivered/Registered Professionals" as an individual who has a waiver of psychologist licensure issued by the Department or has registered with the corresponding state licensing authority for psychologists, marriage and family therapist, [professional counselor] or clinical social workers to obtain supervised clinical hours for psychologist, marriage and family therapist [professional counselor] or clinical social worker license."

BHS provider follow the guidance in the SFDPH-BHS *Service and Staff Billing Privileges Matrix* (Reference D) which identifies the following as a Waivered/Registered LPHA staff:

1. Associate Clinical Social Worker (ASW)
2. Marriage & Family Therapist Intern (MFTi)
3. Professional Clinical Counselor Intern (PCCI)
4. Waivered PhD/PsyD.

Note that the broad privileges afforded to "Waivered/Registered LPHA" staff hinges on: (a) their current and appropriate registration with the state Board and (b) the direction, supervision and oversight of their work by the licensed mental health professional (i.e., by a LPHA).

Non-LPHA Nurses, Psychiatric Technicians & Pharmacists
The SFDPH-BHS *Service and Staff Billing Privileges Matrix* (Reference D) identifies the following as a non-LPHA Nurses, Psychiatric Technicians and Pharmacists (Reference D):

1. Registered Nurse with only Bachelor's or Associates degree
2. Licensed Vocational Nurse
3. Psychiatric Technician
4. Pharmacist.

[5] Medicaid Program, Coverage for Rehabilitative Services (2007). 72 Federal Register 45201, ps 45201-45213

These staff have more narrow band of privileges assigned to them because their training is more narrowly focused on medication and biological interventions. However, as the *Service and Staff Billing Privileges Matrix* indicates, these staff may also qualify as a Mental Health Rehabilitation Specialist (MHRS)—if so, they are afforded additional privileges.

Mental Health Rehabilitation Specialist (MHRS)
The Mental Health Rehabilitation Specialist (MHRS) position is defined in CCR Title 9 as:

> *A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting (CCR, Title 9, §630).*

BHS clarified the definition of an MHRS through Policy guidance that addressed degrees, types of experience and required training (see Reference F, Policy 2.01-3, Credentialing & Service/Billing Privileges in SMHS for MHRS and MHW).

MHRS staff are given a reasonably broad range of privileges in the SMHS program based on two factors:

- Prior Work Experience: MHRS staff must have accrued work experience, providing services to clients, in a field closely related to mental health (in addition to having, at minimum, an Associates degree);;

- Medicaid's Rehabilitation Services Option: the continuum of services available under the Rehabilitation Services Option includes more than just clinical activities and interventions like medication and therapy.

Despite their range of privileges, remember that MHRS staff cannot work independently; they are not permitted to complete some elements of the Assessment and they must obtain the signature of a LPHA or Waivered/Registered LPHA to finalize Assessment and Client Plan/Treatment Plan of Care (TPOC) documents.

Mental Health Workers ("Other Qualified Provider")
California's Medicaid State Plan defines another category of provider in the SMHS program, an "Other Qualified Provider":

> *An individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department (SPA # 12-025; "Qualification of Providers").*

Within BHS, the "Other Qualified Provider" category has been operationalized as a "Mental Health Worker" (MHW) who receives training and works closely under the direction of an MHRS, LPHA or Waivered/Registered LPHA (see Reference F, Policy

2.01-3, Credentialing & Service/Billing Privileges in SMHS for MHRS and MHW). Peer staff are also included in this category.

As seen in the *Service and Staff Billing Privileges Matrix,* the MHW has a more narrow band of privileges and additionally, must have a co-signature on every progress note (either an MHRS or a LPHA).

Graduate-Level Students-Enrolled in Academic Program
DHCS recently provided guidance on the category of graduate-level students enrolled in an academic program but not yet eligible to be registered or waivered:

> *The scope of practice depends on the particular program in which the student or trainee is enrolled and the requirements for that particular program, including any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations. In accordance with the Business and Professions Code, the Board of Psychology, and the Board of Behavioral Sciences, non-licensed trainees, interns, and assistants must be under the immediate supervision of a LMHP who shall be responsible for ensuring that the extent, kind, and quality of the services performed are consistent with his or her training and experience and be responsible for his or her compliance with applicable state law. (Business and Professions Code §§2913, 4980.03, 4980.43(b), and 4996.18(d))*
>
> *An individual participating in a field internship/trainee placement, while enrolled in an accredited and relevant graduate program, working "under the direction" of a licensed, registered, or waivered mental health professional and determined to be qualified by the MHP, may conduct [specific service activities]…within the scope of practice of the discipline of his/her graduate program.*
>
> *If students and trainees do not meet the definition of any of the other defined providers under the State Plan, they may provide some services as Other Qualified Providers under the direction of a LMHP who is authorized to direct services. (See Section 3, Supplement 3 to Attachment 3.1-A; Cal. Code Regs., tit. 9, §1840.314(e))*

As seen in the *Service and Staff Billing Privileges Matrix,* "Graduate Students Enrolled in School" have broad privileges to provide services, but they are required to have a LPHA co-signature on every progress note. As with all SMHS providers, graduate students may only provide a service that is within the scope of practice of the discipline of their graduate program.

Restricted Staff Functions and Roles in SMHS
Staff are limited to the services and billing codes that are assigned to the staff category that appears in the *Service and Staff Billing Privileges Matrix.* In addition, *there are also roles* that are also limited based on the credentials of the staff:

- Directing Others:
    - For clinical services, the role of "directing others to provide SMHS" means "acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans. Individuals are not required to be physically present at the service site to execute direction. The licensed professional directing service assumes ultimate

responsibility for the SMHS provided (DHCS Information Notice #17-040, pages 2-3);

- The following categories of staff may direct others in providing SMHS: (a) LPHA; (B) Waivered/Registered LPHA

- Under the Direction of:
  - For clinical services, the role of "providing services under the direction of" means the requirement to work under the direction of a licensed professional operating within their scope of practice (State Plan, cited in DHCS' MHSUDS Information Notice #17-040, page 3);

  - Per DHCS, the following providers must work under the direction of a licensed professional (and the staff themselves must be licensed):
    - Licensed Vocational Nurses
    - Licensed Psychiatric Technicians
    - Physicians Assistants
    - Pharmacists
    - Occupational Therapists

- Head of Service:
  - For an organization's Medi-Cal certification, the role of "Head of Service" is defined in CCR Title 9 (§1810.435) and refers to the organization's requirement to "have as head of service a licensed mental health professional or mental health rehabilitation specialist as described in Sections 622 through 630."

  - Remember that organizationally, an MHRS staff *can be the Head of Service* per §1810.435, but clinically, the LPHA is required for Assessment, Treatment Plan of Care and it is the licensed professional directing service assumes ultimate responsibility for the SMHS provided the *cannot Direct Services* (per State Plan, cited in DHCS Information Notice #17-040, pages 2-3).

Insights from DHCS' MHSUDS Information Notice #17-040
Major clarifications were issued by DHCS in August 2017 (IN#17-040) regarding scope of practice and the services, activities and functions that are restricted in the SMHS program. All of the following are based on the staff member's scope of practice, requirement for direction by an LPHA, co-signatures, etc.

Assessment

1. Diagnosis, Mental Status Exam, Relevant Conditions (Functional Impairments)/Psychosocial Factors and Medication History: these sections of the assessment are restricted to LPHA, Waivered/Licensed LPHA and Graduate Students Enrolled in School.

   Based on their privileges, other staff could contribute to the assessment through the collection of historic information (e.g., mental health and medical history), substance exposure and use, as well as strengths, risks and barriers to achieving goals.

2. Diagnosis: for BHS, is limited to LPHA, Waivered/Registered LPHA and Graduate Students Enrolled in School.

Client Plan/Treatment Plan of Care (TPOC)

1. Finalizing the Client Plan/TPOC: only the LPHA and/or Waivered/Registered LPHA staff member can finalize the Client Plan/TPOC with their signature.

Summary Table: Clarifications from DHCS

Domain	Insight from DHCS' IN#17-040
Who can complete the following restricted Assessment elements?: • Diagnosis; • MSE; • Relevant Conditions & Psychosocial Factors	These elements are restricted to staff who are credentialed and working within their scope of practice as a LPHA, Waivered/Licensed LPHA and Graduate Students Enrolled in School
Who can finalize an Assessment and a Treatment Plan of Care (TPOC) with their signature?	Only staff who are credentialed as LPHA or Waivered/Registered LPHA

Learn more about the Rehab Option!

Check out CDIP's "Professional Development Workshop #4"

Section 4: Medical Necessity

Medical Necessity in Concept

In 2012, the Institute of Medicine (IOM) convened a group of experts to identify the common elements of medical necessity reflected across payer sources (IOM, 2012[6]). The expert panel described the following general elements:

- Prudent provider with authority: to be medically necessary, the service/procedure is recommended by an eligible provider acting with practicality, wisdom and judiciousness;
- Medical/Rehabilitative purpose: to be medically necessary, the purpose of the service/procedure is to treat a condition (medical condition; functional condition);
- Scope: to be medically necessary, the type, frequency, extent, site and duration of the service/procedure should be clinically appropriate;
- Evidence: to be medically necessary, the service/procedure should be in accordance with generally accepted standards of practice (e.g., scientific evidence, professional standards, expert opinion);
- Value: to be medically necessary, the service/procedure should be cost-effective—that does not mean it must be the "least costly," but rather, not more expensive than other acceptable/effective treatments;
- Not Primarily for Convenience: to be medically necessary, the service/procedure should not be primarily for (a) the convenience of the client or provider or (b) the economic benefit of the health plan/purchaser;
- Individualized: medical necessity must refer to what is medically necessary for a particular client and thus, requires an individual assessment (vs. a general determination of what works in the ordinary case).

The above list is not exhaustive—for rehabilitative and recovery services in particular, experts emphasize the client's understanding and ability to use and improve with services[7]:

- Appropriately signed treatment plan: to be medically necessary, a service must have been ordered and provided though a current and appropriately signed treatment plan;
- Client's willingness to participate and client's ability to benefit: to be medically necessary, the client must be willing to participate in the treatment. Additionally, the client must have the cognitive ability to benefit from the service;

[6] IOM (Institute of Medicine). 2012. *Essential Health Benefits: Balancing Coverage and Cost.* Washington, DC: The National Academies Press.
[7] Thornton, M. (2017). *Coding for Billing Compliance-Laguna Honda Hospital Manual*. Boston: Mary Thornton & Associates.

- Active treatment plan and sufficient intensity of treatment: to be medically necessary, there must be an active treatment plan and services are at a sufficient intensity and duration, given generally accepted standards of practice.

You may be surprised to know that "medical necessity" is not defined in the Federal *Medicaid* statute—each State develops their own definition. The key exception here is Medicaid's EPSDT benefit (Early and Periodic Screening, Diagnosis, and Treatment) for children under the age of 21 years. Under EPSDT, Medicaid programs must cover "necessary health care, diagnostic services, treatment and other measures…to correct or ameliorate defects and physical and mental illnesses and conditions" (IOM, 2012).

In contrast to Medicaid, the authorizing legislation for *Medicare* actually specifies the definition of "medically necessary" services—CMS also includes the term in their glossary:

> *Notwithstanding any other provisions of this file, no payment may be made under Part A or Part B for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member [Social Security Act § 1862 (42 U.S.C. 1395y)].*
>
> *Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor (https://www.cms.gov/apps/glossary).*

Medical Necessity in Regulation: Mental Health Medi-Cal's Specialty Mental Health Services (SMHS) Benefit

Medicaid is a social insurance program. That means it is implemented, in part, through Federal and State Agencies (CMS and DHCS, respectively) and governed by their rules (called regulations, like Federal CFR 42 and State CCR Title 9).

The medical necessity standards and expectations for Mental Health Medi-Cal's SMHS benefit are defined in CCR Title 9, Chapter 11 (§1830.205 and §1830.210 for Outpatient/Non-Hospital). The regulatory language may be new to readers, so we have excerpted the text below and then afterward, provided a practice-based framework to facilitate understanding.

1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.
(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:
(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV™, Fourth Edition (1994), published by the American Psychiatric Association:
(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy and Early Childhood
(D) Elimination Disorders
(E) Other Disorders of Infancy, Childhood, or Adolescence
(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
(G) Mood Disorders, except Mood Disorders due to a General Medical Condition
(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
(I) Somatoform Disorders
(J) Factitious Disorders
(K) Dissociative Disorders
(L) Paraphilias
(M) Gender Identity Disorder
(N) Eating Disorders
(O) Impulse Control Disorders Not Elsewhere Classified
(P) Adjustment Disorders
(Q) Personality Disorders, excluding Antisocial Personality Disorder
(R) Medication-Induced Movement Disorders related to other included diagnoses.
(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:
(A) A significant impairment in an important area of life functioning.
(B) A reasonable probability of significant deterioration in an important area of life functioning.
(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.
(3) Meet each of the intervention criteria listed below:
(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.
(B) The expectation is that the proposed intervention will:
1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).
(C) The condition would not be responsive to physical health care based treatment.
(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:
(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.
(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.
(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshé

Medical Necessity in Practice: Four "Specials" of Specialty Mental Health Services

The medical necessity criteria for SMHS can be distilled down to four elements—as a teaching device/memory aid, we refer to these as the "Four Special Elements of SMHS Medical Necessity":

1. "Special" Diagnosis: the first element is the presence of an included diagnosis—if the primary diagnosis does not appear on the DHCS list of Included Diagnoses for Outpatient (Non-Hospital) Services, then case does not meet medical necessity.

    a. *TIP*: remember that you need a "special" diagnosis—one that appears on the outpatient list published by DHCS. See Reference A in this manual for the current list, but be aware, that list is updated over time and every provider must ensure they have the most current list.

2. "Special" Impairments in Functioning: the second element is the presence of a functional impairment (which stems from the included diagnosis) in an important area of life functioning. DHCS has identified *four different clinical presentations of functional impairments*—two apply to adults; all four apply to children under 21 years old: (1) current significant impairment; (2) a reasonable probability of significant deterioration in functioning; (3) a reasonable probability that a child client will not progress developmentally as individually appropriate; (4) for EPSDT eligible children, a condition that would be corrected or ameliorated with SMHS.

    a. *TIP*: remember that you need to identify which of the "special" impairments your client experiences—one of the following:

        (1) Current and significant impairment in functioning;
        (2) Reasonable probability of significant deterioration in functioning;
        (3) Reasonable probability that a child will not progress developmentally as individually appropriate;
        (4) For EPSDT eligible children, a condition that could be corrected or ameliorated with SMHS.

3. Needing "Special" Interventions: the third element is the client's need for interventions that are directly focused on functional impairments. DHCS has identified four groupings of interventions (and those line up directly with the four clinical presentations of functional impairments). Here again, two of the groupings apply to adults and all four apply to children under 21 years old: (1) interventions will significantly diminish the impairment; (2) interventions will prevent significant deterioration in functioning; (3) interventions will allow a child to progress developmentally as individually appropriate; (4) for EPSDT eligible children, the interventions will correct or ameliorate the condition.

    a. *TIP*: remember to match up your "special impairments" with the "need for special interventions"—the interventions have to do one of the following:

        (1) Significantly diminish the impairment;
        (2) Prevent significant deterioration in functioning;
        (3) Allow a child to progress developmentally as individually appropriate;
        (4) For EPSDT eligible children, correct or ameliorate the condition.

4. Needing "Specialty" Treatment, not Physical Health Care-Based Treatment: the fourth element is need to address the functional impairments through specialty mental health treatments, ***not*** through physical health care-based treatments.

    a. *TIP*: if the client's problem is solely due to a health condition/general medical condition, then physical health care-based treatment is likely needed.

The summary table that follows below can help to illustrate the ***elements of medical necessity that are common across all SMHS clients who meet medical necessity*** (i.e., the presence of an included diagnosis and the need to be treated in a specialty mental health setting) and ***the elements that vary across SMHS clients***

(i.e., the type of functional impairment and corresponding interventions).

Table: SMHS Medical Necessity Summary Table

Four Special Elements	Four Clinical Presentations			
	#1	#2	#3	#4
Diagnosis	included dx	→	→	→
Impairments	current significant impairment	probability of significant deterioration	probability of not progressing developmentally	EPSDT-eligible condition
Interventions	significantly diminish impairment	prevent significant deterioration	probability of not progressing developmentally	EPSDT-eligible condition
Treatment	not physical health based treatment	→	→	→

Additional Details-Included Diagnosis
The table below provides a snapshot of categories and types of excluded and included diagnoses for the SMHS program (but remember, DHCS publishes the actual list of Included Diagnoses for Non-Hospital Services).

Categories of Included Diagnoses for Outpatient (Non-Hospital) Services	Excluded Diagnoses for Outpatient (Non-Hospital) Services
• Pervasive Developmental Disorders except Autistic Disorder • Disruptive Behavior and Attention Deficit Disorders • Feeding and Eating Disorders • Elimination Disorders • Somatoform Disorders • Adjustment Disorders • Personality Disorders excluding antisocial personality disorders • Dissociative Disorders • Schizophrenia Spectrum and Other Psychotic Disorders* • Mood Disorders (except due to a general medical condition) • Anxiety Disorders (except due to a general medical condition) • Factitious Disorders • Paraphilias • Gender Identity Disorders	• "Deferred" or "by history" diagnoses (exception: can be used as opening diagnosis) • Stand Alone "Rule Out" (R/O) diagnoses • Provisional Diagnoses (x vs. y) • "Z" codes • Intellectual Disability • Learning Disorders • Motor Skills Disorder • Communication Disorders • Delirium • Dementia • Amnestic Disorders • Sleep Disorders • Mental Disorders due to a general medical condition • Autistic Disorder • Tic Disorders

Categories of Included Diagnoses for Outpatient (Non-Hospital) Services	Excluded Diagnoses for Outpatient (Non-Hospital) Services
• Impulsive Control Disorders not elsewhere classified • Medication-Induced Movement Disorders related to other included diagnoses	• Cognitive Disorders – dementia with depressed mood or delusions • Substance Induced Disorders with psychotic, mood or anxiety disorders • Anti-Social Personality Disorders • Other conditions that may be the focus of clinical attention

Additional Details-Impairments in Important Area of Life Functioning
The table below provides a snapshot of the domains included in "an important area of life functioning" in the SMHS program. Remember, you must describe how the symptoms associated with the included diagnosis impair the client's functioning.

Life Functioning Domains to Explore
• Living situation • Daily activities and functioning • Family relations • Social relations • Finances • Legal and safety issues • Work and school • Health • Cultural components • Potential for exploitation *Source: BHS Documentation Manual (2005 Ed & 2012 Eds.)*

Additional Details-Criteria for EPSDT Clients
There are additional regulations to be aware of to qualify for EPSDT-funded services—these are described below (and also in Reference B), but check with your program's BHS-CYF Program Manager before qualifying a child client through EPSDT.

Clients who are under age 21 who do not meet SMHS Medical Necessity functional impairment and the intervention criteria described in CCR Title 9 §1830.205 may still qualify when all of the following criteria are met (Source: 9 CCR §1830.210):

A qualifying ICD 10 mental health diagnosis is documented in the client medical record:

1. The client's condition would not be responsive to physical health care based treatment; and

2. All of the following are met: (a) the requirements of (Source: 22 CCR §51340(e)(3))[8] governing EPSDT supplemental services (Source: 22 CCR §51340), or for targeted case management services (Source: 22 CCR §51351); (b) the service that a client will be linked to is medically necessary for the client (Source: 9 CCR §1830.205) or 22 CCR §51340(e)(3); and (c) the requirements of (Source: 22 CCR §51340(f)) that the service to which access is to be gained through case management is medically necessary for the EPSDT-eligible client and the EPSDT-eligible client has a medical or mental health condition or diagnosis.

Insights from DHCS: Diagnosis!

1. Who can formulate a diagnosis? Formulation of a diagnosis requires a provider, working within his/her scope of practice, to be licensed, waivered and/or under the direction of a licensed provider in accordance with California State law. Diagnosis is in the scope of practice for the following provider types: Physicians, Psychologists, LCSWs, LPCC, LMFT, Advanced Practice Nurses, in accordance with the Board of Registered Nursing.

2. If a staff member is NOT licensed, registered/waivered or graduate student, are they allowed to complete a diagnosis? No.

3. Can "by history," "rule out" or "provisional" diagnoses be used in meeting medical necessity? "By history", "Rule Out" and "Provisional" diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a beneficiary may have a "by history", "rule out", or "provisional" diagnosis as long as there is also at least one included diagnosis.

Source: MHSUDS Information Notice No.: 17-040

Learn more!

Check out CDIP's
"SMHS Medical Necessity Training Tool"
&
Tip Sheet on Asperger's and PDD-NOS

[8] See Reference B for 22 CCR §51340 regulations.

Section 5: Client Assessment

The word “assessment” has multiple meanings in the SMHS program—it is a service, a phase of treatment and a document.

DHCS defines an “assessment” service as an activity that is designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental health status determination; analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and, the use of testing procedures (Source: 9 CCR §1810.204).

DHCS defines some requirements for the assessment and allows the County Mental Health Plan (MHP) to define other requirements. For timeliness and frequency of the assessment, DHCS expects the *initial assessment* is required within the first 60 calendar days of Episode Opening and a new assessment is completed as needed, based on the changes in the client’ status/condition, medical/clinical change, and/or a change in diagnosis. For regular ongoing reassessments for ongoing services, DHCS requires the MHP to establish frequency timelines (Source: MHP Contract).

DHCS requires that every SMHS assessment document/form contain 11 required elements. When an assessment is correctly and completely filled out, the 11 required elements capture the information needed to identify medical necessity and the client’s mental health needs. The 11 required elements from DHCS are:

1. Presenting Problem: Describe the client’s presenting complaint and history. You must include the current level of functioning and symptoms. Also address any relevant family history and current family information.

2. Relevant Mental Health Conditions and psychosocial factors: Describe the factors that affect the client’s physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma.

3. Mental Health History: Describe the client’s prior treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports.

4. Medical History: Describe the relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.

5. Medications: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse

reactions to medications and documentation of an informed consent for medications.

6. Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.

7. Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

8. Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma

   > *DHCS MHSUDS Info Notice #17-040 included the following as possible areas of risk: History of Danger to Self (DTS) or Danger to Others (DTO); Previous inpatient hospitalizations for DTS or DTO; Prior suicide attempts; Lack of family or other support systems; Arrest history, if any; Probation status; History of alcohol/drug abuse; History of trauma or victimization; History of self-harm behaviors (e.g., cutting); History of assaultive behavior; Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and, Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).*

9. A mental status examination: A mental status examination.

10. A Complete Diagnosis: A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.

11. Additional clarifying formulation information, as needed: Additional clarifying formulation (clinical/diagnostic formulation) information, as needed.

BHS' Frequency and Timeliness Standards for Assessments

BHS has created assessment forms/documents for A/OA, CYF and the Private Provider Network (PPN). If the assessment forms are filled out completely and correctly, then you will capture all of DHCS' 11 required elements.

The table that follows provides a summary of BHS' standards for timeliness and frequency of assessments.

Table: BHS Standards for Assessment Timeliness & Frequency

Type of Non-Hospital Service	Initial Assessment*	Subsequent Assessment*
Outpatient	Within 60 days of Episode Opening (or prior to first planned service—whichever comes first)	Annually, within 30 days of Anniversary of Episode Opening
TBS	Within 30 days of referral to TBS	Not Applicable: Length of stay is less than 12mos
Day Treatment Rehabilitation	Within 3 full days of Episode Opening	Annually, within 30 days of Anniversary of Episode Opening
Day Treatment Intensive	Within 3 full days of Episode Opening	Annually, within 30 days of Anniversary of Episode Opening
Adult Residential	Within 3 full days of Episode Opening	Annual assessment within 30 days of Anniversary of Episode Opening
Crisis Residential	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Crisis Stabilization	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Medication Treatment-Urgent Meds	The finalized progress note is the document and is due at the end of the contact	Not Applicable: Length of stay is less than 12mos
Medication Treatment-Meds Only	Within 60 days of Episode Opening (or prior to first planned service—whichever comes first)	Annual E&M Level 3 (medical necessity) and full Psychiatric Evaluation every 3 years, within 30 days of Episode Opening
* *when discussing Assessment timeliness and frequency, "within" means the days prior to the Episode Opening, the anniversary, etc.*		

Remember: A reassessment may be required when a client has experienced a significant medical or clinical change, or where a significant amount of time has

elapsed since a prior assessment and diagnosis. The San Francisco MHP specifies that client reassessments be completed at least annually no later than the anniversary date of the client episode opening, or when there is a significant change in the client's condition, whichever occurs sooner.

Client Assessment Tools & Elements for Adults and Children
The Adult and Older Adult (A/OA) Systems of Care and Children, Youth, and Families (CYF) System of Care have two different evidence-based assessment tools that their respective providers are required to use:

1. The A/OA Systems of Care require providers to use the Adult Needs and Strengths Assessment (ANSA).
2. The CYF System of Care requires providers to use the Child and Adolescent Needs and Strengths (CANS).

A/OA Systems of Care Client Assessment
The BHS A/OA assessment form captures all of the required DHCS elements when filled out completely and correctly. If an assessment element is not applicable, indicate "N/A" in the client record at the time of assessment. The A/OA assessment domains and prompts include:

1. [**Presenting Problem**] Describe the presenting problem: (a) identifying info; (b) criteria to justify DSM dx including symptoms, behavior, impairments in functioning, duration, frequency and severity; (c) impact on life/behavior leading to the client to seek services; (d) client's chief goal; (e) cultural explanation problem/illness in client's own words (if EPSDT, state why child/youth will not progress developmentally as individually appropriate without treatment). If this is continued treatment, include the rationale (current/continuing symptoms, behaviors and/or impairments in functioning justifying current diagnoses, medical necessity and continued need for treatment).

2. [**Risk Assessment**] Risk Assessment Narrative: Describe all risk factors, note frustration tolerance, hostility, paranoia, violent thinking and gambling risk behaviors. Also include factors that might lessen risk, such as client's commitment to self-control and involvement in treatment.

   > *DHCS Info Notice #17-040 included the following as possible areas of risk: History of Danger to Self (DTS) or Danger to Others (DTO); Previous inpatient hospitalizations for DTS or DTO; Prior suicide attempts; Lack of family or other support systems; Arrest history, if any; Probation status; History of alcohol/drug abuse; History of trauma or victimization; History of self-harm behaviors (e.g., cutting); History of assaultive behavior; Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and, Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).*

3. **[Psychosocial and Family History and Relevant Conditions Affecting Physical and Mental Status**] Describe the client's living situation, family, employment, activities, social support immigration, physical health, etc. Make sure you identify how these impact the mental health diagnosis. Describe cultural Identification (race, ethnicity, spirituality, sexual orientation). Identify key events from childhood (where/who reared/lived in house where grew up, important/traumatic events, school experience and performance history of physical/sexual abuse, placement history) and adolescence (school and activities, friendships/relationships, sexual experiences, traumas, leaving home, placement history).

4. [**Mental Health History of Client & Family**] Obtain information on current/past conditions, treatment history, level of treatment, family history. Describe most effective treatment and problems with treatment. Include dates, duration, precipitant, and provider contact if known. Include all mental health services, hospitalizations, residential and day treatment, crisis services, case management, and psychological assessment. Obtain the number of PES Visits/Crisis Services/Inpatient Hospitalizations/IMD stays in the past year.

5. [**Substance Use**] Describe substance used (include alcohol, tobacco and caffeine as well as illicit, prescribed and over the counter drugs, if any). Has anyone annoyed/gotten on client's nerves by telling them to cut down/stop? Has client been waking up wanting to use? Has client felt she/he should cut down or stop using? Has client felt guilty/bad about how much she/he uses?

6. [**Medical History & Physical Health Conditions**] Obtain information on last physical exam (and provider information), last dental exam (and provider information), dates/results of most recent PPD/chest x-ray/who read, with PPD history. Describe current treatment (if applicable). Describe allergies (include food, medications and other).

7. [**Medications**] Include all medications, name of prescriber and known allergies (per client report). Include previous medications and OTC medications if relevant. Also note medication adherence issues. Include both Psychotropic and Non-psychotropic.

8. [**Criminal Justice History**] Describe involvement with and types of incidents. Include dates, types of crimes/incidents of violence, involvement in parole/probation; and history of incarceration, if any.

9. [**Mental Status Exam**] Mental Status Exam: (a) attitude; (b) appearance, (c) movement, (d) speech; (e) affect; (f) mood; (g) thought process/content, (h) insight/judgement, (i) memory and orientation, (j) suicidal/homicidal ideation, (k) intelligence, (l) hallucinations/illusions.

10. [**Clinical Formulation**] You will provide a clinical formulation, recommendation and disposition; Provide your current clinical information, hypothetical reasons/context for presentation problem that supports your recommendation for treatment with modality and frequency; If assessment is

an annual update, include client's progress to response to treatment plan objectives.

CYF System of Care Client Assessment
The BHS CYF assessment forms captures all of the required DHCS elements when filled out completely and correctly. If an assessment element is not applicable, indicate “N/A” in the client record at the time of assessment. The CYF prompts appear below for both the 0-4 years Assessment form as well as the 5-18 years Assessment Form.

CYF 0-4 Years Assessment Prompts:

1. [**Presentation**] Describe the client's current presentation (include symptoms, behaviors, onset, duration, severity and family response to current situation).

2. [**Impact on Functioning**] Describe impact of the mental health problem on self-care, home, pre-school and community. Please note whether the impairments are due to symptoms/behavior of the included DSM-5 diagnosis.

3. [**Relevant History**] Describe the precipitating events and other significant life events leading to current situation (e.g., caregiver divorce, immigration, level of acculturation-assimilation, losses, moves, social changes, financial difficulties).

4. [**Cultural Factors**] Describe the cultural factors which may influence presenting problems as viewed by child/youth/parent/caregiver and clinician (may include ethnicity, race, religion, spiritual practice, sexual orientation, caregiver SES, living environment).

5. [**Risk Behaviors**] Describe aggressive-violent behavior to self/others. Include the level of impairment impact on child's functioning in home, in day care/preschool, and in other community settings (e.g., school suspension, law enforcement/incarceration, crisis services and hospitalization). Describe any self-harming behaviors (e.g., head banging, or expressed thoughts, e.g., I hate myself; I want to die). Identify the date of onset; Self-destructive/suicidal behavior/danger to self (include level of impairment [e.g., ideation, plan, threats, attempts/gestures, crisis services, hospitalization).

   DHCS Info Notice #17-040 included the following as possible areas of risk: History of Danger to Self (DTS) or Danger to Others (DTO); Previous inpatient hospitalizations for DTS or DTO; Prior suicide attempts; Lack of family or other support systems; Arrest history, if any; Probation status; History of alcohol/drug abuse; History of trauma or victimization; History of self-harm behaviors (e.g., cutting); History of assaultive behavior; Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and, Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

6. [**Substance Abuse**] Describe any substance/alcohol abuse (specify onset, type-including tobacco and caffeine), frequency and amount, and level of impairment (e.g., missing work/school, law enforcement/incarceration, family's level of concern and attempts to intervene).

7. [**Child Strengths & Supports**] Describe the client's individual strengths and supports. Also identify the family's strengths and needs.

8. [**Caregiver Strengths & Needs**] Describe family and community supports AND caregiver and foster caregiver strengths/needs.

9. [**Foster Caregiver**] Describe the foster caregiver's strengths.

10. [**Psychiatric History**] Obtain information on past treatment, including the Psychiatric provider, reason for treatment, date of treatment and outcome (was it helpful and why).

11. [**Current Medical**] Obtain Medical Provider type, name, phone number and the date any past records were requested.

12. [**Alternative Healing**] Obtain Alternative Healing provider name, reason for treatment, date of treatment and outcome (was it helpful and why).

13. [**Current Medications**] Provide the name, dosage, date started, date of last dose, effectiveness/side effects, and prescriber. Is a medication evaluation needed? Does the client follows a medication regimen as directed?

14. [**Medical History**] Describe past/current illnesses and medical conditions (including previous hospitalization), allergies. Identify the date of last physical exam and last dental exam.

15. [**Developmental History Risk Factors & Abuse/Trauma History**] Describe significant events in prenatal/birth/early childhood stages, as well as enduring or pervasive developmental or cognitive difficulties. Describe any abuse history (include type, age, and details of any neglect, and/or physical, sexual, and emotional abuse):

16. [**Abuse/Trauma**] Describe abuse history (include type, age, and details of any neglect, and/or physical, sexual, and emotional abuse).

17. [**Formal Service**] Obtain past/current involvement with and staff names for Special Educational Services, HSA, Court Ward, Probation Officer, AB3632, FIT, FMP, CSOC.

18. [**Care Intensity & Organization**] Describe the level of intensity of services needed and as well as supports for access (e.g., transportation).

19. [**Mental Status Exam**] What is the client's current mental status (document clinical observations that address the appropriateness of client's appearance, response to situation, ability to regulate, motor functioning, language, expression, play, cognition and relatedness. Rate CANS items. (orientation, appearance, behavior, relatedness, level of alertness, speech, abnormal movements. Include a description of mood, affect, thought flow, thought content, delusions, hallucinations, intellectual functioning, insight/judgement, other mental status findings.

20. [**Clinical Formulation**] Your clinical formulation will include hypothetical reasons/context for presenting problems; if applicable, include any relevant cultural factors; Note any parent/guardian behaviors that contribute to infant/child presenting problems or impairments; Describe target symptoms/focus of treatment (hypothetical reasons/context for presenting problems; if applicable, include any relevant cultural factors; Describe Impairments and their relationship to symptoms; Describe interventions used and how they have reduced the impairment or symptoms; Interventions to be used now, and why?

CYF 5-18 Years Assessment Prompts:

1. [**Presentation**] Describe the client's current presentation (include symptoms, behaviors, onset, duration, severity and family response to current situation.

2. [**Impact on Functioning**] Describe the impact on self-care, home, school and community. Please note whether the impairments are due to symptoms/behavior of the included DSM-5 diagnosis.

3. [**Relevant History**] Describe the precipitating events and other significant life events leading to current situation (e.g., divorce, immigration, level of acculturation-assimilation, losses, moves, social changes, financial difficulties.

4. [**Cultural Factors**]: Describe the cultural factors which may influence presenting problems as viewed by child/youth/parent/caregiver and clinician (may include ethnicity, race, religion, spiritual practice, sexual orientation, caregiver SES, living environment).

5. [**Risk Behaviors**] Describe aggressive-violent behavior to others[(include level of impairment (e.g., school suspension, law enforcement/incarceration, crisis services and hospitalization)]; Describe self-destructive/suicidal behavior/danger to self (include level of impairment [e.g., ideation, plan, threats, attempts-gestures, crisis services, hospitalization).

   > *DHCS Info Notice #17-040 included the following as possible areas of risk: History of Danger to Self (DTS) or Danger to Others (DTO); Previous inpatient hospitalizations for DTS or DTO; Prior suicide attempts; Lack of family or other support systems; Arrest history, if any; Probation status; History of alcohol/drug abuse; History of trauma or victimization; History of self-harm behaviors (e.g., cutting); History of assaultive behavior; Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and, Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).*

6. [**Substance Abuse**] Describe substance/alcohol abuse (specify onset, type-including tobacco and caffeine), frequency and amount, and level of impairment (e.g., missing work/school, law enforcement/incarceration, family's level of concern and attempts to intervene).

7. [**Child Strengths**] Describe the child's strengths and supports as well as the family strengths and needs.

8. [**Caregiver Strengths**] Describe the caregiver's strengths.

9. [**Foster Caregiver**] Describe the foster caregiver's strengths.

10. [**Psychiatric History**] Obtain information on past treatment, including the Psychiatric provider, reason for treatment, date of treatment and outcome (was it helpful and why).

11. [**Current Medical**] Obtain Medical Provider type, name, phone number and the date any past records were requested.

12. [**Alternative Healing**] Obtain Alternative Healing provider name, reason for treatment, date of treatment and outcome (was it helpful and why).

13. [**Current Medications**] Obtain current medication name, dosage, date started, date of last dose, effectiveness/side effects, and prescriber. Will the client need a medical evaluation? Does the client follow a medication regimen?

14. [**Medical History**] Describe past/current illnesses and medical conditions (including previous hospitalization), allergies. Identify the date of last physical exam and last dental exam.

15. [**Developmental History**] Describe significant events in prenatal/birth/early childhood stages, as well as enduring or pervasive developmental or cognitive difficulties. Describe significant events in prenatal/birth/early childhood stages, as well as enduring or pervasive developmental or cognitive difficulties. Describe significant events in latency stage (peer/sibling relations, extracurricular activities, delinquency).

16. [**Abuse/Trauma**] Describe any abuse history (include type, age, and details of any neglect, and/or physical, sexual, and emotional abuse).

17. [**Formal Service**] Obtain past/current involvement with and staff names for HSA, Court Ward, Probation Officer, Special Education, AB3632, FIT, FMP, CSOC.

18. [**Mental Status Exam**] What is the client's current mental status (orientation, appearance, behavior, relatedness, level of alertness, speech, abnormal movements)? Include Mood, affect, thought flow, thought content, delusions, hallucinations, intellectual functioning, insight/judgement, other mental status findings.

19. [**Clinical Formulation**] Your clinical formulation will include hypothetical reasons/context for presenting problems; if applicable, include any relevant cultural factors; Note any parent/guardian behaviors that contribute to infant/child presenting problems or impairments; Describe target symptoms/focus of treatment (hypothetical reasons/context for presenting problems; if applicable, include any relevant cultural factors; Describe Impairments and their relationship to symptoms; Describe interventions used and how they have reduced the impairment or symptoms; Interventions to be used now, and why?

Client Assessment Dates, Signatures, Professional Degree, Licensure/Job Title

All client assessments for both the CYF and A/OA Systems of Care must include the following (Source: DHCS Medi-Cal SMHS 101 Training, August 2017):

1. The date of service/client assessment;
2. The signature of the person completing the client assessment (or electronic equivalent) including;
   a. The person's type of professional degree, licensure or job title; and
   b. The relevant identification number, if applicable;
3. The date the documentation was entered into the client medical record.

A LPHA/Waivered-Registered LPHA must finalize and sign/co-sign the assessment.

Insights from DHCS: Assessments

1. Can I use the assessment from a client's recent hospitalization? The assessment which includes the diagnosis is designed to evaluate the current status of a client's mental, emotional, or behavioral health. The status of a client's mental, emotional, or behavioral health may change as a client transitions from inpatient to outpatient services. As such, a provider must not rely on an inpatient diagnosis when performing a client assessment for outpatient services. However, a provider must review the inpatient assessment documentation to inform the outpatient client assessment and verify the diagnosis reflects the client's current mental, emotional, or behavioral health status.

2. What if two clinician's arrive at different diagnoses for the same client? All client diagnoses must be accurate, truthful and complete. In instances where there is a difference of opinion regarding a client's diagnosis between LPHA providers, the providers involved should consult and collaborate to determine the most accurate diagnosis.

3. What elements of the assessment are restricted to licensed, registered/waivered and specific graduate students? The diagnosis, mental status examination, medication history and the assessment of relevant conditions and psychosocial factors are restricted. An MHP may designate other providers to contribute to the assessment (e.g., collection of mental health and medical history, substance exposure/use and identification of strengths, risks and barriers to achieving goals.

Insights from DHCS: Assessments

4. What are examples of "risks" that should be included in the Risk section of the assessment?

   - History of Danger to Self (DTS) or Danger to Others (DTO);
   - Previous inpatient hospitalizations for DTS or DTO;
   - Prior suicide attempts;
   - Lack of family or other support systems;
   - Arrest history, if any;
   - Probation status;
   - History of alcohol/drug abuse;
   - History of trauma or victimization;
   - History of self-harm behaviors (e.g., cutting);
   - History of assaultive behavior;
   - Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and,
   - Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

5. Can I estimate the time spent in assessment? No-providers should not estimate the amount of time they spend assessing a client. Time performing an assessment can either be claimed piece-by-piece or the time can be totaled and submitted as one claim (e.g., separate claims can be submitted for conducting the face-to-face assessment; for reviewing the beneficiary's records to obtain history, and for writing up the assessment; or, a single claim can be submitted detailing all of these activities).

6. What is considered to be a "significant change" in the client's condition that would require an update? There is no specific language in regulation or in the MHP contract defining a "significant change" in a beneficiary's condition. Examples may include a beneficiary who has never been suicidal makes a suicide attempt; or, a beneficiary who regularly participates in client plan services suddenly stops coming to appointments. Major life events that might lead to a change in the beneficiary's condition include, but are not limited to: job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), change in residence/living situation.

Source: MHSUDS Information Notice No.: 17-040

Learn more about Assessments!

Check out CDIP's "Assessment Requirements" & "Assessment Writing" tools!

Section 6: Client Plan/Treatment Plan of Care (TPOC)

Each behavioral health client must have a client plan developed in partnership with the client and their families or other significant support person(s), as appropriate. Each client plan must include documentation of a client's participation in the development of and agreement with the client plan (Source 9 CCR § 1810.440 (c)(1). The client plan must be updated at least annually or when there are significant changes in the beneficiary's condition. BHS calls the client plan the "Treatment Plan of Care" (TPOC).

Client Plan Required Elements
DHCS requires that 11 required elements appear in every Client Plan document. These 11 requirements are enumerated in the contract between DHCS and the County Mental Health Plan (for TBS specific client plan requirements, see TBS section):

1. **Initial Client Plan & Client Plan Updates**: The Initial Client Plan is finalized within the MHP's timeliness standards. The client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition.

2. **Specific Objectives**: Client Plan objectives must be specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

3. **Proposed Interventions & Detailed Description**: The Client Plan contains the proposed type(s) of interventions/modalities. There must be a detailed description of the intervention to be provided.

4. **Frequency of Interventions**: The Client Plan includes the proposed frequency of the intervention(s).

5. **Duration of Interventions**: The Client Plan includes the proposed duration of the intervention(s).

6. **Focus of Interventions**: The Client Plan interventions focus on and address the identified functional impairments as a result of the mental disorder or emotional disturbance.

7. **Consistency of Interventions with Objectives & Diagnosis**: The Client Plan interventions are consistent with both: (1) Client Plan goal(s)/treatment objective(s) and (2) the qualifying diagnoses.

8. **Staff Signatures (for LPHA) and Co-Signatures (for non-LPHA)**: The Client Plan is signed by: (1) person providing the service(s) or (2) person representing a team or program providing the service(s) or, (3) a person representing the MHP providing the service(s) or (4) co-signed by a [LPHA] if the Client Plan is used to establish that services are provided under the direction of [non-LPHA].

9. **Client Participation In & Agreement With Client Plan**: The client's participation in and agreement with the Client Plan is documented by one of the following: (1) reference to the client's participation in/agreement written within the body of the Client Plan, (2) the client's signature* on the client plan or (3) a description of the client's participation in/agreement documented in the medical record

   The client's signature* (or client's legal representative's signature) must appear on the Client Plan if both of the following are true: (1) the client is expected to be in long-term treatment [defined by County Mental Health Plan] and (2) the Client Plan includes more than 1 type of SMHS (e.g., client receiving both "Therapy" and "Targeted Case Management").

   *If the client refuses or is unavailable to sign the Client Plan, then the Client Plan must include a written explanation of the refusal/unavailability of the signature."

   > *DHCS' MHSUDS Information Notice #17-040 clarified how a provider addresses a client's refusal to sign the treatment plan (page 11): Each time a beneficiary's signature or the signature of the beneficiary's legal representative is required on a client plan or an updated client plan "and the beneficiary refuses or is unavailable for signature, the client plan [or updated plan] shall include a written explanation of the refusal or unavailability." The written explanation may be on the plan itself or in a progress note. Although not required, it is best practice to make additional attempts to obtain the beneficiary's signature and document the attempts in the client record. (MHP Contract; Cal. Code Regs., tit. 9. § 1810.440 (c)(2)(B)).*

10. **Evidence of Offering Copy of Client Plan to Client**: The Client Plan will include documentation that the contractor offered a copy of the client plan to the beneficiary.

11. **Dates & Staff Degree/Title on the Client Plan**: The Client Plan must include all of the following (1) the date of service; (2) the staff's signature, professional degree and title of job/licensure; and (3) the date the documentation was entered into the medical record.

Client Plan Effectiveness Dates

A client plan is effective once it has been signed and dated by the required LPHA/Waivered-Registered LPHA staff member(s) (Source: 9 CCR § 1810.440 (c)(1)). BHS providers use the electronic health record (Avatar) to track timeliness and frequency of the TPOC by populating the "TPOC Begin" and "TPOC End" fields (see Reference H in this manual for the AOA and CYF Memos that describe the requirements).

Planned and Unplanned Services-BHS Standards
The table below shows the services and service activities they can be delivered before the Client Plan is finalized. This information was recently clarified by DHCS (Source: DHCS MHSUDS Information Notice No.: 17-040).

Unplanned Services/Activities	Planned Services/Activities

• Assessment
• Plan Development
• Crisis Intervention
• Crisis Stabilization
• Specified *activities* within Targeted Case Management (TCM)/Intensive Care Coordination (ICC):
  o Assessment, Plan Development and Referral/Linkage to obtain needed services
• Specified *activities* within Medication Support Services:
  o Assessment, Evaluation and Plan Development
	• Collateral
	• Rehabilitation
	• Therapy
	• Therapeutic Behavioral Services (TBS)
	• Intensive Home Based Services (IHBS)
	• Treatment Foster Care (TFC)
	• Specified *activities* within TCM/ICC:
	  o Monitoring and Follow-up Activities
	• Specified activities within Medication Support Services:
	  o Direct Treatment and Monitoring
	• Adult Residential Services
	• Crisis Residential Services
	• Day Treatment Rehabilitation and Intensive

BHS' Frequency and Timeliness Standards for Client Plans/TPOC

Type of Non-Hospital Service	Initial Client Plan/ TPOC*	Subsequent Client Plan/TPOC*
Outpatient	Within 60 days of Episode Opening (or prior to first planned service—whichever comes first)	Annually, within 30 days of Anniversary of Episode Opening
TBS	Within 30 days of referral to TBS	Not Applicable: Length of stay is less than 12mos. Note the requirement to "review" every 30 days.
Day Treatment Rehabilitation	Within 3 full days of Episode Opening	Annually, within 30 days of Anniversary of Episode Opening
Day Treatment Intensive	Within 3 full days of Episode Opening	Annually, within 30 days of Anniversary of Episode Opening
Adult Residential	Within 3 full days of Episode Opening	Annually, within 30 days of Anniversary of Episode Opening
Crisis Residential	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Crisis Stabilization	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Medication Treatment-Urgent Meds	The finalized progress note is the document and is due at the end of the contact	Not Applicable: Length of stay is less than 12mos
Medication Treatment-Meds Only	Within 60 days of Episode Opening (or prior to first planned service—whichever comes first)	Annually, within 30 days of Anniversary of Episode Opening

* *when discussing Client Plan/TPOC timeliness and frequency, "within" means the days prior to the Episode Opening, the anniversary, etc.*

Remember: All planned services must appear on the TPOC in order to receive reimbursement. All services should be directed toward the client's impairments (and those impairments should be reflected in the TPOC Objectives). The TPOC Objectives are expected to vary over time--OCPA does not allow you to copy and paste the same Objective year after year (without some type of clear documentation about the medical necessity rationale for continuing Objectives that are not being met).

Insights from DHCS-Treatment Plan of Care (TPOC)

1. What is the expectation for obtaining the signature of a child client (under 18 years old)? Is there a minimum age for a minor to independently sign their client plan? There is no minimum age for a minor to independently sign a client plan, assuming the client plan is not used to obtain the minor's consent to treatment. The client plan is a collaborative process between the beneficiary and the provider. The beneficiary should understand what they are signing based on their participation in that process.

2. What if a client refuses to sign the Client Plan? Each time a beneficiary's signature or the signature of the beneficiary's legal representative is required on a client plan or an updated client plan "and the beneficiary refuses or is unavailable for signature, the client plan [or updated plan] shall include a written explanation of the refusal or unavailability." The written explanation may be on the plan itself or in a progress note. Although not required, it is best practice to make additional attempts to obtain the beneficiary's signature and document the attempts in the client record. (MHP Contract; Cal. Code Regs., tit. 9. § 1810.440 (c)(2)(B)).

3. What is considered to be a "significant change" in the client's condition that would require an updated client plan? There is no specific language in regulation or in the MHP contract defining a "significant change" in a beneficiary's condition. Examples may include a beneficiary who has never been suicidal makes a suicide attempt; or, a beneficiary who regularly participates in client plan services suddenly stops coming to appointments. Major life events that might lead to a change in the beneficiary's condition include, but are not limited to: job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), change in residence/living situation.

4. What's the difference between a "proposed" and "actual" intervention? Proposed interventions are the services a provider anticipates delivering to a beneficiary when preparing the beneficiary's client plan. MHPs are required to ensure that client plans "identify the proposed type(s) of intervention/modality…to be provided" to the beneficiary. The actual interventions are those that are actually delivered to a beneficiary. The actual interventions are documented in progress notes.

5. Can the frequency for delivery of an intervention be "PRN," "as needed," "ad hoc," or as a frequency range (e.g., 1-4x's/month? Use of terms such as "as needed" and "ad hoc" do not meet the requirement that a client plan contain a proposed frequency for interventions. The proposed frequency for delivery of an intervention must be stated specifically (e.g., daily, weekly, etc.), or as a frequency range (e.g., 1-4 x's monthly). Duration must also be documented in the client plan and refers to the total expected timespan of the service (e.g., the beneficiary will be provided with two individual therapy sessions per week for 6 months (MHP Contract).

Insights from DHCS-TPOC (continued)

6. What SMHS can be provided to the client prior the Client Plan being approved?

- The following **SMHS services** are reimbursable prior to the Client Plan being approved:
  - Assessment
  - Plan Development
  - Crisis Intervention
  - Crisis Stabilization

- The following **activities** are reimbursable before the Client Plan is approved:
  - The specific activities of assessment, plan development and referral/linkage elements of Targeted Case Management and Intensive Care Coordination
  - The specific activities of assessment, evaluation or plan development elements of Medication Support Services
  - Medication Support Services if there is an urgent need which must be documented

7. What services must appear on the approved Client Plan to receive reimbursement?

- Mental Health Services (except assessment and plan development)
- Intensive Home Based Services (IHBS)
- Specific activities of monitoring and follow up activities to ensure plan is being implemented and that it adequately addressed client's needs
- Therapeutic Behavioral Services (TBS)
- Day Treatment Intensive and Day Treatment Rehabilitation
- Adult Residential & Crisis Residential Treatment Services
- Medication Support Services (non-emergency)
- Psychiatric Health Facility Services
- Psychiatric Inpatient Services

Source: MHSUDS Information Notice No.: 17-040

Learn more about Client Plans!

Check out CDIP's "TPOC Writing Training"
&
"Vignette/Example with TPOC Objectives-Interventions" tools

Section 7: Progress Notes

Progress notes document the actual services delivered to the client. DHCS requires 11 required elements appear in every progress note. All providers must ensure that progress notes describe how services provided reduced the impairment(s), restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan (Source: DHCS MHSUDS Information Notice No.: 17-040).

Progress Note Elements
These 11 items are enumerated in the contract between DHCS and the County Mental Health Plan.

1. Relevant Aspects of Client Care: Timely documentation of relevant aspects of client care, including documentation of medical necessity.

2. Details of the Encounter: Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

3. Interventions and Details: Interventions applied, beneficiary's response to the interventions, [how services provided reduced impairment/restored functioning/prevented deterioration in an important area of life functioning out lined in the Client Plan], and the location of the interventions.

4. Date of Service: The date the services were provided.

5. Referrals: Documentation of referrals to community resources and other agencies, when appropriate?

6. Follow-Up Care or Discharge Summary: Documentation of follow-up care or, as appropriate, a discharge summary?

7. Service Time: The amount of time taken to provide services (actual time, not estimated).

8. Signature, Degree & Licensure/Title: The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title.

9. Date of Documentation: The date the documentation was entered in the medical record.

10. Timeliness, Frequency & Legibility: For the following services, every contact/encounter must be: (a) documented as a progress note and (b) finalized in the medical record within 5 days from the date of service [include "Late Entry" at beginning of note of beyond 5 days]. All documentation must be legible.

11. Multi-Provider Notes: When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include: (a) documentation of each person's involvement

in the context of the mental health needs of the beneficiary; (b) the exact number of minutes used by persons providing the service (c) signature(s) of person(s) providing the services?

Documentation of Medical Necessity in Progress Notes
DHCS has clarified that the components of medical necessity that must be documented in the progress note, including: (a) the specific intervention that was provided, (b) how the intervention provided reduced the impairment(s) or restored functioning or allowed developmental progress as appropriate or prevented significant deterioration in an important area of life functioning outlined in the client plan, and (c) the beneficiary's response to the intervention.

While not all components of medical necessity must be documented in a progress note, the progress notes must clearly link the intervention to the identified functional impairment(s), which are as a result of the beneficiary's identified mental health diagnosis.

The interventions should be described in such a way that an external reader (chart auditor, other treatment provider) would be able to determine if the interventions were clinically appropriate to the impairments and if there was a reasonable likelihood that the interventions would reduce those impairments, restore functioning, prevent deterioration, or allow developmental progress as appropriate (Source: DHCS MHSUDS Information Notice No.: 17-040).

BHS Frequency & Timeliness Standards for Progress Notes
As a best practice, progress notes and service documentation should be fully finalized with required co-signatures on the same day as the service. *However*, the exact timeliness standards are determined by the type of required documentation (e.g., a progress note for every contact vs. one weekly summary for a week of services). The table that follows shows the frequency and timeliness standards for Non-Hospital Services.

In all instances, if the service documentation is not fully finalized within 5 business days of the expectation, then the documentation is considered to be late and the late documentation must include "LATE ENRY" at the beginning of the note.

In addition to defining the frequency and timeliness standards for service documentation, BHS encourages providers to use a structured format to document progress notes and services. A good format for managed care is "**P**roblem-**I**ntervention-**R**esponse-**P**lan" (see the Appendix, Reference C – P-I-R-P Format). (Source: DPH BHS Medical Records Policy). Progress notes should be unique to each client and never cloned across clients.

Progress notes that are not finalized (e.g., left in "draft" in the electronic health record) cannot be claimed and are not considered to meet the compliance standards for completeness and timeliness.

The table summarizes the frequency and timeliness standards for notes, by type of service. Also, refer to Sections in this manual that describe specific services—additional details are provided.

Table: BHS Standards for Progress Notes Timeliness & Frequency

Type of Non-Hospital Service	Time Claimed In	Progress Note Standard*
Outpatient	Minutes/ Staff Time	Every contact is documented in progress note
TBS	Minutes/ Staff Time	Every contact is documented in progress note
Day Treatment Rehabilitation	Blocks of Time	Weekly Summary & Monthly Collateral Note
Day Treatment Intensive	Blocks of Time	Daily Note, Weekly Clinical Summary & Monthly Collateral Note
Adult Residential	Calendar Days	Weekly Summary
Crisis Residential	Calendar Days	Daily Note
Crisis Stabilization	Blocks of Time	Progress note (4 hour blocks)
Medication Treatment- Urgent Meds	Minutes/ Staff Time	The contact is documented at the time of service in a progress note
Medication Treatment-Meds Only	Minutes/ Staff Time	Every contact
* *In all instances, if the service documentation is not fully finalized within 5 business days of the expectation (e.g., every contact; 4 hour blocks), then the documentation is considered to be late and the late documentation must include "LATE ENRY" at the beginning of the note*		

Additional Progress Note Requirements

The DPH BHS Medical Records Policy 3.10-02 includes the following progress note documentation requirements:

1. Cultural and linguistic accommodations offered or made on behalf of the client or family/caregiver must be documented in every progress note.

2. A client's exact quotes, not paraphrasing, regarding significant and sensitive issues must be documented in progress notes.

3. Changes in a client's risk status must be noted in the client record.

4. All referrals to community resources and other agencies should be documented, when appropriate.

5. Dates of follow-up appointments should be documented.

6. A description of interventions used and progress made toward the treatment goals by the client and family (when applicable) must be documented.

7. A progress note should indicate whether a reimbursable and non-reimbursable service was provided and requires a billing code to reflect the type of service provided.

8. The names of other clients should not be used in another client's progress note.

Progress Notes and Services in Specific Clinical Scenarios

Progress Notes – Group Services
When services are being provided by two or more persons at one point in time, the number of staff group facilitators and the unique involvement of each shall be documented in the context of the mental health needs of the beneficiary. The progress note should include the total number of group participants (Medi-Cal and non-Medi-Cal participants) and clearly indicate length of group session with documentation time included (or documentation time clearly recorded separately). In addition, when multiple providers render a covered service to more than one participant, the total number of minutes of the session must be distributed among the group participants (regardless of payer source), and prorated among the providers at the group session" (Sources: Medi-Cal Billing Manual, Chapter 7, §7.5.5 and (9 CCR §1840.314(c)).

For group notes, staff must enter a group note for each client in the group in his/her client medical record. Progress notes for group services must document:

1. The total staff time (if more than one staff provides a group service, the total time spent by all staff should be recorded);
2. The total number of clients, regardless of the funding stream.

The group progress note must include an "individualized" portion that is specific to the client—for example, documenting each client's individual benefit, receptivity and behavior during the group.

When one progress note is entered in the client medical record for a group session, it may be signed by one provider. In addition, while one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note must 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 also must be met.

Furthermore, when services are being provided "by two or more persons at one point in time, each person's involvement shall be documented in the context of the mental health needs of the beneficiary" (Source: 9 CCR §1840.314(c)).

Apportioning Time for Group Services (DHCS Examples)
DHCS recently provided examples to County Mental Health Plans (MHPs) on apportioning group service time across participants (Source: DHCS MHSUDS Information Notice No.: 17-040).

DHCS' EXAMPLE METHOD #1

- ***Set of Facts:***
  - *Group: 100 minutes*
  - *Providers: 2*
  - *Participants: 10*
  - *Provider 1: provides 100 minutes of a covered service*
  - *Provider 2: provides 60 minutes of a covered service*

- ***Method**: Divide each provider's minutes providing a covered service by the number of group participants.*
  - *Provider 1: 100/10=10*
  - *Provider 2: 60/10= 6*

- ***Result**:*
  - *Provider 1 would bill 10 minutes per Medi-Cal client*
  - *Provider 2 would bill 6 minutes per Medi-Cal client.*

***DHCS' EXAMPLE METHOD #2:** One provider writes all progress notes (10 beneficiaries) and documents specific involvement for each of the 2 providers as well as the specific service time of each provider and their documentation time*

- ***Set of Facts**:*
  - *Group Session: 100 minutes*
  - *Providers: 2*
  - *Participants: 10*
  - *Provider 1: renders 100 minutes of a covered service*
  - *Provider 2: renders 60 minutes of a covered service*
  - *Documentation Time: Provider 1 spends 80 minutes to complete all ten (10) progress note for both providers on all clients.*

- ***Method**:*
  - *Provider 1: 100 minutes of service time + 80 minutes of documentation time = 180 minutes divided by 10 clients = 18 minutes*
  - *Provider 2: 60 minutes of service time divided by 10 clients = 6 minutes*

- ***Result**:*
  - *Provider 1 would bill 18 minutes per beneficiary and provider 2 would bill 6 minutes per beneficiary*

DHCS' EXAMPLE METHOD #3: *each provider does separate progress notes on all 10 beneficiaries documenting their specific involvement and the amount of service and documentation time*

- ***Set of Facts****:*
  - *Group Session: 100 minutes*
  - *Providers: 2*
  - *Participants: 10*
  - *Provider 1 renders 100 minutes of a covered service*
  - *Provider 2 renders 60 minutes of a covered service*
  - *Documentation Time: Provider 1 spends 80 minutes to complete progress notes on all ten (10) beneficiaries and Provider 2 spends 70 minutes to complete progress notes on all ten (10) beneficiaries*

- ***Method****:*
  - *Provider 1: 100 minutes of service time + 80 minutes of documentation time = 180 minutes divided by 10 beneficiaries = 18 minutes*
  - *Provider 2: 60 minutes of service time + 70 minutes of documentation time = 130 minutes divided by 10 beneficiaries = 13 minutes*

- ***Result****:*
  - *Provider 1 would bill 18 minutes per beneficiary and provider 2 would bill 13 minutes per beneficiary.*

Progress Notes for Services Provided by Multiple Staff
When two or more staff provide significant and distinct services in a single contact, each staff should write a separate note and claim separately to an appropriate Avatar code for the service provided by that individual staff member. To receive reimbursement for specialty mental health services where two or more providers are providing services to one or more clients, the following conditions and documentation requirements must be met:

1. Staff must be intervening at the same time.

2. A legitimate reason for multiple staff must be documented.

3. Each staff person's involvement must be documented in the context of the mental health needs of the client (nature, scope, effectiveness and duration of the interventions).

4. The exact number of minutes claimed for each staff person must be documented separately by separate claims or the same claim with time for each staff person separately indicated.

5. Signatures of each staff person providing the service (or electronic equivalent), their type of professional degree, licensure OR job title and the date the documentation was entered in the medical record.

Progress Notes – Two or More Services in One Client Contact
When two or more significant and distinct services or service types are delivered within a single contact with a client, each service must be documented in a separate progress note that meets all documentation requirements. It is not

appropriate to combine multiple significant and distinct services under a single progress note that simply reflects the predominant service. The exception to this rule is “Plan Development” which may be combined with another service under the same progress note documenting a single contact with a client.

Learn more about Progress Notes & Services!

Check out CDIP’s “Clinical Documentation Training Powerpoint” for example progress note text
&
The “PIRP Notes” tool!

Insights from DHCS-Progress Notes

1. What components of medical necessity need to be established and documented in every progress note for each outpatient service? Components of medical necessity that must be documented in the progress note include the specific intervention that was provided, how the intervention provided reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the client plan, and the beneficiary's response to the intervention. While not all components of medical necessity must be documented in a progress note, the progress notes must clearly link the intervention to the identified functional impairment(s), which are as a result of the beneficiary's identified mental health diagnosis. The interventions should be described in such a way that a reviewer reading the note would be able to determine whether the interventions were clinically appropriate to the impairments and whether there was a reasonable likelihood that the interventions would reduce those impairments, restore functioning, prevent deterioration, or allow developmental progress as appropriate.

2. Why are providers discouraged from using checkboxes and "canned" templates in progress notes? If allowed by the MHP, the use of check boxes for routine information can be captured by using check boxes; however, use of check boxes would not be adequate or descriptive enough to capture specific individualized information regarding how the intervention reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the client plan, and the beneficiary's response to the intervention.

3. How should the use of techniques such as motivational interviewing, unconditional positive regard, empathetic listening, etc., be documented to ensure medical necessity and progress note requirements are met? Progress notes documenting the use of evidence-based practices such as motivational interviewing, and techniques such as unconditional positive regard, and empathetic listening should describe how the technique used during the intervention assisted to reduce impairment, restore functioning, allow developmental progress as appropriate, or prevent significant deterioration in an important area of life functioning outlined in the client plan, and the beneficiary's response to the intervention.

4. Are claims for services provided to a beneficiary with a substance use disorder reimbursable? If there is a co-occurring substance use disorder, interventions are claimable as long as the primary focus of the interventions is to address the functional impairment(s) that is a result of the included mental health diagnosis. The treatment of a beneficiary who has the requisite medical necessity for SMHS is reimbursable through Medi-Cal regardless of the co-occurrence of a substance use disorder (Cal. Code Regs., tit. 9 §1820.205(a)(1)(H) and 1830.205).

Insights from DHCS-Progress Notes (continued)

5. Is time spent reviewing a beneficiary's chart reimbursable? For which SMHS and under what circumstances is it reimbursable?

   - Record review can be reimbursable when performed as part of the following services and service activities:

     - Mental Health Services (assessment, plan development, collateral, rehabilitation, therapy)
     - Targeted Case Management
     - Medication Support Services
     - Crisis Intervention

   - In contrast, chart review activities are included in the hourly, half day, full day, or calendar day rate for the following services and cannot be claimed separately:

     - Day Treatment Rehabilitation and Intensive
     - Adult Residential
     - Crisis Residential
     - Psychiatric Health Facility
     - Crisis Stabilization

6. If a provider reviews a beneficiary's chart, in preparation for a session with a beneficiary, and the beneficiary no-shows, is the time for chart review claimable? If so, can the provider submit a subsequent claim for chart review in preparation of the beneficiary's next appointment? Yes, as long as the provider documents the circumstances of the beneficiary no-show, the time spent to review the chart in preparation for the beneficiary's appointment is reimbursable. The provider may submit another claim for chart review prior to the beneficiary's next appointment, as long as the time claimed is reasonable and in preparation for the beneficiary's appointment

7. Must there be a reason related to medical necessity documented in progress notes in order to provide services in a location other than a clinic setting? Rehabilitative Mental Health Services are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency. It is not necessary to document the reason for providing services in a location other than a clinic setting, e.g., at a beneficiary's home, in a park setting, in a vehicle. Services should be provided in the least restrictive setting

8. Can a provider claim Medi-Cal reimbursement for services provided in a vehicle or while the provider is driving if the intervention is therapeutic, included in the client plan, benefits the client, and documentation meets progress note requirements? These services may be claimed as long as the medical necessity criteria are met for the provision of SMHS, the intervention is on the client plan when a client plan is required, and all progress note requirements are met.

Insights from DHCS-Progress Notes (continued)

9. What is the definition of "case conference"? Can a provider bill Medi-Cal for time in a case conference? Although the term "case conference" is not specifically defined in the State Plan, MHP contract, or applicable regulations, it may refer to a discussion between direct service providers and other significant support persons or entities involved in the care of the beneficiary. It may be similar or comparable to a multi-disciplinary team meeting. If the case conference concerns the development of a treatment plan for a beneficiary, the conference could be claimed as Plan Development. Similarly, if the term refers to a discussion between multiple providers concerning the assessment of a beneficiary, the conference could be claimed as Assessment. If the discussion between multiple providers concerns coordination of services and linkage or referrals, etc., the conference could be claimed as TCM.

Source: MHSUDS Information Notice No.: 17-040

Section 8: Client Case Closures and Closing Summary

Source: DPH SFHN-BHS Medical Records Procedures for Closing Cases Policy

Client Case Closures

When the case is inactive for 90 days from the last service date, staff must proceed to case closure. Exceptions to this requirement include:

- For Special Programs for Youth clients under the CYF System of Care, case closure is required after eleven months of inactivity from the last service date.
- For "Meds Only" clients ("medication services"), case closure is required after six months of inactivity from the last service date.
- For Adult Residential Treatment Services clients, when a client discharges from the facility, staff must close the case and complete a Closing Summary.

Client Closing Summaries

A Closing Summary must be completed upon discharge of each client based on the standards below. In every instance, you must document the disposition of the case in a progress note.

A/OA SOC	CYF SOC	Medication-Only Clients
Complete the ANSA Closing Summary if the client has received **six or more services**	Complete the CANS Closing Summary if the case has been opened for **more than 30 days after completion** of the assessment (initial or annual)	Complete the MD Closing Summary if the case is solely staffed by a prescriber and the case is only receiving medication services. If the client were to continue to receive TCM with another staff, then the MD Closing Summary is not required

Definition of Closing Date

The closing date is the date of the last electronic health record entry. This last entry could be a billable or non-billable service. For example, if a "NO SHOW" is listed as the last entry in the client record, the date of the "NO SHOW" should be used as the closing date.

Non-Billable Service

Completing Closing Summaries is not billable to Medi-Cal Short-Doyle Specialty Mental Health Services. Time spent completing the Closing Summary should be documented under billing code, "ADM99"

Note—if you provide a service to the client that meets medical necessity and document the service appropriately, then the service may be reimbursable. For example, if you conduct an assessment service (administer CANS/ANSA) to identify if the client meets medical necessity for SMHS vs. ready for discharge and you meet with the client to review the results and referrals to services to maintain functioning, then the activity could be billable.

Section 9: Cultural and Linguistic Services

Cultural and Linguistic Services Requirement Documentation
The following Cultural and Linguistic Services requirements must be met and documented in the client medical record on every occasion (Sources: 9 CCR §1810.405, 9 CCR §1810.410, and 42 CFR §438.10):

1. Clients whose primary language is not English must be made aware of the availability of and offered or linked to oral language interpreter services in their primary language;
2. Clients who are hearing impaired must be made aware of the availability of and offered or linked to sign language interpreter services; and
3. Clients who are visually impaired must be provided treatment specific information in alternative formats (e.g. braille, audio, or large print formats).

There must be documentation in the client medical record of the client's response to the offer of interpretive services (Source: DHCS FY 2016-17 Chart Review Protocol). There also must be documentation in the client medical record of service-related personal corrrespondence in the client's preferred language (Source: DHCS FY 2016-17 Chart Review Protocol).

If the need for language assistance is identified in the client assessment, there must be documentation in the client medical record where clients were linked to culture-specific and/or linguistic services such as referrals to community-based organizations or other community resources (Source: FY 2016-17 DHCS Chart Review Protocol).

Finally, linkages to intepreter services also must be documented in the client medical record. Interpreter services includes both oral and sign language interpreter services (Source: FY 2016-17 DHCS Chart Review Protocol).

Note: as of September 25, 2017, a final *DHCS FY 2017-18 DHCS Chart Review Protocol* had not been released; however, a DHCS-released "working draft" of the *FY 2017-18 DHCS Chart Review Protocol* was consisent with the *DHCS FY 2016-17 Chart Review Protocol*.

Section 10: Rehabilitative Mental Health Services

As defined in §1810.247 of CCR Title 9, there are seven categories of Specialty Mental Health Services (SMHS; listed below). Outpatient (non-hospital) providers generally use three of those categories: Rehabilitative Mental Health Services, Targeted Case Management and EPSDT Supplemental SMHS (Source: 9 CCR §1810.247):

1. ***Rehabilitative Mental Health Services:***
    a. Mental Health Services
        i. Assessment
        ii. Plan Development
        iii. Collateral
        iv. Rehabilitation
        v. Therapy
    b. Medication Support Services
    c. Day Treatment Intensive
    d. Day Treatment Rehabilitation
    e. Crisis Intervention
    f. Crisis Stabilization
    g. Adult Residential Treatment Services
    h. Crisis Residential Treatment Services
2. Psychiatric Inpatient Hospital Services
3. ***Targeted Case Management***
4. Psychiatrist Services
5. Psychologist Services
6. ***EPSDT Supplemental SMHS***
    a. Therapeutic Behavioral Services (TBS)
    b. Intensive Care Coordination (ICC)
    c. Intensive Home Based Services
    d. Therapeutic Foster Care
7. Psychiatric Nursing Facility Services.

"Rehabilitative Mental Health Services" are services recommended by a physician or other LPHA within the scope of his or her practice under State law both to reduce mental disorders and emotional disturbances and to restore, improve, and/or maintain a client's functional level

Additional characteristics of Rehabilitative Mental Health Services include:

- Allowing clients to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention.

- Providing services to enable a child to achieve age-appropriate growth and development.

- Serving clients in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency.

For clarity and organization, we use Section 10 to first, define the Mental Health Services category and then define the specific services within. Section 19 covers TCM and the EPSDT Supplemental Services are described in Sections 20-23.

Mental Health Services–Definition
Mental Health Services are defined under 9 CCR §1810.227 and California State Plan Amendment (SPA) 12-025 as noted below.

9 CCR §1810.227	"Mental Health Services" means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, 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.
CA SPA 12-025	"Mental Health Services" are individual, group or family-based interventions that are designed to provide reduction of the beneficiary' s mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, 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. Mental health services may be provided face-to-face, by telephone or by telemedicine with the beneficiary or significant support person(s) and may be provided anywhere in the community. This service includes one or more of the following service components: (1) Assessment; (2) Plan Development; (3) Therapy; (4) Rehabilitation; and (5) Collateral.

Mental Health Services may be provided face-to-face or by telephone with the client, their family, or significant support persons and anywhere in the community (Source: 9 CCR §1840.324).

Assessment (Mental Health Services): Definitions

9 CCR §1810.204	Assessment: “Assessment” means a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
CA SPA 12-025	"Assessment" means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures.

Assessment services must be provided within a clinician’s scope of practice—see the Service and Staff Billing Privilege Matrix (Reference D) to identify the types of credentialed staff who may provide assessment services.

Plan Development (Mental Health Services): Definitions

9 CCR §1810.232	“Plan Development” means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.
CA SPA 12-025	"Plan Development" means a service activity that consists of one or more of the following: development of client plans, approval of client plans and/or monitoring of a beneficiary's progress.

Plan Development services must be provided within a clinician’s scope of practice—see the Service and Staff Billing Privilege Matrix (Reference D) to identify the types of credentialed staff who may provide plan development services.

Collateral (Mental Health Services): Definitions

9 CCR §1810.206	"Collateral" means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.
CA SPA 12-025	"Collateral" means a service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity.

Significant Support Persons

Significant support means persons, in the opinion of the client or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a client who is a minor, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client (Source: 9 CCR §1810.246.1).

Rehabilitation (Mental Health Services): Definitions

9 CCR §1810.243	"Rehabilitation" means a service activity which includes, but is not limited to 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.
CA SPA 12-025	"Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary'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 beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

Rehabilitation services must be provided within a staff member's scope of practice—see the Service and Staff Billing Privilege Matrix (Reference D) to identify the types of credentialed staff who may provide rehabilitation services.

Therapy (Mental Health Services): Definitions

9 CCR §1810.250	"Therapy" means a service activity that 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.
CA SPA 12-025	"Therapy" means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

Therapy must be provided within a clinician's scope of practice—see the Service and Staff Billing Privilege Matrix (Reference D) to identify the types of credentialed staff who may provide therapy. It is important to note, that for Medicare billing, if the activity lasts less than 16 minutes, then it does not meet the minimum criteria for therapy (CPT 90833: "psychotherapy for 16-37 minutes with patient") and it cannot be billed or reimbursed.[9]

Family Therapy

Family therapy is not a specifically defined service under Medi-Cal; however, these services may be provided, when medically necessary, and claimed as Therapy. Each client for which a family therapy claim will be submitted **must be present** at the therapy session. Progress notes for each therapy session must clearly document how the session focused primarily on reducing each client's symptoms as a means to improve his or her functional impairments or to prevent deterioration and to assist the client in meeting the goals of their client plan. DHCS has clarified that family therapy time is **not pro-rated** across participants (i.e., does not use the group therapy billing formula) (Source: DHCS MHSUDS Information Notice No.: 17-040).

[9] CMS (September 18, 2014). Outpatient Psychiatry & Psychology Services-Fact Sheet. Retrieved from https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31887_33/Outpatient_Psych_Fact_Sheet09.18.14.pdf.

Section 11: Medication Support Services

Medication Support Services Definitions
Medication Support Services are defined under 9 CCR §1810.225 and CA SPA 12-025.

9 CCR §1810.225	"Medication Support Services" means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.
CA SPA 12-025	Medication Support Services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary. Services 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 beneficiary 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 mental health care and helps them make specific, deliberate, and informed decisions about their treatment options and mental health care. Medication support services may be provided face-to-face, by telephone or by telemedicine with the beneficiary or significant support person(s) and may be provided anywhere in the community. This service includes one or more of the following service components: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; medication education including instruction in the use, risks and benefits of and alternatives for medication; collateral; plan development

This service is not duplicative of the drug counseling requirements described in 42 CFR 456.170.

Medication Support Services Scope of Practice
Consistent with scope of practice, Medication Support Services may be provided by the following staff:

1. Licensed Physician (MD/DO);
2. Certified Nurse Practitioner (NP);
3. Registered Nurse (RN);
4. Certified Nurse Specialist (CNS);
5. Licensed Vocational Nurse (LVN);
6. Licensed Psychiatric Technician (LPT);
7. Licensed Pharmacist (PharmD, RPh).

Medication Consent Requirements
Source: DPH SFHN-BHS Psychiatric Medication Consent in Ambulatory Care Policy
Medication Support Services prescribers must obtain and retain a current written medication consent form signed by the client or legal representative (e.g. parent or caregiver) agreeing to treatment with each prescribed medication. A new consent form must be completed and signed for each new medication prescribed (Source: 9 CCR §851). Please see DPH SFHN-BHS Medication Consent Form for A/OA Systems of Care and DPH SFHN-BHS Medication Consent Form for CYFSOC. These requirements apply to all clients.

Psychiatric medication consent forms must contain the following elements to be considered compliant with Medi-Cal requirements, all of which must be discussed with the client and/or parent/caregiver:

1. What condition or diagnoses the client has that medications are prescribed to address;
2. Which symptoms the medication(s) should reduce and how likely the medication(s) will work;
3. What are the chances of getting better without taking the medication(s);
4. Reasonable options or alternatives to taking the medication(s);
5. Name, dosage, dosage range, frequency, route of administration and duration of each prescribed medication;
6. Common side effects of the medication(s), including possible additional side effects which may occur beyond three months or long-term;
7. If antipsychotic medications are prescribed, notice that antipsychotic medications may cause additional side effects for some persons, including

persistent involuntary movements which are potentially irreversible, and may continue after the antipsychotic medication has been stopped; and

8. Any special instructions you should know about taking the medication(s).

In addition, there must be documentation that clients and/or legal guardians have been counseled that medication consent, once given, may be withdrawn at any time (Source: DHCS MHSUDS Information Notice No.: 17-040).

All client medication consent forms must include:

1. Date of service;

2. Signature of person providing the service (or electronic equivalent);

3. Person's type of professional degree AND licensure OR job title (see examples below);

4. The date the documentation was entered into the medical record[10]; and

5. Client or legal representative's signature and date signed.

Examples for signing with "persons' type of professional degree AND licensure OR job title:"

- Psychiatrist: signature, MD, psychiatrist
- Nurse Practitioner: signature, MSN, NP
- Pharmacist: signature, PharmD, clinical pharmacist

Note that "type of professional degree" is defined as your educational degree, not board certification and "licensure" is defined as the type of your license, not the license number.

Medication Support Services General Billing Rules
The following general billing rules apply to Medication Support Services:

1. **Progress Notes**
   The client's progress notes should include the evaluation of the client's signs and symptoms, the client's compliance with the medication, the response to medication, consideration of drug interactions, adverse drug effects when applicable, and any changes in dose and medication(s) prescribed, when applicable (Source: Personal communication from BHS Office of Compliance 2012).

2. **Non-Medication Support Billing**
   When providing a service that is **not** ***primarily*** medication support, medication support staff must use the relevant service code billing associated with the service provided (e.g. case management, therapy, collateral, etc.). Refer to current BHS Billing guidelines.

[10] Note that when e-signatures are available for medication consent forms, the BHS Electronic Health Record will capture the entry date entered into the medical record.

3. **Phone Contact** 9 CCR 1840.316(b)(4)
   In contrast to Medicare, for Medi-Cal billing, Medication Support Services allows services provided by phone contact or non-face to face. “Units of time may be billed regardless of whether there is face-to-face or phone contact with the beneficiary.”

4. **Multiple Providers**
   When Medication Support Services are provided to a client by a physician and nurse concurrently, the time of both staff should be claimed. If both staff provide the same services, then one note may be written that covers both staff and one claim submitted that includes the time of both staff. If two staff provide different services during the contact with the client (e.g. a medical doctor writes the prescription and a nurse gives an injection), two notes should be written with each staff submitting his or her own claim with his or her own time.

5. **Medication Administration**: For medication administration, the progress note needs to include:
   a. Medication, dosage, frequency and route
   b. Date and time of administration
   c. Site/location of any injection
   d. The lot and/or vial number if medication was dispensed from a multi-dose container
   e. Any unusual or adverse response to the medication
   f. Best practice for injections: the date of the previous injection, and the date of the next planned injection (Source: DPH SFHN-BHS Clinic Medication Room Policy)

H0034 Medication Support Services Table
If an MD/DO/NP provides a service that cannot be billed with an E&M code, they will use H0034. RN/CNS/LVN/LPT/PharmD (when consistent with scope of practice) will always use H0034).

H0034 Medication Support Service Description:

- *STAFF: All Medication Support Staff*
- *MD/DO/NP: when services provided cannot be billed with an E&M code*
- *RN/CNS/LVN/LPT/PharmD: when consistent with scope of practice*

Service Description	Medication Support Service
Monitor and assess psychotropic medication adherence, tolerability, and response	Evaluation of clinical effects of medication
Adjust medication regimen including drug, dose, frequency, and time of day to optimize response and adherence to medications	Medication regimen adjustment
Inform client of medication risk and benefits. Discuss alternatives to psychotropic medications. Obtain signed informed consent.	Obtaining informed consent for medication (Source: DPH SFHN-BHS Psychiatric Medication Consent in Ambulatory Care Policy)
Provide client or significant support person education regarding the proper use, benefits, risks, and side effect management of medications.	Medication education
Develop medication related treatment plan goals. Assess client's progress toward medication related treatment plan goals.	Medication plan development
Review medication orders, confirm client identity, assess response and side effects, administer or dispense medications.	Medication administration or dispensing (Source: DPH SFHN-BHS Clinic Medication Room Policy)
Client specific consultations with providers or treatment team about client's medications.	Medication related consultation with providers
Contact client or significant support person by phone to discuss medications.	Phone calls to client and significant support persons about medications
Communicate with pharmacy, prepare prescription orders for transmission, authorize prescription refills, resolve issues related to client's prescriptions.	Phone calls to pharmacy and transmitting medication orders

Source: Created by the DPH SFHN-BHS multidisciplinary team (2012)

Medication Support Services: Unplanned (Prior to Finalization of Client Plan) & Planned (Post-Finalization of Client Plan)
DHCS has recently clarified the specific activities with Medication Support Services (MSS) that may be delivered before vs. after the Client Plan/TPOC has been finalized (Source: DHCS MHSUDS Information Notice No.: 17-040).

The key to understanding the DHCS guidance is the realization that MSS is a "bundled service" that includes distinct elements of assessment, plan development as well as direct treatment:

> *"Medication Support Services" means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of*

> *mental illness. Service activities may include but are not limited to* evaluation of the need for medication*; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral* and plan development related to *the delivery of the service and/or* assessment of the beneficiary *(CCR Title 9, §1810.225)*

Per DHCS, when appropriately delivered and documented, a prescriber may deliver the assessment element ("evaluation for the need for medication") and the plan development element ("plan development related to…the assessment of the beneficiary) before the Client Plan/TPOC is finalized (pages 12-13 of DHCS Information Notice #17-040):

> *For TCM, ICC, and* ***Medication Support Services*** *provided prior to a client plan being in place, the progress notes* ***must clearly reflect that the service activity provided was a component of a service that is reimbursable prior to an approved client plan being in place****, and not a component of a service that cannot be provided prior to an approved client plan being in place.*

However, the direct treatment and monitoring elements of Medication Support Services are considered to be "planned" activities and cannot be reimbursed prior to the completion of the Client Plan/TPOC.

Medication-Only ("Meds-Only"): Treatment Guidelines
In order for a client to meet the criteria of "meds only," the following guidelines should be met (Source: OCPA-BHSCO & BHS Medical Director):

1. Meets medical necessity: The client must meet medical necessity criteria for continued services.

2. Clinically stable: The client's mental health condition (impairment) and symptoms have been stabilized with psychiatric medication. The client's mental health needs are met through periodic visits.

3. Functionally stable: The client has reached their recovery goals and their desired level of functioning in their community.

4. Prevention of deterioration: The client needs to receive psychiatric medications to maintain their improvements in community functioning and to prevent significant deterioration in functioning.

5. Complex and specialized medication regimen: The client's medication regimen is sufficiently complex/specialized and a Primary Care provider is unable to effectively prescribe and monitor the medication and the client's mental health status.

Medication-Only ("Meds-Only"): Staffing, Services, Documentation & Workflow
For a meds-only client, the prescriber holds full case responsibility. The prescriber's name should be used as the "Admitting Practitioner" field of Avatar, BHS' current electronic health record.

For a meds-only client, the Treatment Plan of Care (TPOC) can contain the following interventions: *Medication Support Services and Targeted Case Management (TCM)*. TCM is included in the TPOC so the prescriber can rapidly respond to a client's needs/use/benefit of services if there is a change in the client's mental/behavioral status. *Given the meds-only criteria described above, the amount, frequency and duration of TCM is expected to be minimal*.

The assessment and TPOC frequency and timeliness standards for a meds-only client are identified in Sections 5 & 6 respectively and summarized below:

- Assessment:
    - Initial Assessment: the outpatient assessment is due within 60 calendar days of the Episode Opening.
    - Subsequent Assessments:
        - An E&M Level 3 Psychiatric Service must be conducted **annually** for the purposes of confirming the client's current status and the medical necessity criteria (i.e., prevention of significant deterioration in functioning). This should occur within 30 days of the client's anniversary of the Episode Opening.
        - A full Psychiatric Assessment must be conducted and finalized **every 3 years** for the purposes of confirming the client's current status and the medical necessity criteria (i.e., prevention of significant deterioration in functioning). This should occur within 30 days of the client's anniversary of the Episode Opening.
- TPOC: the TPOC is based on the client's current mental status.
    - Initial TPOC: the outpatient is due within 60 calendar days of the Episode Opening.
    - Subsequent TPOCs: a client who meets the guidelines for meds-only should have *a TPOC annually, within 30 days of the Anniversary of Episode Opening*.
    - TPOC Objectives: The meds-only guidelines require the client to have achieved clinical stability and recovery goals—thus, *it is expected that the TPOC objectives for a single client may be similar over time since the focus is prevention of significant deterioration in functioning*. However, the prescriber's assessment and progress notes will substantiate that the objectives are medically necessary, reflect the client's/legal guardian's participation and agreement via signature, etc.

- Workflow:
    - Change in condition/needs: when any of the guidelines for meds-only are no longer met, the case must be re-evaluated for medical necessity, mental health needs, staffing, etc.

Urgent Meds Guidelines
DHCS has provided guidance to Mental Health Plans on claiming for "urgent medication support services" (Source: DHCS MHSUDS Information Notice No.: 17-040; DHCS communication with BHS, 08/05/2017). In the past, BHS referred to this as "One-Shot" Medication Evaluation. The following guidelines should be met:

1. Urgent clinical need: The client must have a current and urgent clinical need to obtain medication that is clearly documented.

2. Recent receipt of behavioral health services: The client must have recently received behavioral health/psychiatric medication (e.g., recent discharge from inpatient hospital; recent prescribing from a primary provider). The prescriber will verify that the treatment is clinically appropriate.

3. Service sufficiency: the client's urgent mental health need is met through the contact with the prescriber.

Urgent Meds: Staffing, Services, Documentation & Workflow
For an urgent meds client, the case is staffed solely by a prescriber. The prescriber's name should be used as the "Admitting Practitioner" field of Avatar, BHS' current electronic health record.

- Assessment:
    - Initial Assessment: a progress note must document the required elements and the note must be completed at the time of service. The note must also describe the urgent need and why an urgent service is required to prevent crisis, decompensation, etc.
        - If a client has a previously completed client assessment and diagnosis, the prescriber can conduct a brief review, have a brief interview with the client with or without significant support person and provide a brief Medication Support Service (DHCS communication with BHS, 08/05/2017).

- TPOC:
    - There is **no TPOC document** for one-time only urgent meds

- Workflow: ***Any ongoing treatment in the same episode will require a full assessment and TPOC. Otherwise, the case is opened and closed on the same day - no ongoing treatment is provided in the episode***"
(communication from BHS Medical Director and BHS Compliance 05/16/2018).

Medication Support Services Clinical Examples: P-I-R-P Progress Notes Format

Clinical Scenario	Progress Note Elements			
	Problem	**Intervention**	**Response**	**Plan**
Client has a question about medications	Bob calls to report possible adverse effects of bupropion. Complains of dry mouth with onset 2 weeks after starting bupropion. Take bupropion for major depression with symptoms of depressed mood and anhedonia that caused him to lose his job.	Provided medication management services to client via phone. Informed the client that dry mouth is relatively common with bupropion (incidence 15-30%). Recommend that he increase fluids, and to discuss possible change in medication with psychiatrist at his next visit. Assessed medication adherence (client states he adheres to med regimen) and mental status (client denies SI and HI; thought processes are linear and goal-directed).	Client expresses understanding of the information provided, and wishes to continue with bupropion for now. States meds help him deal with recent bedbug outbreak at his hotel.	Client agrees to take meds as prescribed and to try recommendations for dry mouth. Follow-up with MD on Wed 3/4/15 at 10:00 a.m.
Case staffed by Prescriber and Clinician—client has presented with new symptoms with clinician. Prescriber and Clinician consult to understand the change in client's status.	Client is presenting to therapist with new auditory hallucinations.	Reviewed client's presentation including acute risk factors. Discussed current symptoms, and contributing factors: environmental, biological and cultural.	MD and clinician agree symptoms most consistent with PTSD. No acute safety concerns. Continue to pursue neuropsych testing and consider medication recommendations.	MD has appt w/client next week to assess if meds are indicated at this time, and review appropriate interventions.

Clinical Scenario	Progress Note Elements			
	Problem	**Intervention**	**Response**	**Plan**
Medication Administration Client has an appointment to receive a medication injection	Lucy receives medication to improve her impairments in life functioning (homelessness; work). She comes to the clinic stating "I need my shot"	Confirmed current med orders and last administration (last dose given 7/15/16). Praised the client for presenting on time this month considering her past history of frequently showing up days late for injection. Administered haloperidol decanoate 100mg to left deltoid. Multi-dose vial lot F67456. Assessed side effects (client states that she doesn't have any problems related to meds). Provided med education to the client on possible adverse effects. Mental status exam conducted-- Lucy presents as disheveled and tangential.	Client expresses understanding of the information provided, but seems suspicious.	Lucy agrees to return Fri 9/9/16 9:00 a.m. for next shot at injection clinic. She will meet with her therapist Tue 8/30/16 2 p.m., and her psychiatrist on the same day at 3 p.m.
Medication Distribution Client has an appointment to receive an oral medication (client's medications stored in clinic medication room)	Client comes to clinic and states "I need my meds." Client has dx of major depression and medication helps prevent a significant decline in his self-care functioning and a reoccurrence of distress/suffering from his symptoms	Confirmed that client takes medication as prescribed (sertraline 100mg po every morning) and assessed side effects (occasional upset stomach). Distributed one week of sertraline 100mg po every morning in pharmacy-prepared blister packs. Reinforced importance of med adherence. Assessed for acute risk factors, none identified. Evaluated client's mental status—his mood is "good" and his affect is congruent.	Miguel accepts medications. Miguel agreed to monitor his insomnia (primary symptom) and make sure to eat food before he takes his meds. Client was able to identify that sertraline prevents the recurrence of depressed mood and insomnia.	Miguel agrees to take meds as prescribed. He will return next Monday for med distribution, and will f/u with psychiatrist on Monday 2/9/15 at 9:00am. Client is being considered for step-down to primary care, and has apt to talk to primary care provider on Friday.

Clinical Scenario	Progress Note Elements			
	Problem	**Intervention**	**Response**	**Plan**
Medication Refill OrderConnect refill for an existing client who is known to provider and clinically stable.	P: Patient calls requesting med refill.	I/R/P: Chart/orders reviewed. Reports adherence with treatment, good symptom control, no adverse effects. Med refilled per order so that treatment not interrupted, to prevent decompensation. RTC: 1 month		
Source: Created by DPH SFHN-BHS multidisciplinary staff, 2016.				

Section 12: Evaluation and Management Service Billing Codes

E&M Service Overview

Evaluation and Management (E&M) service billing codes are used by medical doctors and nurse practitioners to bill for medication management services when they are evaluating a client face-to-face to inform progress toward a client's treatment plan of care goals.

E&M Service Documentation Requirements

For initial client assessments and client re-assessments, all 11 elements of the client assessment must be completed.

E&M Service Billing Rules

In general, the more complex a client visit, the higher the level billed within the appropriate category. To bill E&M services, services provided must meet the definition of the E&M billing level (see next page: *E&M Billing Code Selection Decision Making Process*), be documented in the client record, and reflect the services provided.

For initial psychiatric assessments, prescribers should use Billing Code 90792. For medication mostly clients, when the annual assessment is done by the prescriber, either Billing Code 90792 or the appropriate E&M code should be used. No more than one E&M service code may be billed per day unless progress notes include a reason tied to medical necessity and a code modifier is used.

E&M Service with Psychotherapy Billing Rules

When a client receives an E&M service with a psychotherapy service on the same day by the same provider, both services may be billed to Medi-Cal if they are significant and separately identifiable in the client's record and billed using the correct codes. The correct E&M code selection must be based on the elements of history and exam and medical decision making required by the complexity of the client's condition (see next page). The psychotherapy add-on code is chosen based on the amount of time spent providing psychotherapy. Psychotherapy add-on codes are defined on the next page.

Add-On Code	Time Spent Providing Psychotherapy*
90833 – 30 minutes	Psychotherapy for 16 to 37 minutes with patient and/or family member when performed with an E&M service
90836 – 45 minutes	Psychotherapy for 38 to 52 minutes with patient and/or family member when performed with an E&M service
90838 – 60 minutes	Psychotherapy for 53 minutes or longer with patient and/or family member when performed with an E&M service

* Note: psychotherapy add-on code must be listed separately in addition to code for primary procedure.

An add-on code is eligible for payment only if reported with an appropriate primary service performed on the same date of service. Time spent for the E&M service is separate from the time spent providing psychotherapy, and time spent providing psychotherapy cannot be used to meet criteria for the E&M service. Providers must

clearly document in the client record the amount of time spent providing the E&M service and the psychotherapy service rather than entering "one" total time period that includes both services—here are two examples:

- If psychotherapy is provided for 47 minutes during an E&M service on the same day by the same provider, then add-on code 90836 would be billed for the psychotherapy service along with the correct E&M code.

- One progress note may be entered into the client record for both psychotherapy and E&M service, BUT the progress note must identify that a psychotherapy service was provided AND identify the amount of time psychotherapy was provided AND meet documentation requirements for both psychotherapy and the E&M service.

Remember, for a psychotherapy add on…

- You must provide specific documentation of the therapy activity in a progress note. That note must "stand alone" to justify the additional service. Avatar users should create a P-I-R-P format progress note to document the additional service.

- If the activity lasts less than 16 minutes, then it does not meet the minimum criteria (CPT 90833: "psychotherapy for 16-37 minutes with patient") and it cannot be billed.[11]

E&M Billing Code Selection Decision Making Process

There are <u>three key components and five types of service</u> that must be considered when selecting the appropriate E&M billing level.

Key Components	Types of History
• History • Examination • Medical Decision Making	• Problem-Focused • Expanded Problem-Focused • Detailed • Comprehensive

[11] CMS (September 18, 2014). Outpatient Psychiatry & Psychology Services-Fact Sheet. Retrieved from https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31887_33/Outpatient_Psych_Fact_Sheet09.18.14.pdf.

The chart at the top of the next page shows below that must be met for each of the five levels of E&M services across the three key components. In addition, the "Typical Face-to-Face Time" with clients is included for each service type. Two of three components (history, exam, medical decision making) must be met to use an E&M code.

KEY COMPONENTS WHEN SELECTING APPROPRIATE E&M BILLING LEVELS FOR EXISTING CLIENTS				
EEML 1 to 5 Codes	**History**	**Exam**	**Medical Decision Making**	**Typical Face-to-Face Time**
EEML1	Not required	Not required	Not required	5
EEML2	Problem-focused	Problem-focused	Straightforward	10
EEML3	Expanded problem-focused	Expanded problem-focused	Low	15
EEML4	Detailed	Detailed	Moderate	25
EEML5	Comprehensive	Comprehensive	High	40

Component #1: Client History
Please refer below to determine which of the five types of service to select under each of the three key components of a client history. To qualify for a given type of service, all items indicated in a row must be met.

E&M Code	Type	Chief Complaint	History of Present Illness (HPI)	Review of Systems (ROS)	Past Medical, Family and/or Social History (PMFSH)
EEML2	**Problem-focused**	Required	Brief HPI 1 to 3 elements or 1-2 chronic conditions	N/A	N/A
EEML3	**Expanded problem-focused**	Required	Brief HPI 1 to 3 elements or 1-2 chronic conditions	1 pertinent problem	N/A
EEML4	**Detailed**	Required	Extended HPI 4+ elements or 3 chronic conditions	Extended ROS 2 to 9 elements	1 Problem Pertinent
EEML5	**Comprehensive**	Required	Extended HPI 4+ elements or 3 chronic conditions	Complete ROS 10+ elements	Complete PMFSH at least 2 elements

Component #2: Client Examination
To choose the type of examination, perform and document the required number of examination elements using the reference chart below and the chart at the top of the next page.

Problem-Focused EEML2	Expanded EEML3	Detailed EEML4	Comprehensive EEML5
1 to 5 elements	At least 6 elements	At least 9 elements	All elements from constitutional & psychiatric sections, plus at least 1 from musculoskeletal

System/Body Area	Examination Elements
Constitutional	• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance
Musculoskeletal	• Muscle strength and tone • Gait and station
Psychiatric	• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation to time, place and person • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect

Component #3: Criteria for Each Type of Medical Decision Making
Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option by considering the following criteria:

1. The number of possible diagnoses and/or the number of management options that must be considered;
2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed;
3. The risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options**.**

In choosing the type of medical decision making, at least two of the three criteria must be met for the type of decision making. Please see the reference table at top of next page.

E&M Code	Type of Decision Making	Criterion #1: Number of Diagnoses/ Management Options	Criterion #2: Amount and/or Complexity of Data to be Reviewed	Criterion #3: Risk of Significant Complications, Morbidity, and/or Mortality
EEML2	**Straightforward**	Minimal	Minimal/none	Minimal
EEML3	**Low Complexity**	Limited	Limited	Low
EEML4	**Moderate Complexity**	Multiple	Moderate	Moderate
EEML5	**High Complexity**	Extensive	Extensive	High

Section 13: Day Treatment Intensive and Day Rehabilitation

Day Treatment Intensive and Day Rehabilitation Service Definition
Day Treatment Intensive and Day Rehabilitation are defined under (9 CCR §1810.213) and 9 CCR §1810.212 respectively, as well as CA SPA 12-025.

9 CCR §1810.213	"Day Treatment Intensive" means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
CA SPA 12-025	"Day Treatment Intensive" is a structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals. It may also include rehabilitation, process groups and other interventions. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living within a community setting. Services are available for at least three hours each day. The Day Treatment Intensive program is a program that lasts less than 24 hours each day. Day treatment intensive services must have a clearly established site for services although all services need not be delivered at that site. This service may include the following service components: (1) Assessment; (2) Plan Development; (3) Therapy; (4) Rehabilitation; and (5) Collateral.
9 CCR §1810.212	"Day Rehabilitation" means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
CA SPA 12-025	"Day Rehabilitation" is a structured program including rehabilitation, skill building groups, process groups, and adjunctive therapies which provides services to a distinct group of individuals. It may also include therapy, and other interventions. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day Rehabilitation is a program that lasts less than 24 hours each day. This service may include the following service components: (1) Assessment; (2) Plan Development; (3) Therapy; (4) Rehabilitation; and (5) Collateral.

Day Treatment Intensive and Day Rehabilitation Program Description
Each provider is required to develop and maintain a written detailed program description for both Day Treatment Intensive and Day Rehabilitation programs that must describe the specific activities of the service and reflect each of the required components of the program.

In addition, both Day Treatment Intensive and Day Rehabilitation programs are required to have an established protocol for responding to clients experiencing a mental health crisis. In most cases, the crisis protocol is included in the Program Description, but it also may be a separate document. The crisis protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other SMHS necessary to address the client's urgent or emergency psychiatric condition (crisis services) (DHCS MHSUDS Information Notice No.: 17-040).

Day Treatment Intensive and Day Rehabilitation Service Activities
Day Treatment Intensive and Day Rehabilitation must include, at a minimum, all of the following service activities (Source: DHCS MHSUDS Information Notice No.: 17-040):

1. Therapeutic Milieu;
2. Community Meetings;
3. Process Groups;
4. Skill-Building Groups; and
5. Adjunctive Therapies.

In addition, Day Treatment Intensive programs must provide:

1. Psychotherapy (which may include individual or group therapy);
2. An established mental health crisis protocol; and
3. Written weekly schedules with all of the required service components, as well as document when and where all service components of the program will be provided. The schedule must include the program staff delivering each component of the program, including their qualifications and scope of responsibilities. The weekly detailed schedule must be available to clients and as appropriate their families, caregivers or significant support persons (Source: DHCS MHSUDS Information Notice No.: 17-040).

Day Rehabilitation may include psychotherapy instead of process groups or in addition to process groups (Source: DHCS MHSUDS Information Notice No.: 17-040).

In terms of program frequency requirements, community meetings must be conducted at least once per day, and, in the Day Treatment Intensive setting, must include a provider whose scope of practice includes psychotherapy. There are no explicit frequency requirements for other service components of the therapeutic milieu (Source: DHCS MHSUDS Information Notice No.: 17-040).

Day Treatment Intensive and Day Rehabilitation Attendance Requirements
The client is expected to be present for ALL scheduled hours of operation for each day. In addition, a Day Treatment Program consists of the following:

- Half day: Minimum of 3 program hours (excluding breaks and meals);
- Full day: More than 4 program hours (excluding breaks and meals).

Day Treatment Intensive and Day Rehabilitation Unavoidable Client Absences
Entire full or half days of day treatment/rehabilitation services may be claimed *only if:*

1. The client was present for at least 50% of the program time on a given day, and
2. There is a documented reason for an "unavoidable absence" which clearly explains why the client could not be present for the full program and includes the total number of minutes/hours the client actually attended the program (e.g., 3 hours, 58 minutes). Examples include:
    - Family emergency,
    - Beneficiary became ill,
    - Court appearance,
    - Appointment that cannot be rescheduled (note needs to explain why an appointment cannot be rescheduled),
    - Family event (e.g., funeral, wedding),
    - Transportation issues.

In cases where absences are frequent, a provider must re-evaluate the client's need for the day rehabilitation or day treatment intensive program and take appropriate action (Source: DHCS MHSUDS Information Notice No.: 17-040).

Day Treatment Intensive and Day Rehabilitation Documentation Requirements
Day Treatment Intensive and Day Rehabilitation programs must meet all documentation requirements included in this manual for client assessments, client plans, progress notes, and other documentation in the client medical record (Source: MHP Contract – Exhibit A Attachment I: Service, Administrative and Operational Requirements, Section 8, Requirements for Day Treatment Intensive and Day Rehabilitation, Subsection H. Documentation Standards).

Day Treatment Intensive Documentation Requirements and Frequency
For Day Treatment Intensive, there must be: 1) daily progress note; 2) a weekly clinical summary for each client; and 3) documentation of at least one contact per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. In addition to the required elements identified in the "Progress Notes" section of this manual (Section 7), the daily progress note for Day Treatment Intensive services must include:

Daily progress notes may be signed by a LPHA, Registered/Waivered staff and Mental Health Rehabilitation Specialists. All other staff daily notes must be co-signed by a LPHA. The weekly Clinical Summary for Day Treatment Intensive must include:

1. Dates of service within the time period covered by the progress note;
2. A summary describing what was attempted and/or accomplished toward the client's goals(s) by the client and service staff;

3. Status of the client (symptoms, behaviors, impairments justifying continued Day Treatment Intensive services);
4. Plan (should interventions be modified, do other behaviors need to be addressed); and
5. Staff signatures, discipline, and professional license/registration number or title.

The weekly clinical summary may be signed by a LPHA or Registered/Waivered staff. For all other staff, a LPHA must co-sign the weekly clinical summary.

Day Rehabilitation Documentation Requirements and Frequency
For Day Rehabilitation, progress notes must be completed weekly (every 7 calendar days) at a minimum. In addition to the required elements identified in the "Progress Notes" section of this manual (Section 7), the daily progress notes for Day Rehabilitation services must include:

1. Time period covered by the progress note;
2. Dates of service within the time period covered by the note;
3. The total number of minutes/hours the client actually attended the program;
4. If the client was unavoidably absent and does not attend all of the scheduled hours of the Day Treatment Intensive program, there must be a separate entry in the client medical record that documents the reason for the unavoidable absence and the total time the client actually attended the program;
5. A summary describing what was attempted and/or accomplished toward the client's goals(s) by the client and service staff;
6. The signature (or electronic equivalent) of the staff person who provided services on each date of service. One signature may cover multiple dates of services for that staff.

In addition to the documentation requirements above, at least one contact per month must be documented in the client record with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor.

Progress notes may be signed by an LPHA, Waivered or Registered staff and Mental Health Rehabilitation Specialist (MHRS). Graduates students must have their progress notes co-signed by a LPHA and all other staff must have their progress notes co-signed by a LPHA or an MHRS.

Day Treatment Intensive and Day Rehabilitation Authorization Requirements (MHP Contract):

- Day Treatment Intensive services must be authorized by the Department prior to delivery and claiming;
- Day Treatment Intensive services must be reauthorized at least every three months;
- Day Rehabilitation must be reauthorized at least every six months; and

- Mental Health Services (MHS) must be authorized when provided concurrently with Day Treatment Intensive services, excluding services to treat emergency and urgent conditions. MHS shall be authorized with the same frequency as the concurrent Day Treatment Intensive services.

Day Treatment Intensive and Day Rehabilitation Staffing Requirements
The following staffing requirements apply to both Day Treatment Intensive and Day Rehabilitation programs (Source: MHP Contract):

- Program staff may be required to spend time on Day Treatment Intensive activities outside the hours of operation and therapeutic milieu.

- At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

- If staff have other responsibilities (e.g., as staff at another mental health program), programs must maintain documentation of the scope of responsibilities for these staff and the specific times in which Day Treatment Intensive and Day Rehabilitation activities are being performed exclusive of other activities.
- Programs serving more than 12 clients must include staff from at least two of the following staff categories (9 CCR §1840.350):

  1. Physicians
  2. Psychologists or related waivered/registered staff
  3. Licensed Clinical Social Workers or related waivered/registered staff
  4. Marriage and Family Therapists or related waivered/registered staff
  5. Registered Nurses
  6. Licensed Vocational Nurses
  7. Psychiatric Technicians
  8. Occupational Therapists
  9. Mental Health Rehabilitation Specialists

Day Treatment Intensive and Day Rehabilitation Staffing Requirements
Differences in staffing requirements for Day Treatment Intensive and Day Rehabilitation include:

- For Day Treatment Intensive, at a minimum, there must be an average ratio of at least one staff to 8 clients in attendance during the period the program is open. Other staff may be utilized according to program need, but shall not be included as part of the ratio formula (Source: 9 CCR §1840.350).

- For Day Rehabilitation, at a minimum, there must be an average ratio of at least one staff to 10 clients in attendance during the period the program is open. Other staff may be utilized according to program need, but shall not be included as part of the ratio formula (Source: 9 CCR §1840.350).

- For Day Treatment Intensive, at least one staff person whose scope of practice includes psychotherapy (MHP Contract).

Day Treatment Intensive and Day Rehabilitation Program Requirements
The following program requirements apply to both Day Treatment Intensive and Day Rehabilitation programs:

- In cases where absences are frequent, the need for the client to be in the program must be re-evaluated and appropriate action taken (MHP Contract).

- A written program description that describes the specific activities of each service and reflect each of the required components of the services (MHP Contract).

- At least one contact per month with a family member, caregiver or other significant support person identified by an adult client or one contact per month with the legally responsible adult for a client who is a minor. This contact may be face-to-face, by email, telephone or other method. Adult clients may decline this service component. The contact should focus on the role of the support person in supporting the client's community reintegration and shall occur outside the hours of operation and outside the therapeutic program for Day Treatment Intensive (State Contract).

Section 14: Crisis Intervention

Service Definition
Crisis Intervention is defined under 9 CCR §1810.209 and **CA SPA 12-025**. See below.

9 CCR §1810.209	"Crisis Intervention" means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in 9 CCR §1840.338 and 9 CCR §1840.348.
CA SPA 12-025	Crisis Intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Crisis intervention may be provided face-to-face, by telephone or by telemedicine with the beneficiary and/or significant support persons and may be provided in a clinic setting or anywhere in the community. This service includes one or more of the following service components: (1) Assessment; (2) Collateral; (3) Therapy; and (4) Referral

Crisis Intervention Providers
Crisis Intervention services may be provided within their scope of practice by a Licensed Practitioner of the Healing Arts; a waivered or registered Licensed Practitioner of the Healing Arts; the following non-LPHA staff: a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, and a Pharmacist.

BHS Policy 2.01-3 specifies the elements of Crisis Intervention that may be conducted by an MHRS and MHW staff and co-signing requirements (signed by either a Licensed Practitioner of the Healing Arts (LPHA) for an MHRS and signed by either an MHRS or LPHA for MHW).

Crisis Intervention Special Documentation Requirements & Billing Rules
In addition to all applicable documentation requirements in this manual, the acuity of the client or situation which jeopardizes the client's ability to maintain community functioning must be clearly documented.

Crisis Intervention Special Billing Rules
If an out-of-office situation is presented to a responding staff member as a crisis and the staff member finds the situation not to be a crisis upon arrival, the service may still be claimed as Crisis Intervention if the crisis described in the originating call is so documented.

Section 15: Crisis Stabilization

The guidance contained in this section is specific to Crisis Stabilization-Urgent Care which is delivered by a contracted provider in the community. The guidance for Crisis Stabilization-Emergency Room (provided through Psychiatric Emergency Services at ZSFGH) is defined in a separate manual.

Crisis Stabilization Service Definition

1. Crisis Stabilization is defined under 9 CCR §1810.210 and CA SPA 12-025.

9 CCR 1810.210	"Crisis Stabilization" means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site, and staffing requirements described in 9 CCR §1840.338 and 9 CCR §1840.348.
CA SPA 12-025	Crisis Stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the beneficiary or others, or substantially increase the risk of the beneficiary becoming gravely disabled. Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization. Crisis stabilization is an all-inclusive program and no other Rehabilitative Mental Health Services are reimbursable during the same time period this service is reimbursed. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All beneficiaries receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the beneficiary' s needs will be made, to the extent resources are available. This service includes one or more of the following service components: (1) Assessment; (2) Collateral; (3) Therapy, (4) Crisis Intervention; (5) Medication Support Services; and (6) Referral.

DHCS distinguishes between "Crisis Stabilization: Emergency Room" and "Crisis Stabilization: Urgent Care:

> ***Crisis Stabilization: Emergency Room: CCR Title 9, § 1840.338 and § 1840.348***
> *Crisis Stabilization: Emergency Room is a service lasting less than 24 hours provided to (or on behalf of) a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include (but are not limited to) Assessment, Collateral, and Therapy. Crisis Stabilization differs from Crisis Intervention in that stabilization is delivered by providers who meet contact, site, and staffing requirements for Crisis Stabilization described in 9 CCR §1840.338 and 9 CCR §1840.348. Crisis Stabilization must be provided onsite at a licensed 24-hour health care facility, as part of a hospital-based outpatient program, certified by the state to perform crisis stabilization. The maximum allowance provided in CCR, Title 22 for 'Crisis Stabilization-Emergency Room' shall apply when the service is provided in a 24-hour facility, including a hospital outpatient department.*
>
> ***Crisis Stabilization: Urgent Care: CCR Title 9, § 1840.105***
> *Crisis Stabilization: Urgent Care follows the same guidelines as 'Crisis Stabilization: Emergency Room' above, except that the maximum allowance for this category shall apply when the service is provided at an appropriate site other than an emergency room (citation: 2013, Mental Health Medi-Cal Billing Manual)*

2. Unplanned Service: "Crisis Stabilization is an unplanned Specialty Mental Health Service (SMHS).

3. Assessment:

   A. SMHS Required Contents of Assessment: Providers must complete the Assessment (click to go to Assessment Section) .

   B. SMHS Required Timeliness of the Assessment:
      (1) *Initial Assessment*: due at the time of admission (Source: MHSUDS Information Notice #17-040).
      (2) *Annual Assessment*: the expected length of stay for Crisis Stabilization-Urgent Care is less than 24 hours—the annual assessment requirement is not applicable.

4. Treatment Plan of Care (TPOC)
   Crisis Stabilization-Urgent Care is an unplanned service and the expected length of stay for is less than 24 hours. The initial and annual TPOC requirements are not applicable.

5. Service Documentation:

   A. Contents of service documentation: Unless the element is not applicable, the Progress Notes for Crisis Stabilization-Urgent Care must contain the same required information as other Outpatient Services notes described in Section 7.

B. Timeliness of Service Documentation (Source: 9 CCR §1840.322):

(1) At a minimum, providers must document every four-hour block of service time within a single Progress Note (Source: FY16-17 Annual Review Protocol, page 117). An "hour" is defined by the client's admission time (e.g., if the admission is 5:15 a.m., then the first hour of service is 5:15 a.m. – 6:14 a.m.).

(2) *First "hour" of service*: The first hour of service is defined as the client's admission time rounded up to the next hour.

Example 1: Client admitted at 1:10 p.m. and receives services for 50 minutes. Even though only spent 50 minutes is spent with the client, for billing, staff should round up to 60 minutes.

Example 2: Client is admitted at 11:50 p.m. Even though the client only received 10 minutes of service, for billing, staff should round up to 60 minutes.

See the section below title "Claiming for Service Functions Based on Hours of Time."

6. Billing and Claiming Issues and Guidelines:

A. Medicare billing: Depending on the provider's status (e.g., Medicare certified) and the client's clinical scenario (e.g., receipt of Crisis Stabilization within 72 hours of inpatient services), some portions of a Crisis Stabilization service may be billed to Medicare (Source: DHCS Medi-Medi Site).

B. Service & Billing Privileges
See the Staff Billing and Service Privileges Matrix (Reference D) to determine the type of staff who are permitted to bill Crisis Stabilization Services and when co-signatures are required on Weekly Summary documents and other documents.

C. Billing Code in EHR/Avatar:
The billing code for Crisis Stabilization is S9484.

D. Claiming rules from CCR, Title 9 §1840.322 ("*Claiming for Service Functions Based on Hours of Time*"):

(1) The following requirements apply for claiming of services based on time;

(2) Partial blocks of time shall be rounded up or down to the nearest one-hour increment except that services provided during the first hour shall always be rounded up.

E. Lockout rules from CCR Title 9 §1840.368 ("*Lockouts for Crisis Stabilization*"):

(1) Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric

Nursing Facility Services are reimbursed, except on the day of admission to those services.

(2) Crisis Stabilization is a package program and no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management.

(3) The maximum number of hours claimable for Crisis Stabilization in a 24-hour period is 20 hours.

7. Site and Contact Requirements from 9 CCR §1840.338 ("*Crisis Stabilization Contact and Site Requirements*"):

   A. Crisis Stabilization shall be provided onsite at a licensed 24-hour health care facility or hospital-based outpatient program or a provider site certified by the Department or BHS to perform crisis stabilization.

   B. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Immediate access and reasonable proximity shall be defined by the Mental Health Plan. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.

   C. All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the beneficiary's need shall be made, to the extent resources are available.

8. Requirements for Staffing from CCR, Title 9 §1840.348 ("*Crisis Stabilization Staffing Requirements*"):

   A. A physician shall be on call at all times for the provision of those Crisis Stabilization Services that may only be provided by a physician.
   B. There shall be a minimum of one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times beneficiaries are present.
   C. At a minimum, there shall be a ratio of at least one licensed mental health or waivered/registered professional on site for each four beneficiaries or other patients receiving Crisis Stabilization at any given time.
   D. If the beneficiary is evaluated as needing service activities that can only be provided by a specific type of licensed professional, such persons shall be available.
   E. Other persons may be utilized by the program, according to need.
   F. If Crisis Stabilization services are co-located with other specialty mental health services, persons providing Crisis Stabilization must be separate and distinct from persons providing other services.

Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services.

Section 16: SMHS Offered in Residential Treatment Settings

This section of the documentation manual focuses on non-hospital SMHS provided by "Community Residential Treatment Systems" (CRTS) which are also known as Social Rehabilitation Programs (SRPs). CRTS/SRPs along with Community Treatment Facilities (CTFs) and Special Treatment Programs (STP) in Skilled Nursing Facilities (SNF/STP) are all considered to be "Mental Health Treatment Programs."[12]

This Section covers two SMHS provided by CRTS/SRPs:

1. Adult Residential Treatment Services (Transitional and Long-Term Residential) and
2. Crisis Residential Treatment Services (aka Acute Diversion Unit)

It is important to note that the organizations providing Adult Residential Treatment and Crisis Residential services have ***additional requirements*** based on their status as a ***Social Rehabilitation Program***. Below is a summary of information that relates to Social Rehabilitation Programs:

1. ***Care, Supervision & Physical Building–Licensing by CDSS***
   The California Department of Social Services' (CDSS) Community Care Licensing (CCL) is responsible for inspecting and licensing the care/supervision program and the physical building for Residential Facilities that include: Small Family Home; Crisis Nursery; Temporary Shelter; Transitional Care for Children; Transitional Housing Placement Program; Community Treatment Facility; Group Home; Adult Residential Care Facility for Persons with Special Health Care Needs; Adult Residential Facility and Social Rehabilitation (citation: Source: http://ccld.ca.gov/)
2. ***Mental Health Treatment Program Provider–Certification by DHCS***
   The California Department of Health Care Services (DHCS) is responsible for certifying residential programs as a Mental Health Treatment Program Provider. CRTS/SRPs offer different types of Residential treatment:

   - Short-Term Crisis Residential: Offers alternatives to acute hospitalization; provides stabilization and diagnostic services for no longer than three months.
   - Transitional Residential: Provides an activity program that encourages utilization of community resources for no longer than 18 months.
   - Long-Term Residential: Provides rehabilitation services for the chronically mentally ill who need long-term support and care for up to two to three years, in order to develop independent living skills (DHCS Certification)

[12] http://www.dhcs.ca.gov/services/MH/Pages/MentalHealthTreatmentProgramscertifiedbyDHCSare.aspx

3. ***Regulatory Oversight of Social Rehabilitation Programs–CCR Title 9, Division 1, Chapter 3, Article 3.5***
   The regulations over Specialty Mental Health Services appear in CCR, Title 9, Division 1, Chapter 11. Every provider who bills Mental Health Medi-Cal must follow these regulations, as well as County MHP requirements. The regulations over Social Rehabilitation Programs appear in a completely different Chapter of CCR Title 9 (Source: Chapter 3, Article 3.5, Standards for the Certification of Social Rehabilitation Programs). Programs that are certified by DHCS as Social Rehabilitation Programs must follow these additional regulations.

Section 17: Adult Residential Treatment Services

1. Definitions: "Adult Residential Treatment Service" is defined within 9 CCR §1810.203 and in the California State Plan Amendment (12-025) and must be consistent with the Social Rehabilitation requirements of 9 CCR §532.2 .

CCR, Title 9, §1810.203	"Adult Residential Treatment Service" means rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral
CA SPA 12-025	Adult Residential Treatment Services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills and to access community support systems that support recovery and enhance resiliency. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Adult residential treatment services assist the beneficiary in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability of independent living upon discharge from the program. The program will also provide a therapeutic environment in which beneficiaries are supported in their efforts to acquire and apply interpersonal and independent living skills. Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site. Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service. In an adult residential treatment facility, structured day and evening services are available seven days a week. Services include: (1) Individual and group counseling; (2) Crisis intervention such as counseling focusing on immediate problem solving in response to a critical emotional incident to augment the beneficiary's usual coping mechanisms; (3) Family counseling with significant support persons, when indicated in the client's treatment/rehabilitation plan; (4) The development of community support systems for beneficiaries to maximize their utilization of non-mental health community resources; (5) Counseling focused on reducing mental health symptoms and functional impairments to assist beneficiaries to maximize their ability to obtain and retain pre-vocational or vocational employment; (6) Assisting beneficiaries to develop self-advocacy skills through observation, coaching, and modeling; (7) An activity program that encourages socialization within the program and general community, and which links the beneficiary to resources which are available after leaving the program; and (8) Use of the residential environment to assist beneficiaries in the acquisition, testing, and/or refinement of community living and interpersonal skills. This service includes one or more of the following service components: (1) Assessment; (2) Plan Development; (3) Therapy; (4) Rehabilitation; and (5) Collateral.

2. Authorization: Adult Residential Treatment Services are authorized through BHS Placement.

3. Planned Service: Adult Residential Treatment Service is a planned Specialty Mental Health Service (SMHS). All service modalities for which reimbursement is being sought must be included in the Client Plan. Providers cannot bill for Adult Residential Treatment Services unless the service appears on the Client Plan, is medically necessary, etc. (Source: FY 2016-17 DHCS Chart Review Protocol, see page 112) (Source: DHCS MHSUDS Information Notice No.: 17-040).

4. Assessment:

   A. SMHS Required Contents of Assessment: Providers must complete the SMHS Assessment as described under Section 5 of this manual.

   B. SMHS Required Timeliness of the Assessment:

      (1) *Initial Assessment*: must be full completed and finalized by an LPHA within three full days after the Episode Opening date (example: for a client is admitted on Monday, the initial assessment must be completed by Thursday, 11:59 p.m., which is three full days after Monday).

      (2) *Annual Assessment*: within 30 days before the Episode Opening Anniversary.

   C. Additional Required Content from Social Rehabilitation Program Certification Standards (CCR, Title 9, Chapter 3, Article 3.5, §532.2):

      At the admission to program, there must be a written assessment of each client on admission that includes (at least):

      (1) Health and psychiatric histories
      (2) Psychosocial skills
      (3) Social support skills
      (4) Current psychological, educational, vocational and other functional limitations
      (5) Medical needs, as reported
      (6) Meal planning, shopping and budgeting skills

5. Treatment Plan of Care (TPOC):

   A. Contents of TPOC: Providers must complete the SMHS TPOC as described under Section 6 of this manual.

   B. Timeliness of the TPOC:

      (1) *Initial TPOC*: must be fully completed and finalized by an LPHA within three full days after the Episode Opening date (example: for a client is admitted on Monday, the initial TPOC must be completed by Thursday, 11:59 p.m., which is three full days after Monday).

      (2) *Annual TPOC*: within 30 days of the Episode Opening Anniversary.

6. Service Documentation:

   A. Contents of service documentation: All progress notes must include the following elements at a minimum, unless not applicable for the Weekly

A. Summary (Source: DPH SFHN-BHS Behavioral Health Progress Notes Policy):
   (1) The date service(s) was provided;
   (2) The billable or non-billable service type provided;
   (3) The billing code for the billable or non-billable service;
   (4) The place of service;
   (5) Cultural and linguistic accommodations offered or made on behalf of the client or family/caregiver;
   (6) Changes in a client's risk status;
   (7) All referrals to community resources and other agencies, when applicable;
   (8) Date(s) of follow up appointment(s)
   (9) The total face-to-face time and documentation time and/or travel time in minutes – be precise in calculating the minutes for service and documentation time.
      i. Note that Medicare considers "face-to-face" time to be the time with the patient.

B. Timeliness of Service Documentation:
   (1) At a minimum, a weekly progress note (weekly summary) is required (Source: FY 2016-17 DHCS Chart Review Protocol, see page 117). The weekly progress note must be finalized by 11:59 p.m. of each seventh client day.

> ***OPTIONAL ALTERNATIVE*: when appropriately documented and finalized, seven consecutive daily notes can meet the documentation standard, in lieu of a Weekly Summary for Adult Residential Treatment Services. The following must be true:**
>
> - *Standard "Service Week"*: documentation follows a standard "service week" where 7 days are defined as Sunday (12:00am) through Saturday (11:59pm)
> - *Daily Notes Written by End of Shift*: for timeliness, the daily note must be completed by the end of the staff person's shift
> - *Record Review and Audit Liability*: if a single Daily Note is missing from the medical record during a record review/audit, then the complete service week for that missing note will be disallowed
> - *Daily Note LATE ENTRY*: if the Daily Note is not fully finalized with required co-signature within 5 business days from the date of service, the documentation will be required to include [LATE ENTRY]

   (2) There shall be a separate progress note entered in the client record whenever a scheduled session takes place with the client.
   (3) Progress notes entered in the client record must identify the specific activities in which a client participated.
   (4) There must be documentation of an ongoing review process by staff and the client of progress towards reaching established goals the treatment/ rehabilitation plan in the client record adhering to the following schedule (Source: 9 CCR §532.2(c)(3))
      A. Transitional Residential Treatment Program: at least once every 30 days;
      B. Long Term Residential Treatment Program: at least once every 60 days.
   (5) Where a client plan requires services to be provided by another program or agency, there shall be documented evidence in the client record of communication between all persons responsible for carrying out specific aspects of the client plan (Source: 9 CCR §532.2(d)).
   (6) When another mode of Specialty Mental Health Services is provided such as Mode 15 – Outpatient Services, Adult Residential Treatment Service providers must adhere to the timeliness standards for those SMHS.
   (7) Medication Support Services must be billed separately from Adult Residential Treatment Services (9 CCR §1840.326(b)).

7. Billing and Claiming Issues and Guidelines

A. Not Billable to Medicare: Adult Residential Treatment Services is one of the Specialty Mental Health Services that is not eligible for Medicare reimbursement (for clients who have both Medicare and Medicaid insurance). BHS claims the service directly to DHCS Mental Health Medi-Cal. (Source: 2013 DHCS Mental Health Medi-Cal Billing Manual).

B. Service & Billing Privileges:
See the Service Billing and Privileges Matrix (Reference D in this manual) and Policy 2.01-3 (Credentialing and Service/Billing Privileges in SMHS for MHRS/MHW; Reference F in this manual) to determine the type of staff who are permitted to bill Adult Residential Services and when co-signatures are required on Weekly Summary and other documents.

C. Billing Code in EHR/Avatar:
(1) Staff do not assign a billing code when they are creating the Weekly Summary (remember, Adult Residential is reimbursed calendar days, not by the Weekly Summary and is a bundled service).
(2) If/when staff provide Medication Support Services or another SMHS, they use the appropriate billing code for that Mode of service.

D. Claiming rules from 9 CCR §1840.320 ("*Claiming for Service Functions Based on Calendar Days*"):
(1) The following services are reimbursed on calendar days: Adult Residential Treatment Services; Crisis Residential Treatment Services; Psychiatric Health Facility Services.
(2) A day shall be billed for each calendar day in which the beneficiary receives face-to-face services and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.
(3) Board and care costs are not included in the claiming rate.
(4) The day of admission may be billed but not the day of discharge.

E. Lockout rules from 9 CCR §1840.362 ("*Lockouts for Adult Residential Treatment Services*"):
Adult Residential Treatment Services are not reimbursable under the following circumstances:
(1) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission.
(2) When an organizational provider of both Mental Health Services and Adult Residential Treatment Services allocates the same staff's time under the two cost centers of Mental Health Services and Adult Residential Treatment Services for the same period of time.

8. Site and Contact Requirements from 9 CCR §1840.332 ("*Adult Residential Treatment Service Contact and Site Requirements*"):

A. Adult Residential Treatment Services shall have a clearly established certified site for services, although all services need not be delivered at that site. Services shall not be claimable unless there is face-to-face

contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

B. Programs that provide Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the Department as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program in accordance with Chapter 3, Division 1, of Title 9. Facility capacity must be limited to a maximum of 16 beds.

C. In addition to Social Rehabilitation Program certification, programs which provide Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with §51000.

9. Requirements for Staffing from CCR, Title 9 §1840.354 ("*Adult Residential Treatment Service Staffing Requirements*"):

A. Staffing ratios and qualifications in Adult Residential Treatment Services shall be consistent with Title 9, §531(b) and (c);
B. There is a clear audit trail of the number and identity of the persons who provide Adult Residential Treatment Services and function in other capacities.

Services Discharge and Closing Summary
Adult Residential Treatment Services providers must complete a written discharge summary prepared by staff and the client that includes at a minimum an outline of services provided, goals accomplished, reason and plan for discharge and referral follow-up plans (Source: 9 CCR §532.2) This information must be included on the Closing Summary form for every client discharged. Please refer to Client Closing Summaries in this manual.

Adult Residential Treatment Staffing Requirements (Source: 9 CCR §1840.351):
Staffing ratios, qualifications, and requirements for Adult Residential Treatment Services include the following (Source: 9 CCR §531):

For Transitional Residential Treatment Programs:

1. A greater number of staff must be present during times when there are greater numbers of clients in programmed activities.
2. Staff schedules must be determined by the program based on the number of clients in the program during specific hours of the day, level of care provided by the program, and the range of services provided within the facility.
3. At least one staff member must be present at any time there are clients at the facility.

4. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 2.5 clients served. All scheduled hours in the facility shall be considered part of this required full-time equivalent staffing ratio.

5. There must be documentation of the number and identity of the persons who provide Adult Residential Treatment Services and function in other capacities.

For Long-Term Transitional Residential Treatment Programs:

1. Staff scheduling must provide for the maximum number of staff to be present during the times when clients are engaged in structured activities.
2. At least one direct service staff shall be on the premises 24-hours a day, seven (7) days per week. Direct service staff are employees whose duties include the treatment, training, care and/or supervision of the program's clients.
3. Additional staff, including part-time or consulting services staff, shall be on duty during program hours to provide specialized services and structured evening services.
4. When only one staff member is on the premises there shall be staff on call who can be contacted by telephone if an additional staff person is needed and can be at the facility and on duty within 60 minutes after being contacted.
5. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff member for each 2.8 clients served.

There also must be a clear audit trail of the number and identity of the persons who provide Adult Residential Treatment Services and who also function in other capacities.

Section 18: Crisis Residential Treatment Services

1. Definitions: "Crisis Residential Treatment Service" is defined within 9 CCR §1810.208 and in the California State Plan Amendment (12-025). These definitions appear below.

CCR §1810.208	"Crisis Residential Treatment Service" means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.
CA SPA 12-025	Crisis Residential Treatment Services are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term--3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. The timing, frequency, and duration of the various types of services provided to each beneficiary receiving Crisis Residential Treatment services will depend on the acuity and individual needs of each beneficiary. For example, a beneficiary newly admitted to a crisis residential treatment program would be more likely to receive crisis intervention or psychotherapy than the development of community support systems, which would be more appropriate as the beneficiary prepares for discharge from the program. Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site. Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service. In a crisis residential treatment facility, structured day and evening services are available seven days a week. Services include: (1) Individual and group counseling; (2) Crisis intervention such as counseling focusing on immediate problem solving in response to a critical emotional incident to augment the individual's usual coping mechanisms; (3) Planned activities that develop and enhance skills directed towards achieving client plan goals; (4) Family counseling with significant support persons directed at improving the beneficiary's functioning, when indicated in the client's treatment/rehabilitation plan; (5) The development of community support systems for beneficiaries to maximize their utilization of non-mental health community resources; (6) Counseling focused on reducing mental health symptoms and functional impairments to assist beneficiaries to maximize their ability to obtain and retain pre-vocational or vocational employment; (7) Assisting beneficiaries to develop self-advocacy skills through observation, coaching, and modeling; (8) An activity program that encourages socialization within the program and general community, and which links the beneficiary to resources which are available after leaving the program; and (9) Use of the residential environment to assist beneficiaries in the acquisition, testing, and/or refinement of community living and interpersonal skills. This service includes one or more of the following service components: 1) Assessment; 2) Plan Development; 3) Therapy; 4) Rehabilitation; 5) Collateral; and 6) Crisis Intervention.

2. Authorization: Crisis Residential Treatment Services are authorized though BHS Placement, expect when the service is a true hospital diversion service.

3. Planned Service: "Crisis Residential Treatment Service" is a planned Specialty Mental Health Service (SMHS). Providers cannot bill for Crisis Residential Treatment Services unless the service appears on the TPOC, is medically necessary, etc. (Sources: FY16-17 DHCS Chart Review Protocol, page 112; 9 CCR §532.2) (Source: DHCS MHSUDS Information Notice No.: 17-040).

4. Assessment:

   A. SMHS Required Contents of Assessment: Providers must complete the SMHS Assessment as described under Section 5 of this manual (click to go to Assessment Section).

   B. SMHS Required Timeliness of the Assessment:

      (1) *Initial Assessment*: due at the time of admission (Source MHSUDS information Notice #17-040).

      (2) *Annual Assessment*: Not applicable. Length of stay is less than 12mos.

   C. Additional Required Content from Social Rehabilitation Program Certification Standards (CCR, Title 9, Chapter 3, Article 3.5, §532.2):

      At the admission to program, there must be a written assessment of each client on admission that includes (at least):

      (1) Health and psychiatric histories
      (2) Psychosocial skills
      (3) Social support skills
      (4) Current psychological, educational, vocational and other functional limitations
      (5) Medical needs, as reported
      (6) Meal planning, shopping and budgeting skills

5. Treatment Plan of Care (TPOC):

   A. Contents of TPOC: Providers must complete the SMHS TPOC as described in Section 6.

   B. Timeliness of the TPOC:

      (1) *Initial TPOC*: at the time of admission to program.

      (2) *Annual TPOC*: Not applicable—length of stay is less than 12 months.

6. Service Documentation:
   A. Contents of service documentation: The Daily Progress Notes shall include and address unless not applicable for the Daily Note (e.g., procedure code):

      (1) Date(s) of service;
      (2) Procedure code;
      (3) Activities in which the client participated;
      (4) Client's behaviors and staff intervention;
      (5) Progress toward objectives or documentation of lack of progress;

(6) Involvement of family members, if appropriate;
(7) Contact with other programs/agencies/treatment personnel involved with the client's treatment.

B. Timeliness of Service Documentation:
(1) At a minimum, a daily progress note is required (Source: FY16-17 Annual Review Protocol, page 117).
(2) When providers of Crisis Residential Treatment Services also provide another type of SMHS (e.g., Mode 15 Outpatient Services), the provider must also adhere to the timeliness standards for those SMHS as well (e.g., document every Medication Support Service contact in a progress note, billed by the minute).

6. Billing and Claiming Issues and Guidelines:
A. Not Billable to Medicare:
Crisis Residential Treatment Services is one of the Specialty Mental Health Services that is not eligible for Medicare reimbursement (for clients who have both Medicare and Medicaid insurance). BHS claims the service directly to DHCS' Mental Health Medi-Cal. (Source: 2013 DHCS Mental Health Medi-Cal Billing Manual, page 41).

B. Service & Billing Privileges:
See the Service Billing and Privileges Matrix (Reference D in this manual) and Policy 2.01-3 (Credentialing and Service/Billing Privileges in SMHS for MHRS/MHW; Reference F in this manual) to determine the type of staff who are permitted to bill Crisis Residential Services and when co-signatures are required on documents.

C. Billing Code in EHR/Avatar:
(1) Staff do not assign a billing code when they are creating the Daily Progress Note (remember, Crisis Residential is reimbursed calendar days, not by the Daily Progress Note).
(2) If/when staff provide another SMHS, they use the appropriate billing code for that Mode of service.

D. Claiming rules from CCR, Title 9 §1840.320 ("*Claiming for Service Functions Based on Calendar Days*"):
(1) The following services are reimbursed on calendar days: Adult Residential Treatment Services; Crisis Residential Treatment Services; Psychiatric Health Facility Services.
(2) A day shall be billed for each calendar day in which the beneficiary receives face-to-face services and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.
(3) Board and care costs are not included in the claiming rate.
(4) The day of admission may be billed but not the day of discharge.
E. Lockout rules from CCR Title 9 §1840.364 ("*Lockouts for Crisis Residential Treatment Services*"):
Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services: Mental Health Services; Day Treatment Intensive; Day Rehabilitation; Psychiatric Inpatient Hospital Services;

Psychiatric Health Facility Services; Psychiatric Nursing Facility Services; Adult Residential Treatment Services; Crisis Intervention; and Crisis Stabilization.

7. Site and Contact Requirements from 9 CCR §1840.334 ("*Crisis Residential Treatment Service Contact and Site Requirements*"):
   A. Crisis Residential Treatment Services shall have a clearly established certified site for services although all services need not be delivered at that site. Services shall not be claimable unless there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.
   B. Programs shall have written procedures for accessing emergency psychiatric and health services on a 24-hour basis.
   C. Programs providing Crisis Residential Treatment Services shall be certified as a Social Rehabilitation Program (Short-term Crisis Residential Treatment Program) by the Department in accordance with Chapter 3, Division 1, of Title 9. Facility capacity shall be limited to a maximum of 16 beds.
   D. In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services shall be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with Section 51000.

8. Requirements for Staffing from CCR, Title 9 §1840.356 ("*Crisis Residential Treatment Service Staffing Requirements*"):

   A. Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with §531(a);
   B. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Crisis Residential Treatment Services and function in other capacities.

Section 19: Targeted Case Management

Targeted Case Management Definitions
State Plan Amendment Definition (Source: CA 12-025; Sources: 42 CFR 440.169 and 9 CCR §1810.249)

§1810.249	"Targeted Case Management" 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.

State Plan Amendment

Targeted Case Management (TCM) means services that assist a beneficiary to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include (dependent upon the practitioner's judgment regarding the activities needed to assess and/or treat the beneficiary): 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:

TCM may be provided face-to-face, by telephone, or by telemedicine with the beneficiary or significant support person and may be provided anywhere in the community. TCM contacts with significant support persons may include helping the eligible beneficiary access services, identifying needs and supports to assist the eligible beneficiary in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible beneficiary's needs (42 CFR 440.169(e)).

TCM includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for establishment or continuation of TCM services to access any medical, educational, social, or other services. These assessment activities include:
    a. Taking client history;
    b. Identifying the individual's needs and completing related documentation, reviewing all available medical, psychosocial, and other records, and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the individual; and
    c. Assessing support network availability, adequacy of living arrangements, financial status, employment status, and potential and training needs. Assessments are conducted on an annual basis or at a shorter interval as appropriate.

2. Development and Periodic Revision of a Client Plan that is:

    a. Based on the information collected through the assessment;
    b. 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 individual;
    c. Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals;
    d. Identifies a course of action to respond to the assessed needs of the eligible individual; and
    e. Develops a transition plan when a beneficiary has achieved the goals of the Client Plan.

	3. Referral and Related Activities: a. To help an eligible individual obtain needed services including activities that help link an individual with medical, alcohol and drug treatment, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual; b. To intervene with the client/others at the onset of a crisis to provide assistance in problem resolution and to coordinate or arrange for the provision of other needed services; c. To identify, assess, and mobilize resources to meet the client's needs. Services would typically include consultation and intervention on behalf of the client with Social Security, schools, social services and health departments, and other community agencies, as appropriate; and d. Placement coordination services when necessary to address the identified mental health condition, including assessing the adequacy and appropriateness of the client's living arrangements when needed. Services would typically include locating and coordinating the resources necessary to facilitate a successful and appropriate placement in the least restrictive setting and consulting, as required, with the care provider. 4. Monitoring and Follow-Up Activities: a. Activities and contacts that are necessary to ensure the Client Plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met: (1) Services are being furnished in accordance with the individual's Client Plan; (2) Services in the Client Plan are adequate; and (3) There are changes in the needs or status of the individual, and if so, making necessary adjustments in the Client Plan and service arrangements with providers. b. Activities to monitor, support, and assist the client on a regular basis in developing or maintaining the skills needed to implement and achieve the goals of the Client Plan. Services would typically include support in the use of psychiatric, medical, educational, socialization, rehabilitation, and other social services. Monitoring and update of the Client Plan is conducted on an annual basis or at a shorter interval as appropriate.

Targeted Case Management Eligible Clients

The authority to provide the Targeted Case Management (TCM) services comes from California's Medicaid State Plan. The word "targeted" means that an identified population has been identified (targeted) for services.

There are two targeted groups who receive TCM services within Medi-Cal's SMHS program: (a) Medi-Cal beneficiaries who meet medical necessity for SMHS; (b) Children under the age of 21 (EPSDT)

Activities Within TCM: Unplanned (Prior to Finalization of Client Plan) & Planned (Post-Finalization of Client Plan)
DHCS recently clarified the specific activities with TCM that may be delivered before vs. after the Client Plan/TPOC has been finalized (pages 12-13 of Information Notice No.: 17-040):

> *For TCM, ICC, and Medication Support Services provided prior to a client plan being in place, the **progress notes must clearly reflect that the service activity provided was a component of a service that is reimbursable prior to an approved client plan being in place**, and not a component of a service that cannot be provided prior to an approved client plan being in place.*

The key to understanding the DHCS guidance is to focus on the definition of TCM that appears in California's Medicaid State Plan—that definition is broader and more detailed that the definition that appears in CCR Title 9 §1810.249:

1. When appropriately delivered and documented, the following activities within TCM *are reimbursable prior to the completion* of the Client Plan/TPOC:

    a. Comprehensive **assessment** and periodic reassessment of individual needs to determine the need for establishment or continuation of TCM services to access any medical, educational, social, or other services;

    b. Development and periodic revision of a **Client Plan/TPOC**;

    c. **Referral and linkage** to help a client obtain needed services, including medical, alcohol, and drug treatment, social and educational services.

2. The following activities within TCM are *NOT REIMBURSABLE prior to the completion* of the Client Plan/TPOC:

    a. **Monitoring** and **Follow-Up** Activities

Section 20: Intensive Care Coordination (ICC)

Service Definition[13]

Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for beneficiaries with intensive needs. Clients need not be a member of the *Katie A*. class to receive ICC. ICC services are intended to link clients to services provided by other child serving systems, to facilitate teaming, and to coordinate mental health care. If a client is involved in two or more child serving systems, ICC is used to facilitate cross-system communication and planning.

Although there may be more than one mental health providers participating on a Child and Family Team (the team comprised of the client, their family, and individuals working to address the client's needs and strengths), an ICC coordinator serves as the single point of accountability to:

- Ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the child or youth;
- Facilitate a collaborative relationship among the child or youth, his/her family and involved child-serving systems;
- Support the parent/caregiver in meeting their child or youth's needs;
- Help establish the Child and Family Team (CFT) and provide ongoing support;
- Organize and match care across providers and child serving systems to allow the child or youth to be served in his/her home community.

ICC may be provided to clients living and receiving services in the community (including in a TFC home), as well as to clients who are currently in the hospital, group home, Short Term Residential Therapeutic Program, or other congregate or institutional placement.

When ICC is provided in a hospital, psychiatric health facility, community treatment facility, or psychiatric nursing facility, it solely will be used for the purpose of coordinating placement of the client on discharge from those facilities and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, nonconsecutive periods of 30 calendar days or less per continuous stay in the facility, as part of discharge planning.

Service Components/Activities

While the key service components of ICC are similar to TCM, ICC differs in that it is integrated into the CFT process, and it typically requires more active participation by the ICC provider in order to ensure that the needs of the client are

[13] Note: Guidance provided in this section of the manual is based on the June 26, 2017, DHCS draft of the "Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries".

appropriately and effectively met. As such the ICC service components include the following:

1. Comprehensive Assessment and Periodic Reassessment
   These assessment activities are different from the clinical assessment to establish medical necessity for specialty mental health services but must align with the mental health client plan. Information gathering and assessing needs is the practice of gathering and evaluating information about the client and family which includes gathering and assessing strengths, as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of clients.

2. Development and Periodic Revision of the Plan
   Planning within the Core Practice Model (CPM) is a dynamic and interactive process that addresses the goals and objectives necessary to assure that clients are safe, live in permanent loving families and achieve well-being. This process is built on an expectation that the planning process and resulting plans reflect the client's and family's own goals and preferences and that they have access to necessary services and resources that meet their needs.

   The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (child welfare, education, juvenile probation, etc.) are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with service to the client and/or family are coordinated to support and ensure successful and enduring change.

3. Referral, Monitoring and Follow-Up Activities
   Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The CFT is also responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan to address the changing needs of the client and family in a timely manner, but not less than every 90 days. Intervention strategies should be monitored on a frequent basis so that modifications to the plan can be made based on results, incorporating approaches that work and refining those that do not.

4. Transition
   When the client has achieved the goals of his/her client plan, developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources.

Examples of each of the above service components and activities can be found under Reference G.

Provider Qualifications
Provider qualifications are the same as those allowed for Targeted Case Management services.

Documentation Requirements
ICC must be documented in accordance with Medi-Cal documentation requirements, San Francisco MHP policies and procedures, and the contract between DHCS and the San Francisco MHP. Providers must meet all applicable documentation requirements including those found under Section 4, Section 5, Section 6 and Section 7 of this manual.

Claiming for Multiple Staff
When multiple staff are claiming for ICC services, the following requirements must be met:

1. Each staff may claim to ICC for time at the CFT meeting clearly linked to the mental health client plan goals and/or the information gleaned during the meeting that contributed to the formulation of the mental health client plan or revisions.

2. Medi-Cal reimbursement must be based on staff time, including the length of the meeting, plus any documentation and travel time (e.g., a single staff member who participates in the CFT meeting cannot claim for more time than was provided).

3. Progress notes must include evidence of incorporation of Core Practice Model (CPM) elements described in the CPM Guide. Please see Reference G for examples of ICC progress notes.

Service Lockouts
Service limitations and lockouts for ICC are equivalent to TCM service limitations and lockouts as described below:

- TCM does not include, and Federal Financial Participation (FFP) is not available when the TCM activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.2F).
- TCM does not include, and Federal Financial Participation (FFP) is not available when the TCM activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.2F).
- TCM does not include, and Federal Financial Participation (FFP) is not available when the TCM activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care program services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (Source: 42 CFR 441.18(c)).

- FFP is only available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program, except for case management that is included in an individualized education program or individualized family service plan

consistent with section 1903(c) of the Act. (Sections 1902(a) (25) and 1905(c).

- For members of the target group who are transitioning to a community setting, TCM services will be made available for up to 30 calendar days, for a maximum of three, non- consecutive periods of 30 calendar days or less per hospitalization or inpatient stay, prior to the discharge of a covered stay in a medical institution. The target group does not include individuals who are inmates of public institutions. (Source: 9 CCR §1840.374)

- ICC may be provided solely for the purpose of coordinating placement of the child or youth on discharge from the hospital, psychiatric health facility, or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, nonconsecutive periods of 30 calendar days or less per continuous stay in the facility, as part of discharge planning.

Claiming and Reimbursement
ICC is reimbursed at the same rates as Targeted Case Management services. To clearly distinguish ICC from general TCM, ICC uses a different procedure code (T1017 HK) and service function code (07).

Insights from DHCS-Intensive Care Coordination

1. Can ICC be delivered to a client prior to the completion of the Client Plan/TPOC? When documented correctly, the following activities within ICC can be delivered and reimbursed prior to the completion of the Client Plan/TPOC:

    - Comprehensive Assessment and Periodic Reassessment
    - Development and Periodic Revision of the Plan
    - Referral/linkage to help the client obtain needed services, including medical, alcohol, and drug treatment, social and educational services.

Remember, the Client Plan/TPOC must be completed prior to delivering the "Monitoring and Follow-Up Activities" component of ICC.

Source: MHSUDS Information Notice No.: 17-040

Section 21: Intensive Home Based Services (IHBS)

Service Definition[14]

Intensive Home Based Services (IHBS) are mental health rehabilitation services provided to Medi-Cal clients as medically necessary. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a client's functioning and are aimed at helping the client build skills necessary for successful functioning in the home and community and improving the client's family ability to help the client successfully function in the home and community.

Service Components/Activities

Service activities may include, but are not limited to:

1. Medically necessary, skills-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the client's family and/or significant others to assist them in implementing the strategies;
2. Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
3. Development of skills or replacement behaviors that allow the client to fully participate in the Child and Family Team (CFT) and service plans, including, but not limited to, the plan and/or child welfare service plan;
4. Improvement of self-management of symptoms, including self-administration of medications as appropriate;
5. Education of the client and/or their family or caregiver(s) about, and how to manage the client's mental health disorder or symptoms;
6. Support of the development, maintenance and use of social networks including the use of natural and community resources;
7. Support to address behaviors that interfere with the achievement of a stable and permanent family life;
8. Support to address behaviors that interfere with seeking and maintaining a job;
9. Support to address behaviors that interfere with a client's success in achieving educational objectives in an academic program in the community;
10. Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

IHBS Provider Qualifications

Intensive Home Based Services are typically but not always provided by paraprofessionals under clinical supervision. Peers, including a Parent

[14] Note: Guidance provided in this section of the manual is based on the June 26, 2017, DHCS draft of the "Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries".

Partner/Advocate, may provide IHBS, if qualified to provide the service. Provider qualifications for IBHS are the same as those allowed for Mental Health Services. See reference chart below (taken from the from the June 26, 2017, DHCS draft manual).

ICC and IHBS Services and Billing Code Privileges

Type of Staff	May direct services by through: • Signature on Client Plan • Supervision of staff providing service	May provide services and/or may function as the client's care coordinator	May conduct: • Mental Status Exam • Diagnostic information
Licensed Practitioners of the Healing Arts (LPHA)	YES	YES	YES
Registered/Waivered LPHA	YES	YES	YES
Registered Nurse (RN) with Master's degree in Psychiatric/Mental Health Nursing	YES	YES	YES
RN	NO—NOT FOR SFDPH-BHS	YES	***NO***
Licensed Vocational Nurse	***NO***	YES	***NO***
Licensed Psychiatric Technician	***NO***	YES	***NO***
Trainee for CSW, MFT, Clinical Psychology (post BA/BS but pre-Master's/PhD degree)	***NO***	YES	YES, with LPHA signature
Mental Health Rehabilitation Specialist	***NO***	YES	***NO***
Staff with Mental Health related BA/BS, or 2 years of experience in Mental Health	***NO***	YES	***NO***
Staff without either BA/BS, or2 years of experience in Mental Health	***NO***	YES	***NO***
***SFDPH-BHS Billing Codes:* KTAICC = ICC; KTAIHBS = IHBS**			

IHBS Documentations Requirements
Intensive Home Based Services documentation requirements are the same as those found under Section 4, Section 5, Section 6 and Section 7 of this manual in addition to any additional DHCS and the San Francisco MHP documentation requirements.

IHBS Service Limitations/Lockouts
Mental health services (including IHBS) are not reimbursable when provided by day treatment intensive or day rehabilitation staff during the same time period that day treatment intensive or day rehabilitation services are being provided. Authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehabilitation services are provided.

Certain services may be part of the child's or youth's course of treatment, but may not be provided during the same hours of the day that IHBS services are being provided to the child or youth. These services include:

- Day Treatment Rehabilitative or Day Treatment Intensive,
- Group Therapy, and
- Therapeutic Behavioral Services (TBS).

IHBS Claiming for Reimbursement
In order to distinguish IHBS from non-inpatient Specialty Mental Health Services when claiming, IHBS uses a different procedure code and modifier (H2015 HK) and service function code (57). IHBS will be reimbursed at the same rates as Mental Health Services.

Section 22: Therapeutic Foster Care (TFC)

TFC Service Definition[15]

The Therapeutic Foster Care (TFC) service model provides short-term, intensive, highly coordinated, trauma-informed, and individualized SMHS service activities to clients, up to age 21, who have complex emotional and behavioral needs, and who are placed with trained, intensely supervised, and supported TFC parents working through and under the direction of a TFC Agency. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth and provides trauma-informed interventions that are medically necessary for the client.

The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma-informed interventions that are medically necessary for the child or youth. The SMHS service activities provided through the TFC service model assist the child or youth in achieving client plan goals and objectives, improve functioning and well-being, and help the child or youth to remain in a family-like home in a community setting, thereby avoiding residential, inpatient, or institutional care.

The TFC service model is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS service activities available under the EPSDT benefit, as a home-based alternative to high level care in institutional settings, such as group homes and, in the future, as an alternative to Short Term Residential Therapeutic Programs (STRTPs).

The TFC home may also serve as a step down from STRTPs. SMHS activities provided through the TFC service model should not be the only SMHS that a client would receive. The SMHS service activities provided through the TFC service model are part of a continuum of care for clients. Providers are encouraged to continue to develop the resources, supports, and services needed to maintain foster children and youth in family-based home settings, while promoting permanency for the client through family reunification, adoption, or legal guardianship. These efforts may include the provision of Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Wraparound services, as appropriate.

The SMHS activities provided through the TFC service model must be delivered using a Child and Family Team to develop and guide the planning and service delivery process.

TFC Indicators of Needs for SMHS Components through the TFC Model

The SMHS activities provided through the TFC service model are appropriate for clients with more intensive needs, or clients who are in or at risk of residential, inpatient, or institutional care, but who could be effectively served in the home and community.
Following are the circumstances in which TFC may be an appropriate services model to address a client's mental health needs. These circumstances should be

[15] Note: Guidance provided in this section of the manual is based on the June 26, 2017, DHCS draft of the "Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries".

considered as indicators of need for TFC and are intended to identify clients who should be assessed to determine if TFC is medically necessary:

1. The client is at risk of losing his or her placement and/or being removed from his or her home as a result of the caregiver's inability to meet the client's mental health needs; and, either:

    a. There is recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the client's mental health needs, and the child or youth is immediately at risk of residential, inpatient, or institutional care; or
    b. In cases when the client is transitioning from a residential, inpatient, or institutional setting to a community setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the client, or support effective rehabilitation.

TFC Agency Role
The TFC Agency is:

- A California Foster Family Agency (FFA) that meets licensure and accreditation requirements established by the California Department of Social Services (CDSS), and that is able to approve TFC homes, and that is able to accept for placement from county placing agencies; and
- A Medi-Cal SMHS provider that has a contract with a MHP as a Medi-Cal provider (or an MHP that has been certified by DHCS) to provide TFC services. The TFC Agency may provide a wide array of other SMHS, if these SMHS are included in its contract with the MHP.

The TFA Agency is responsible for ensuring the TFC parent meets both resource family approval (RFA) program standards and meets the required qualifications as a TFC Parent. The TFC parent will work under supervision of the TFC Agency. A Licensed Practitioner of the Healing Arts (LPHA) or a Waivered or Registered Mental Health Professional (WRMHP) employed by the TFC Agency will provide direction to the TFC parent, and will ensure the TFC parent is following the client plan. The TFC Agency's LPHA/WRMHP assumes ultimate responsibility for directing the SMHS service activities provided through the TFC service model by the TFC parent.

The TFC Agency will provide the management oversight of a network of TFC parents. The TFC Agency activities include:

- Recruiting, approving (unless already approved by the county), and annually re-approving TFC parents, following both the RFA process and Medi-Cal SMHS requirements, as a TFC parent who has the ability to meet the diverse therapeutic needs of the child or youth;
- Providing, at a minimum, a 40-hour training for the TFC parent prior to providing SMHS service activities through the TFC service model, as outlined in the TFC Parent Qualifications document;
- Actively participating in the CFT to identify supports for the child and family, including linking with a TFC parent who can best meet the child's or youth's individual needs;
- Integrating the TFC parent and appropriate staff into the existing CFT;

- Providing competency-based training to the TFC parent, both initially and ongoing;
- Providing ongoing supervision and intensive support to the TFC parent;
- Monitoring the child's or youth's progress in meeting client plan goals related to SMHS service activities provided through the TFC service model;
- Maintaining documentation (progress notes) related to the TFC parent and child or youth, which is included in the child's or youth's client plan;
- Providing Medi-Cal-related reports, as required, to the MHP or designee;
- Providing other supports to the TFC parent and child or youth (i.e. Parent Partner and/or youth mentor); and
- As it relates to the care of the individual child or youth, the TFC Agency is responsible for the following:
- Collaborating and coordinating with the ICC coordinator and CFT in the development and implementation of the client plan;
- Assessing the child's or youth's progress in meeting client plan goals related to the provision of SMHS service activities provided through the TFC service model, and communicating progress through the CFT;
- Incorporating evidence informed practices in the training of TFC parents and the treatment of the child or youth.
- The TFC Agency may also be responsible for providing other non-TFC medically necessary SMHS, if included in its contract with the MHP.

Role of the TFC Parents as a SMHS Provider

The TFC parent serves as a key participant in the trauma- informed, rehabilitative treatment of the child or youth, as set forth in the client plan. The TFC parent provides one or more of the following TFC service model SMHS service activities:

- Plan Development (limited to when it is part of the CFT): The TFC parent will participate as a member in the CFT in care planning, monitoring, and review processes. The TFC parent also will observe, monitor, and alert the TFC Agency and members of the CFT about changes in the client's needs.

  Example: The TFC parent informs the LPHA/Waivered/Registered LPHA that the client's disruptive behaviors in school are now resolved, but a change in the client plan is needed due to increased obstinacy and defiance by the client at the TFC home;

- Rehabilitation: The TFC parent will implement in-home informed practices which include trauma-informed rehabilitative treatment strategies set forth in the client plan. Examples of services to be provided include: providing skills-based interventions (including coaching and modeling); developing functional skills to improve self-care; and improving self-management in areas of anger management or self-esteem or peer relations.

  Examples of services to be provided include: providing skills-based interventions (including coaching and modeling); developing functional skills to improve self-care; and improving self- management in areas of anger management or self-esteem or peer relations;

- Collateral: The TFC parent will meet the needs of the client in achieving his or her client plan goals by reaching out to significant support person(s) and providing consultation, and/or training for needed medical, vocational, or other services to assist in better utilization of mental health services by the client.

  Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the client in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the client; and family counseling with the significant support person(s) to improve the functioning of the client. The client may or may not be present for this service activity.

  The TFC parent activities related to collateral include meeting the needs of the client in achieving his/her TFC client plan goals by reaching out to significant support person(s) and providing consultation and training for needed medical, vocational, or other services to assist in better utilization of SMHS by the client.

TFC Client Reassessment
Since SMHS delivered through the TFC service model are intended to be high intensity and relatively short-term, the child's or youth's progress must be reviewed in coordination with the Child and Family Team, at a minimum, within the first three (3) months/90 days after the service model is initiated and every three (3) months/90 days thereafter.

TFC Documentation Requirements
The SMHS service activities provided through the TFC service model must meet documentation requirements found under Section 4, Section 5, Section 6, and Section 7, in addition to any other DHCS and San Francisco MHP requirements. Service activities also must listed in the child's or youth's client plan.

The TFC parent must write and sign a progress note for each day of service. Each progress note must meet Medi-Cal documentation standards. A LPHA or Waivered/Registered LPHA employed by the TFC agency must be review and co-sign each progress note to indicate that service activities are appropriate and that documentation requirements are met.

It is anticipated that TFC parents will not have access to Avatar. The TFC Agency will be required to ensure there is a process in place to enter TFC parent progress notes into the client medical record. A sample progress note form and notes is provided under Reference G for TFC parents to use.

TFC Parent Provider Qualifications
Parents who provide TFC services must meet the San Francisco MHP requirements for "Mental Health Workers" with the requirement that TFC parents be at least 21 with a high school diploma, or equivalent degree, and otherwise be determined to be qualified to provide TFC services.

TFC Documentation Requirements & Frequency
TFC shall be documented in accordance with Medi-Cal documentation requirements, the San Francisco. MHP policies and procedures, and the contract between DHCS and the San Francisco MHP. Providers must meet all applicable documentation

requirements including those found under Section 4, Section 5, Section 6 and Section 7 of this manual, as well as the following minimum documentation requirements:

- The TFC parent(s) must write and sign a daily progress note for each day of service. The progress note must meet Medi-Cal documentation standards. Most likely, the TFC parent will not have access to the client medical record and will not document into it directly. Providers are required to ensure that TFC parent progress notes are entered into the client medical record by qualified staff.

- A LPHA or waivered/registered LPHA must review and co-sign each progress note to indicate service activities are appropriate and that documentation requirements are met. Before co-signing the daily progress note, the supervising LPHA/WRMHP also will ensure that the daily progress note meets the Medi-Cal documentation standards of the client's qualifying behavior, activities, progress, and achievements or progress toward specific outcomes outlined in the client's client plan.

- The provider must comply with the mental health documentation requirements prescribed by the San Francisco MHP and the contract between DHCS and the San Francisco MHP.

- TFC services must be included in the client plan.

TFC Claiming and Reimbursement
Service activities provided through the TFC service model must be claimed at a per diem rate using Mode of Service 05 (24-hour) and Service Function Codes 95 – 98. Service activities provided through the TFC service model must be claimed using procedure Code S5145 with the Procedure Modifier HE.

TFC Service Limitations
TFC does not include:

1. Reimbursement for the cost of room and board; or
2. Other foster care program related services (e.g., assessing adoption placements, serving legal papers, home investigations, administering foster care subsidies), or other parenting functions such as providing food or transportation.

TFC Service Lockouts
TFC services are not Medi-Cal reimbursable under the following circumstances:

1. When a client is receiving Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services, except for the day of admission/discharge to/from these facilities;
2. While a client is detained in juvenile hall or is otherwise considered an inmate; or
3. While a client is in a Short Term Residential Therapeutic Program (STRTP) or other residential setting. except for the day of admission/discharge to/from these facilities

Section 23: Therapeutic Behavioral Services (TBS)

TBS Service Definition
Therapeutic Behavioral Services, or TBS, is a one-to-one behavioral mental health service available to children and youth with serious emotional challenges who are under 21 years old and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal). TBS can help children/youth and parents/caregivers, foster parents, group home staff, and school staff learn new ways of reducing and managing challenging behaviors, as well as strategies and skills to increase the kinds of behavior that will allow children and youth to be successful in their current environment. TBS is designed to help children and youth and parents and caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the needs of the child and youth and their family.

TBS can be provided anywhere in the community: at home, school, other places such as after-school programs and organized recreation programs except during Medi-Cal service lockouts.

As an EPSDT Supplemental Specialty Mental Health Service (Source: 9 CCR §1810.215), TBS is not a stand-alone service; it is a short-term, supplemental specialty mental health service for clients that meet medical necessity criteria and defined class criteria:

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

TBS Intervention Definition
A TBS intervention is defined as an individualized one-to-one behavioral assistance intervention to accomplish outcomes specifically outlined in a written TBS treatment plan.

TBS Collateral Service Definition
A TBS collateral service activity is an activity provided to significant support persons in a client's life rather than to the client. Progress notes must clearly indicate the overall goal of the collateral service activities to help improve, maintain, and restore the client's mental health status through interaction with the significant support person.

TBS Client Assessment Requirements
A TBS client assessment may be made as part of an overall assessment for specialty mental health services or may be a separate document specifically establishing whether TBS is needed. A TBS client assessment must be completed within 30 days or less of a referral.

In addition to minimum assessment items for Specialty Mental Health Services, TBS client assessments must document:

1. Medical necessity criteria specifically for TBS;
2. Client is a full-scope Medi-Cal client under 21 years;
3. Client is a member of the certified class, receiving specialty mental health services, and has specific behaviors that require TBS;
4. Client has specific targeted behaviors that jeopardize continuation of a residential placement, put the client at risk for psychiatric hospitalization, or the specific behaviors that are expected to interfere with a plan to transition to a lower level of residential placement;
5. Clinical information that demonstrates TBS is necessary to sustain a residential placement or successfully transition to a lower level of residential placement and that TBS can be expected to provide a level of intervention necessary to stabilize the client in the existing placement;
6. Observable and measurable changes and indicate when TBS services have been successful and could be reduced or ended; and
7. Identification of skills and positive adaptive behaviors that the client uses to manage the problem behavior and/or uses other circumstances that could replace the specified problem behaviors.

TBS Client Plan Requirements

TBS client plans of care must be completed within 30 days or less of a referral for services. TBS plans of care can be a separate plan of care or part of a more comprehensive plan but must document all of the following:

1. The targeted behaviors that jeopardize a client's placement or transition to lower level of care;
2. Plan goals;
3. Benchmarks (the objectives to be met as the client progresses toward plan goals;
4. A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan developed with the family/caregiver (if available and appropriate), a specific description of the changes in the behaviors that the interventions are intended to produce including the estimated time frame for these changes, and a specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving expected results;
5. Transition plan that describes the method the treatment team will use to decide how and when TBS will be decreased and ultimately discontinued including assisting parents/caregivers/school personnel with skills and strategies to provide continuity of care when TBS is discontinued;
6. For transition age youth, a plan for transition to adult services when the client is no longer eligible (21 years and older) and will need continued services;
7. Signature of the clinician that developed the care plan or is providing the service(s) and/or a clinician representing the San Francisco Mental Health

Plan and a co-signature of a licensed physician or clinician when the person providing the service is not licensed or waivered;

8. Evidence of a client's degree of participation and agreement with the client plan as evidenced by a client's or legal guardian's signature (when a signature is not available or there is a refusal to sign a client plan, a written explanation must be included in the progress notes as to why the signature could not be obtained); and
9. Evidence that a copy of the client plan was provided to the client or parent/caregiver upon request.

TBS Client Plan Reviews
All TBS client plans must be reviewed every 30 days to ensure that TBS continues to be effective for the client in making progress toward the specified measurable outcomes in the client's TBS plan.

TBS Client Progress Notes
TBS progress notes must clearly document the specific behaviors that threaten the stability of a current placement or interfere with the transition to a lower level of residential placement and which are the result of the covered mental health diagnosis and the interventions provide to address those behaviors and symptoms. All notes must clearly, concisely, succinctly and legibly include all of the following:

1. Date service was provided;
2. Start time of the service (required for TBS only per DPH SFHN-BHS Behavioral Health Progress Notes Policy/3.10-11));
3. Key clinical decisions and interventions that are directed to the TBS goals of the client:
    a. That are consistent with interventions reflected in the TBS client plan;
    b. Document how interventions changed or eliminated client targeted behaviors and increased adaptive behaviors (were not provided solely for the convenience of the family or other caregivers, a physician, a teacher, or staff);
    c. Focus on identified target behaviors;
    d. Client response and receptivity to interventions; and
    e. Address conditions that are not part of the identified client's mental health condition; Signature of the staff providing the service including their clinical licensure, professional degree and job title;
4. A corresponding note for every TBS service contact including, but not limited to, direct one-to-one TBS service, TBS assessment and/or reassessment, TBS collateral contact, and TBS Plan of Care/Client Plan or its documented review and updates.

All TBS progress notes must include a comprehensive summary covering the time TBS services were provided but do not need to document every minute of service time.

TBS Service Restrictions
TBS is not billable when:

1. Services are solely:
    a. For the convenience of the family or other caregivers, physician, or teacher;
    b. To provide supervision or to assure compliance with terms and conditions of probation;
    c. To ensure a child or youth's physical safety or the safety of others (e.g., suicide watch); or
    d. To address behaviors that are not a result of a child or youth's mental health condition;

2. A child or youth can sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and appropriately handle transitions during the day;

3. A child or youth will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision;

4. On-call time for the staff person providing TBS (note, this is different from "non-treatment" time with staff who are physically "present and available" to provide intervention – only the time spent actually providing the intervention is a billable expense);

5. The TBS staff provides services to a different child or youth during the time period authorized for TBS;

6. Transporting a child or youth (accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented, circumstances);

7. TBS supplants a child or youth's other mental health services provided by other mental health staff.

Section 24: Medi-Cal Billing Overview

General Rules for Claiming Reimbursement
Depending on the mental health service provided to a client, reimbursable units of service are claimed based on minutes of staff time, hours/blocks of time, or calendar days. All claims for services must be supported by a progress note that is entered into the client medical record before the submission of a reimbursement claim regardless of how a service is reimbursed (minutes, hours or calendar days).

Services Claimed on Basis of Staff Time
For the following mental health services, the billing unit is the time of the person delivering the service in minutes of time:

1. Mental Health Services
2. Medication Support Services
3. Crisis Intervention
4. Targeted Case Management (TCM)
5. Therapeutic Behavioral Services (TBS)
6. Intensive Care Coordination (ICC)
7. Intensive Home-Based Services (IHBS).

There are three general rules to follow for claiming reimbursement for these mental health services (Source: DHCS MHSUDS Information Notice No.: 17-040):

1. The exact number of minutes used by staff persons providing a reimbursable service must be reported and billed. No more than 60 units of time may be reported or claimed for any one person during a one-hour period. The units of time reported or claimed for any one person cannot exceed the hours worked.

2. When a person provides service to or on behalf of more than one client at the same time, the person's time must be prorated to each client. When more than one person provides a service to more than one client at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

3. The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity (Source: 9 CCR §1840.316).

DHCS has provided examples of claiming reimbursement for mental health services billed by the minute (Source: DHCS MHSUDS Information Notice No.: 17-040)—see the “Insights from DHCS” box below.

Insights from DHCS-Travel Time

1. What are examples of appropriate claiming for travel that is associated with a reimbursable service activity?

   a. A Licensed Clinical Social Worker (LCSW) provides individual therapy (mental health services) at the clinic to a client for 45 minutes. She spends 12 minutes following the therapy session documenting the interventions provided in a progress note that demonstrates that the interventions address the client's diagnosis, impairments and client goals as indicated in the client plan. This documentation time is reimbursable as mental health services. The total time for this service would be 57 minutes (45 for the individual therapy plus 12 minutes for the related documentation).

   b. An LCSW drives 23 minutes from the clinic or a contract provider site to a client's home to provide individual therapy (mental health services) for 48 minutes to a client. Following the intervention, the clinician drives 24 minutes back to the clinic and spends 13 minutes documenting the intervention provided in a progress note in the client's client medical record. The travel and documentation time are reimbursable as they are directly linked to providing the mental health service. (i.e.: 48-minute session, plus 47 minutes of travel time, plus 13 minutes of documentation time for a total of 108 minutes).

   c. A clinician or other staff member drives 15 minutes from their primary office to a client's school to provide 50 minutes of collateral services (mental health services) to a parent and teacher. Following the intervention, the Marriage and Family Therapist Intern (MFTI) travels 30 minutes to their next community-based client. At the end of the day, the MFTI spends 16 minutes documenting the collateral intervention to the client's significant support persons (collateral resources). The travel time to the school (15 minutes), the 50-minute session and the 16-minute documentation time can be claimed as a collateral service to the first client for a total of 81 minutes. The 30-minute travel time to the next community-based client would be included in the claim for the service provided to the next client, including travel time back to the office and documentation time.

Source: MHSUDS Information Notice No.: 17-040

Services Claimed Based on Blocks of Time

Crisis Stabilization, Day Treatment Intensive and Day Rehabilitation services are claimed based on the block of time a client receives services.

1. Crisis Stabilization is reimbursed based on hours of time (Source: 9 CCR §1840.322):

a. Each one-hour block that a client receives crisis stabilization services may be claimed.
b. Partial blocks of time must be rounded up or down to the nearest one-hour increment except for services provided during the first hour which should always be rounded up.

2. Day Treatment Intensive and Day Rehabilitation are billed on half days or full day of service (Source: 9 CCR §1840.318):

   a. A half-day may be billed for each day in which the client receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.
   b. A full day may be billed for each day in which the client receives face-to-face services in a program with services available more than four hours per day;
   c. Although the client must receive face-to-face services on any full day or half-day claimed, all service activities during that day are not required to be face-to-face with the client.

Note that the requirement for continuous hours of operation does not preclude short breaks between activities. A lunch or dinner break may be appropriate depending on the program's schedule. These breaks may not be included in the total hours of operation of the day program for purposes of determining minimum hours of services.

Services Claimed Based on Calendar Days
Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services are claimed based on calendar days of service (Source: 9 CCR §1840.320):

1. A day may be billed for each calendar day in which the client receives face-to face services and the client has been admitted to the program. Services may not be billed for days the client is not present.
2. Board and care costs are not included in the claiming rate;
3. The day of admission may be billed, but not the day of discharge.

Maximum Claimable Time by Service
Medi-Cal places limited on the maximum time certain specialty mental health services can be billed. The time documented in progress notes for the length of the service provided to the client for these mental health services should not exceed the following maximum claimable amounts in a 24-hour period/day:

- Mental Health Services: Maximum of 2,878 minutes per day.
- Medication Support Services: Maximum 4 hours (240 minutes) per day.
- Targeted Case Management/Brokerage: Maximum of 24 hours (1440 minutes) per day.
- Crisis Intervention: Maximum of 8 hours (480 minutes) per day.
- Crisis Stabilization: Maximum of 20 hours per 24-hour period.

State Cost Effectiveness of Service Rule
Home or community-based specialty mental health services are not reimbursable by Medi-Cal when the total cost to Medi-Cal for providing the service to the client is greater than the total cost to Medi-Cal to provide a "medically equivalent" service at a client's otherwise appropriate institutional level of care where medically equivalent services at the appropriate level are available in a timely manner.

Dual Eligible Clients – Medicare Exclusions
For SFHN-BHS clients who are dual eligible clients (Medi-Cal and Medicare eligible), there are services that are not reimbursable by Medicare and are claimed directly to Medi-Cal. The following SMHS services are not billable to Medicare and are claimed directly to Medi-Cal:

1. Administrative Day Services
2. Adult Residential Treatment Services
3. Crisis Intervention
4. Crisis Residential Treatment Services
5. Crisis Stabilization
6. Day Rehabilitation
7. Day Treatment Intensive
8. Psychiatric Health Facility
9. Targeted Case Management Services
10. Therapeutic Behavioral Services

The following three SMHS activities are not billable to Medicare and are claimed directly to Medi-Cal:

1. Rehabilitation
2. Plan Development
3. Medication Training and Support.

Claiming for Group Services & Multi-Provider Notes
See Section 7 of this manual for guidance on group and multi-provider notes. DHCS has provided examples of three approaches to use to determine the number of minutes each provider may claim for each Medi-Cal client participating in a group session (Source: DHCS MHSUDS Information Notice No.: 17-040):

Claiming for Telephone Services
Claimed services provided by telephone must be actual, Medi-Cal reimbursable services. Leaving a telephone message, scheduling an appointment, or other clerical functions are not Medicare or Medi-Cal reimbursable activities.

Claiming for Travel Time
The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity, as follows:

- Travel time from a provider site[16] to an off-site location(s) where Medi-Cal SMHS are delivered is claimable. The travel time must be directly linked or

[16] A "provider site" is defined as a site with a provider number. This includes affiliated

related to the services provided which should be clearly documented in the progress note. In addition, the amounts of travel time and service time should each be reflected in the progress note.

- Travel time between provider sites or from a staff member's residence to a provider site may not be claimed.

- Travel time between a staff's home and a client's home may be claimed (Sources: MHSUDS Information Notice #17-040, page 29; 9 CCR § 1840.316(b)(3), Medi-Cal Billing Manual).

Claiming for Clients with Co-Occurring Disorders
If there is a co-occurring substance use disorder, interventions are claimable as long as the primary focus of the interventions is to address the functional impairment(s) that is a result of the included mental health diagnosis. The treatment of a client who has the requisite medical necessity for SMHS is reimbursable through Medi-Cal regardless of the co-occurrence of a substance use disorder (Sources: 9 CCR §1830.205 and DHCS MHSUDS Information Notice No.: 17-040).

Adult Residential Treatment Services Billing and Claiming Rules
Adult Residential Treatment Services (Transitional and Long-Term) is reimbursed on a calendar day (Source: 9 CCR §1840.320). The following general Medi-Cal billing rules apply to Adult Residential Treatment Services:

1. A day shall be billed for each calendar day in which the beneficiary receives face-to-face services and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.
2. Board and Care costs are not included in the claiming rate (Source: 9 CCR §1840.312).
3. The day of admission may be billed but not the day of discharge.
4. Staff do not assign a billing code when they are creating the Weekly Summary (remember, Adult Residential is reimbursed calendar days, not by the Weekly Summary).
5. Staff providing Medication Support Services or another Specialty Mental Health Service must use the appropriate billing code for that mode of service.

Crisis Residential Treatment Services Medi-Cal Billing Rules
Crisis Residential Treatment Services (Transitional and Long-Term) is reimbursed on a calendar day (Source: 9 CCR 1840.320). The following general Medi-Cal billing rules apply to Crisis Residential Treatment Services:

- A day can be billed for each calendar day in which the client receives face-to-face services, and the client has been admitted to the program.
- Services may not be billed for the days the client is not present.
- Board and Care costs are not included in the claiming rate (Source: 9 CCR §1840.312).

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satellite sites and school sites.

- The day of admission may be billed but not the day of discharge.
- Medication Support Services must be billed separately from Adult Residential Treatment Services (Source: 9 CCR §1840.326(b)).

Claiming for Diagnostic Services during Assessment
Assessment activities including diagnostic services, are reimbursable by a provider acting within his or her scope of practice when an assessment is in process or when the assessment results in a non-included diagnosis (DHCS MHSUDS Information Notice No.: 17-040)..

Minimum Service Time for Therapy (16 minutes) for Medicare Billing

For Medicare, if the therapy activity lasts less than 16 minutes, then it does not meet the minimum criteria (CPT 90833: "psychotherapy for 16-37 minutes with patient") and it cannot be billed to Medicare.[17]

[17] CMS (September 18, 2014). Outpatient Psychiatry & Psychology Services-Fact Sheet. Retrieved from https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31887_33/Outpatient_Psych_Fact_Sheet09.18.14.pdf.

DPH Frequently Used Mental Health Billing Codes
A more complete matrix of DPH Medi-Cal billing codes can be found under Reference E.

AVATAR CODES	SERVICES	NOTES
ASMT1	Psychiatric Diagnostic Evaluation	Evaluation/analysis of a client's historic and current mental, emotional, and/or behavioral disorders. Review of any relevant family, cultural, medical, substance abuse, legal or other complication factors. Establishes diagnosis and may include the use of testing. TBS Assessment is the Initial Assessment of a child or youth referred for TBS services.
90792	Psychiatric Diagnostic Evaluation with Medical Assessment	Evaluation/analysis of a client's historic and current mental, emotional, and/or behavioral disorders. Review of any relevant family, cultural, medical, substance abuse, legal or other complication factors. Establishes diagnosis and may include the use of testing. TBS Assessment is the Initial Assessment of a child or youth referred for TBS services.
H0032	Plan Development	Development and approval of client plan and monitoring of client progress toward goal attainment, evaluating if the plan needs modification, consultation/collaboration with mental health staff/other professionals involved in a client's treatment plan to assist, develop, and modify plan.
H0034	Medication Support Services	Medication support services include prescribing, administering, dispensing, and monitoring psychiatric medications or biologicals that are necessary to alleviate the mental illness symptoms.
INDTPY	Individual Psychotherapy	Used only by licensed, waivered staff, and graduate students enrolled in school.
IREHAB	Rehabilitation & Psychosocial Service to Individual Client	Services to assist, improve, maintain, restore a client's functional skills, daily living skills, social or leisure skills, and grooming and personal hygiene skills.
GRPTPY	Group Psychotherapy (other than Multi-Family Group)	Used only by licensed, waivered staff, and graduate students enrolled in school.
GREHAB	Group Rehabilitation	Group sessions to assist, improve, maintain, restore a client's functional skills, daily living skills, social or leisure skills, and grooming and personal hygiene skills such as healthy living or stress management groups.

AVATAR CODES	SERVICES	NOTES
90847	Family Therapy	Family therapy with the client present.
90849	Multi-Family Group Psychotherapy	Used only by licensed, waivered staff, and graduate students enrolled in school.
ICOLL	Collateral	Consultation and training of the significant support person(s) such as a family member or roommate to assist in better utilization of services and in understanding the client's serious mental health issues. Significant support persons exclude other professionals.
CRISIS	Crisis Intervention	Crisis includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic intervention to minimize the potential for psychological trauma to address typically life threatening or complex and requires immediate attention to a client in high distress. Used to report the first 30-74 minutes of Psychotherapy for Crisis on a given date and additional block(s) of time, up to 30 minutes each beyond the first 74 minutes.
T1017	Targeted Case Management, Brokerage, Wellness Check	Activities provided to assist a client in being able to access medical, educational, social, prevocational, rehabilitative, or other community services and treatment. Can include interagency or intra-agency communication, coordination, and monitoring regarding appointments and forms, as well as linkages to housing, transportation and finance services.
NM	Medi-Cal Non-Billable	Used for any services provided by a clinical provider when the client is in a "service lock-out" situation such as an inpatient hospital setting; these services may not duplicate services provided by the lock-out facility and are not billable to Medi-Cal. This service code time is reflected in worker productivity.
ADM99	Admin Code Not Billed	Used when a clinical provider is providing services that cannot be billed to either Medi-Cal and/or Medicare such as a phone call to schedule an appointment or completing SSI forms. This service code time is reflected in worker productivity.
ADM00	No Show	Used for client no shows. This service code time is not billable and is not reflected in worker productivity.

Avatar Billing Bulletins

The DPH website publishes regular Avatar Bulletins that offer billing code guidance to providers (DPH Avatar User Support). Recent issues of the "Avatar Billing Bulletin" have provided billing tips and guidance to providers of mental health services on the following topics:

1. Pregnancy Indicator
   A "Pregnancy Indicator" is required on Medi-Cal claims when billing covers mental health treatment services to pregnant Medi-Cal Clients with Restricted Aid Codes. Medi-Cal beneficiaries are assigned an Aid Code to designate their benefit program. Some beneficiaries have Full Scope benefits, while others are restricted to pregnancy or emergency services only. The Pregnancy Indicator allows Providers to notify Medi-Cal that services rendered are related to the clients' pregnancy so they can be approved for payment (April 2012 Avatar Billing Bulletin).
2. Place of Service Codes
   Place of service codes must be used to identify the location of the service.
3. Client Diagnosis
   An ICD-10 client diagnosis is required when submitting claims for Medi-Cal mental health services. The diagnosis effective date must cover the service dates billed (March 2016 Avatar Billing Bulletin)
4. Payer and Financial Information
   The California Welfare & Institutions Code requires County Behavioral Health Systems to obtain Payer and Financial Information (PFI) for all clients receiving mental health and/or substance use disorder treatment services. The PFI establishes the client /family's healthcare benefits and insurance coverages, and patient fee amounts payable for the cost of treatment services they receive. Payer and Financial Information is obtained for all mental health clients at the beginning of his or her episode; and annually thereafter, if continuing to receive services during the client/family's account anniversary date. The PFI is also required whenever there has been a significant change in the Client's healthcare benefits or insurance coverage, or in the family's financial status. This requirement facilitates the updating of CBHS Patient Accounts information to keep it current. Clients or responsible parties who refuse to provide accurate and complete PFI information are billed the full cost of services received from CBHS, in accordance with State DHCS Revenue Policy & Procedures (SFHN-BHS Policy & Procedures Manual).
5. Duplicate Services:
   Creating duplicate records in Avatar can be prevented by reviewing system information for a client before entering a new record. Following are steps to determine if a record already exists for your Client. Please use at least two of these search criteria before you create a new Client record.
6. Place of Service Codes:
   The place where a mental health service is provided must be added to all claims for billing (Place of Service Billing Code Matrix).

NM Codes-Overview

"NM" Billing Codes mean "Non-Medi-Cal" Billing Codes. These are local BHS codes used to track clinically-related activities that cannot be reimbursed through Medi-Cal for a specific reason (usually, a service lock-out scenario).

Separately, the A/OA and CYF SOCs published memos that describe the standards and use of NM codes (in 2013 and 2016, respectively). Those Memos appear on the following pages.

NM Guidance-A/OA SOC Memo (Dated 2/28/2013)

City and County of San Francisco
Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES

Edwin Batongbacal, LCSW
Director, Adult and Older Adult Systems-of-Care
1380 Howard Street, 5th Floor
San Francisco, CA 94103
(415) 255-3446 - FAX (415) 255-3567

Mayor Edwin Lee

MEMORANDUM

DATE: February 28, 2013

TO: CBHS Mental Health Transitional Residential Treatment, and Outpatient Providers

FROM: Edwin Batongbacal, LCSW, Director, CBHS Adult/Older-Adult Systems-of-Care

RE: Lockout of MH Transitional Residential Treatment and Outpatient MHS

Effective immediately, CBHS Mental Health Outpatient Providers may not bill Medi-Cal for Mental Health Services (which are Assessment, Plan Development, and Individual and Group Services) while the client is open in a Mental Health Transitional Residential Treatment service.

Background: CBHS has been notified by the Department of Health Care Services that outpatient Mental Health Services (Assessment, Plan Development, Individual and Group Services) delivered to a client in conjunction with Mental Health Residential Treatment is considered a *lockout,* meaning that outpatient Mental Health Services provided to a client cannot be billed to Medi-Cal if the client is receiving services during that same day in a Mental Health Residential Treatment Facility. *(Note: Crisis Intervention, Case Management and Medication Support Services are not lock-outs, and remain billable to Medi-Cal while a client is in MH Transitional Residential Treatment.)*

CBHS Commitment: CBHS recognizes the value of, and encourages, active client linkage efforts by MH outpatient programs while a client is still in MH Residential Treatment, for the purposes of transitioning clients into the community. Therefore, regardless of Medi-Cal's limitations in paying for such linkage efforts, CBHS still instructs providers to continue to begin such engagement services which may involve not only Case Management services, but also Mental Health Services and Medication Support Services. Providers will still get reimbursed for such services in the following ways below.

Planned Services by a mental health outpatient provider that would be approved by Medi-Cal, while a client is in Transitional Residential Treatment, include:

1. Outpatient Case Management services for the purposes of engaging a client to outpatient services to facilitate a smooth transition when the client leaves Transitional Residential Treatment, and

2. Outpatient Medication Support Services

CBHS Outpatient Providers may also continue to render the Mental Health Services in the table below that are not-billable to Medi-Cal while their client is in Transitional MH Residential Treatment, by using the corresponding non-Medi-Cal Billable Codes below that don't generate a Medi-Cal claim. *(Instead, county General Fund is used to pay or credit providers for productivity for these non-Medi-Cal-billable-coded services.)*

Service Definition – *(Medi-Cal Locked Out if with concurrent MH TRT)*	**Non-Medi-Cal Service Code To Use**
ASSESSMENT – NOT BILLABLE	NMASMT
PLAN DEVELOPMENT – NOT BILLABLE	NMPLDEV
INDIVIDUAL THERAPY – NOT BILLABLE	NMIND
GROUP THERAPY – NOT BILLABLE	NMGRP

Note: Commencement or continued provision of GF-funded Individual or Group Therapy by an Outpatient MH Provider while a client is concurrently enrolled in MH Transitional Residential Treatment has to be clinically justified, given that such services are supposed to be available within the Transitional Residential Treatment program, as defined.

For unregistered clients, or for newly-registered clients who don't yet have a Treatment Plan, below are two ways for mental health outpatient providers to get paid or credited for productivity by CBHS for their services to open and engage clients who are being referred to them while still in MH Transitional Residential Treatment:

1. Outpatient MH providers can bill Mode 45 indirect services to a new unregistered client they are beginning to link with while the client is still in MH Transitional Residential Treatment. This option is simplest, and involves the least paperwork. These clients can be opened later once they come out of the Transitional Residential Treatment programs, and link with the outpatient programs.

2. Outpatient MH providers can also use the non-Medi-Cal-billable Assessment and Plan Development billing codes, in the table above, to enroll the unregistered client, who is in MH Transitional Residential Treatment, into concurrent planned outpatient mental health services, such as Medi-Cal-billable Case Management and Medication Support, and non-Medi-Cal-billable Individual and Group services.

NM Guidance-CYF SOC Memo (Dated 1/19/2016)

Edwin Lee
Mayor

San Francisco Department of Public Health
Behavioral Health Services
Kenneth Epstein, Ph.D., LCSW
Director, Children, Youth & Families System of Care

MEMORANDUM

DATE: January 19, 2016

TO: Child, Youth, & Family System of Care Providers

FROM: Kenneth Epstein, Ph.D., LCSW, Director, CYF SOC

RE: Service Lockouts for CYF Providers

This memo serves to clarify the use of NM codes (Non-Medi-Cal billable) for providers in Behavioral Health Services' (BHS) Children, Youth, and Families (CYF) System of Care (SOC). The use of NM Codes will depend on the clinical scenario, the service setting and service activity.

Background: "Service Lockout" generally means that Medi-Cal will not pay for Mental Health Services (assessment, plan development, therapy, rehabilitation and collateral) at the same time a client is receiving a bundled service (like Crisis Stabilization, Day Treatment Intensive, Psychiatric Inpatient Hospital Services and Medical Hospitalization). This is also true for Medication Support Services.

In addition, Medi-Cal coverage is suspended for incarcerated juveniles and Medi-Cal will not pay for any Mental Health Services or Medication Support Services during that period.

BHS Commitment: BHS values and encourages active client linkage efforts and engagement services. Therefore, BHS instructs providers to provide clinically needed and appropriate linkage efforts to clients regardless of Medi-Cal's inability to pay for Mental Health Services (either due to lockout or suspended Medi-Cal for incarcerated juveniles) or Medication Support Services. Specifically, providers will use the following Non-Medi-Cal billable service codes to document services and receive credit for productivity:

- NMASMT: Assessment Not Billable
- NMPLDEV: Plan Development Not Billable
- NMIND: Individual Therapy Not Billable
- NMGRP: Group Therapy Not Billable
- NMCMB: Case Management Not Billable
- NMCOL: Collateral Not Billable
- NMMED: Medication Support Not Billable

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Service Lockouts for CYF:

1. Edgewood Crisis Stabilization Unit (CSU): This is a 23 hour stay and clinicians keep the case open for continuity in care. However, while the client is at the CSU, Edgewood bills the case through a crisis bundle. Therefore, outpatient mental health services are locked out while the client is in the CSU; with the exception of case management services. Case management may be billed and providers do NOT need to use the NM code. All other services must be captured with a NM code. Please note, the Short Doyle Medical (SDMC) maximum allowed service duration for Crisis Stabilization services is only 20 hours per day. Services with durations over 20 hours are denied by SDMC.

2. Medical Hospitalization: This is a short term stay and clinicians keep the case open for continuity in care. If your client is hospitalized within a medical hospital setting (e.g., pediatrics/ICU due to medical complications related to an eating disorder) you may bill medi-cal for any treatment/services provided within that setting (do not use NM codes). Please note, providers must use the correct Service Location code for these notes.

3. Psychiatric Hospitalization: This is a short term stay and clinicians keep the case open for continuity in care. If your client is hospitalized in a Fee-For-Service (FFS) Inpatient Psychiatric Hospital (e.g., St. Mary's Hospital) Medication Support and Case Management services are billable (no need to use NM code). If a client is in a SDMC Inpatient Psychiatric Hospital (i.e., SFGH or Out-of-County hospital), only Case Management for the purpose of placement within 30 days of discharge is billable (must use Avatar Service Code, IPT1017-Case Management). All other services must be billed with NM codes. For questions related to if a hospital is a FFS or SDMC, please contact David Sickles, RN: David.Sickles@sfdph.org.

4. Residential Treatment: This is typically a long term stay and clinicians close the case to defer to the higher level of care (it is suggested there is no more than two sessions from the outpatient provider once the client is in residential treatment). Any work for continuity in care (e.g., case management for transitioning into placement; medical management) can be billed to medi-cal (no need to use NM code). However, outpatient and residential providers must coordinate care to ensure they are not billing the same code on the same day.

Suspended Medi-Cal Settings for CYF:

1. Juvenile Probation Department / Youth Guidance Center: This is a short term placement where clinicians typically keep the case open for continuity in care. Youth who are detained within JPD are no longer medi-cal eligible, however. Therefore, any work within this setting (e.g., case management; individual therapy; consultation with providers at SPY) must be billed with a NM code.

2. Log Cabin Residential Treatment: This is a long term placement and providers typically close the case to defer to the higher level of care. Any work for continuity in care (e.g., case management for transitioning into placement) must be captured with a NM code.

Section 25: Non-Reimbursable Services

The following services are not reimbursable by Medi-Cal (Source: 9 CCR §1840.312):

1. Academic educational services.
2. Vocational services that have as a purpose actual work or work training.
3. Recreation.
4. Socialization if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of clients involved.
5. Services provided outside a person's scope of practice.
6. Services where there is no progress note for the service.
7. Services not covered by Short-Doyle Medi-Cal or provided to ineligible populations that are not Medi-Cal eligible (e.g. in Juvenile Justice Center or Jail).
8. Services provided during Medi-Cal lockouts (e.g. a client is receiving inpatient services at Zuckerberg San Francisco General Hospital and Trauma Center).
9. Services where documentation indicates a different service was provided than the service claimed.
10. Services already fully reimbursed by other health coverage (e.g. Kaiser).
11. Travel time where the time to travel from the office to the service location is not documented and no medical necessity is indicated for providing the service at a remote location (e.g. home or residential facility).
12. Services where the time claimed is greater than the time documented (e.g. time billed is greater than length of service documented in progress note).
13. Excessive, medically unnecessary or inappropriate services.
14. Representative payee related services.
15. Services where there is no signature of the person providing the service.
16. Solely transportation services or solely clerical services such as faxing, leaving a message, or filling out applications (e.g. SSI forms).
17. Supervision, scheduling appointments, preparing for groups, translation, reviewing client charts before a session, or administrative activities/forms associated with closing a client chart.
18. Housing needs (e.g. completing forms for housing).
19. Phone contacts among service providers that do not meet medical necessity.
20. Grocery store trips that do not include skill training.
21. No shows – missed visit/client not at home.

Section 26: Service Lockouts

Service lockouts are circumstances when Specialty Mental Health Services cannot be billed to Medi-Cal except under certain circumstances listed in the grid below.

Service	Specialty Mental Health Services Lockout Rules
Mental Health Services	• On days when Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services (e.g. Zuckerberg San Francisco General Hospital, or Psychiatric Health Facility Services (e.g. Langley Porter, McAuley are reimbursed (provided to a client) except on the day of admission to any of these facilities; • When provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive services are being provided; • When provided during the same time that Crisis Stabilization-Emergency Room or Urgent Care is provided with the exception of Targeted Case Management; and • Adult Residential Treatment may not bill the same staff's time under the two cost centers for Adult Residential and Mental Health Services for the same period of time.
Medication Support Services	• On days when Psychiatric Inpatient Services or Psychiatric Health Facility Services are reimbursed, except for the day of admission to either service; and • More than 4 hours per client in a 24-hour period.
Day Treatment Intensive	• When crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed, except for the day of admission to those services; and • Mental Health Services are not reimbursable when provided by Day Treatment Intensive staff during the same time period that Day Treatment Intensive services are being provided.

Service	Specialty Mental Health Services Lockout Rules
Day Rehabilitation	• When crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed, except for the day of admission to those services; and • Mental Health Services are not reimbursable when provided by Day Rehabilitation staff during the same time period that Day Rehabilitation services are being provided.
Crisis Intervention	• Days when Crisis Residential Treatment Services, Psychiatric Health Facilities Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services. • Crisis Intervention services that exceed 8 hours in a 24-hour period.
Crisis Stabilization	• On days when psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed, except on the day of admission to those services. • Crisis Stabilization services exceeding 20 hours in a 24-hour period.
Adult Residential Treatment	• When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission. • When an organizational provider of both Mental Health Services and Adult Residential Treatment Services allocates the same staff's time under the two cost centers of Mental Health Services and Adult Residential Treatment Services for the same period of time. • Adult Residential Treatment may not bill the same staff's time under the two cost centers for Adult Residential and Mental Health Services for the same period of time.

Service	Specialty Mental Health Services Lockout Rules
Crisis Residential Treatment	• Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission: o Mental Health Services; o Day Treatment Intensive; o Day Rehabilitation; o Psychiatric Inpatient Hospital Services; o Psychiatric Health Facility Services; o Psychiatric Nursing Facility Services; o Adult Residential Treatment Services; o Crisis Intervention; and o Crisis Stabilization.
Psychiatric Health Facility Services	• The following services are not reimbursable on days when Psychiatric Health Facility Services are reimbursed, except for day of admission to Psychiatric Health Facility Services: o Adult Residential Treatment Services; o Crisis Residential Treatment Services; o Crisis Intervention; o Day Treatment Intensive; o Day Rehabilitation; o Psychiatric Inpatient Hospital Services; o Medication Support Services; o Mental Health Services; o Crisis Stabilization; o Psychiatric Nursing Facility Services.

Service	Specialty Mental Health Services Lockout Rules
TCM	• Targeted Case Management are not reimbursable when the following services are reimbursed, except on the day of admission: o Psychiatric Inpatient Hospital Services (e.g. Zuckerberg San Francisco General Hospital); o Psychiatric Health Facility Services (e.g. Langley Porter, McAuley); o Psychiatric Nursing Facility Services (e.g. Skilled Nursing Facility); • Institution of Mental Diseases (e.g. Skilled Nursing Facility) except for clients under age 21 years old that are receiving services under the direction of a physician in a psychiatric hospital or facility (42 CFR 440.160) and clients aged 65 and older receiving inpatient hospital services, nursing facility services, and intermediate care facility services in institutions for mental diseases (42 CFR 440.140). • *Note: Targeted Case Management services are reimbursable when solely for the coordination of placement of a client or discharge from the hospital, psychiatric health facility or psychiatric nursing facility during the 30 calendar days immediately prior to the day of discharge for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility.*
TBS	• TBS is not reimbursable on days when Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission to the facility; • TBS is not reimbursable during the same time period that Crisis Stabilization is reimbursed by Medi-Cal. • The progress notes overall clearly indicate that TBS was provided solely for one of the following reasons: a) for the convenience of the family, caregivers, physician or teacher; b) to provide supervision or to ensure compliance with terms and conditions of probation; c) to ensure a child's or youth's physical safety or the safety of others (e.g. suicide watch); or d) to address conditions that are not part of the child's or youth's mental health condition. • The progress note clearly indicates that TBS was provided to a client in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential services (during Medi-Cal service lockouts).

DHCS' MHSD Medi-Cal Billing Manual (2013): Claim Limits & Lockouts

MHSD MEDI-CAL BILLING MANUAL

Chapter 7: Claim Limits and Special Conditions

Table 7-1: Multiple Services and Lockouts

HCPCS	H2015	H0046	H2013	H0018	H0019	H2012	H2012	H2012	H2012	T1017	T1017	H2015	H2019	H2010	H2011	S9484	H2015
CR Mode / SDMC Mode of Service	05 / 07-09	05 / 07-09	05 / 05	05 / 05	05 / 05	10 / 12, 18	10 / 12, 18	10 / 12, 18	10 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18
Service Function	10-18	19	20-29	40-49	65-79	81-84	85-89	31-34	35-59	01-06, 08-09	07	10-19, 30-56, 59	58	60-69	70-79	20-29	57
HCPCS/ Procedure Codes	Hospital Inpatient	Hospital Inpatient Admin Day (6)	PHF	Adult Crisis Residential	Adult Residential	Day Tx Intensive Half Day	Day Tx Intensive Full Day	Day Rehab Half Day	Day Rehab Full Day	CM / Brokerage (4)	ICC (4)	MHS (5)	TBS (5)	Med Support (1)	Crisis Intervention (2)	Crisis Stabilization ER & UC (3)	IHBS (5)
H2015 Hospital Inpatient	L	L	A	A	A	A	A	A	A	I	I	A	A	A	A	A	A
H0046 Hospital Inpatient Admin Day (6)	L	L	L	L	L	L	L	L	L	I	I	L	L	L	L	L	L
H2013 PHF	A	L	L	A	A	A	A	A	A	I	I	A	A	A	A	A	A
H0018 Adult Crisis Residential	A	L	A	L	A	A	A	A	A			A	A		A	A	A
H0019 Adult Residential	A	L	A	A	L							I	I			T	T
H2012 Day Treatment Intensive: Half Day	A	L	A	A		L	L	L	L			T	T			T	T
H2012 Day Treatment Intensive: Full Day	A	L	A	A		L	L	L	L			T	T			T	T
H2012 Day Rehabilitative: Half Day	A	L	A	A		L	L	L	L			T	T			T	T
H2012 Day Rehabilitative: Full Day	A	L	A	A		L	L	L	L			T	T			T	T
T1017 Case Mgmt/Brokerage (4)	I	I	I							O							
T1017 ICC (4)	I	I	I								O						
H2015 MHS (5)	A	L	A	A	I	T	T	T	T			O				T	
T2019 TBS (5)	A	L	A	A	I	T	T	T	T				O			T	
H2010 Medication Support (1)	A	L	A											O		T	
H2011 Crisis Intervention (2)	A	L	A	A											O	T	
S9484 Crisis Stabilization ER & UC(3)	A	L	A	A	T	T	T	T	T			T	T	T	T	T, O	T
H2015 IHBS (5)	A	L	A	A	T	T	T	T	T							T	O

I	Institutional Limitations: Audit
L	Lockout: Services that may not occur on the same day
A	Lockout: Except for day of admission and day of discharge
T	Lockout: During actual time service is provided – audit, not a computer edit
O	Override allowed for duplicate services with procedure modifier code
	Multiple services may be allowed on the same day, limited by the maximum time allowed.

(1) Maximum of 4 hours (240 Minutes) per day
(2) Maximum of 8 hours (480 minutes) per day
(3) Maximum of 20 hours per 24 hour period
(4) Maximum of 24 hours (1440 minutes) per day
(5) Maximum of 2878 minutes per day
(6) An Administrative Day may not be billed on the day of admission

Learn more about Lockouts!

Check out CDIP's "Service/Billing Lockouts" tool

Section 27: DHCS' Annual Review Protocol for SMHS—Highlights

Each September, DHCS publishes their "Annual Review Protocol for Specialty Mental Health Services and Other Funded Services" as an Enclosure to an Information Notice (DHCS Letters and Information Notices are the mechanism to update guidance and clarify MHP contract requirements). The Annual Review Protocol is used for chart auditing purposes by both State and local auditors.

You can access all of the DHCS Bulletins, Information Notices and Letters at http://www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx

Below, we have highlighted some of the major components of the Annual Review Protocol.

Protocol Element	Components of the Element
Medical Necessity	• Documentation supporting the current client diagnosis, impairment(s)/ condition(s,) and proposed/ actual intervention(s) must be found in the client record. • A connection must be documented between the functional impairment as it relates to a client's diagnosis and the service(s) provided. • Evidence must be included in the client record that the intervention(s) provided met the intervention criteria listed under "Criterion #3 – Intervention" (e.g. is expected to improve client functioning).
Assessment	• The client assessment must be completed or finalized. • The client assessment or other documents in the client record must contain all of the required elements.

Protocol Element	Components of the Element
Client Plan	• The client plan must contain all of the required elements. • The client plan must be completed. • The client plan must be signed (or the electronic equivalent) by the person providing the service or a person representing a team or program providing the service or a representative of the San Francisco Mental Health Plan or by a LPHA as a co-signer when signing staff require a LPHA co-signature to establish that services were provided under the direction of an approved category of staff. • The client plan must be updated at least annually and/or when there are significant changes in the client's condition (for TBS, the client plan is reviewed every 30 days); • There must be documentation that the client was offered a copy of the client plan. • There must be evidence of the client agreeing to or participating in the client plan. • The client plan must be signed by the client or client's legal representative when required. • There must be written documentation/explanation when the client refused to sign the client plan or was unavailable to sign the client plan. As stated in DHCS' MHSUDS Information Notice #17-040, "Although not required, it is best practice to make additional attempts to obtain the beneficiary's signature and document the attempts in the client record."
Progress Notes	• Progress notes must describe how a service reduced impairment, restored functioning, or prevented deterioration in an important areas of life functioning outlined in the client plan. • Progress notes must indicate the date of service, the amount of time, and client encounters including relevant clinical decisions, when decisions are made, and/or alternative approaches for future interventions. • The number of minutes a client participated in services must be documented. • Services must be finalized in a timely manner (e.g. within 5 days of service for mental health services). • The person providing the service must sign the progress note. • Evidence must support clients are receiving the services that are claimed.

Protocol Element	Components of the Element
Cultural and Linguistic Services	• There must be documentation in the client medical record that a client was made aware of the availability of oral language or sign interpreter services, when applicable. • There must be documentation in the client medical record that oral language or sign interpreter services were offered and provided to the client and an indication of the client's response (e.g. refusal of services or choice to use a family member or friend as an interpreter), when applicable. • There must be documentation in the client medical record that a client was linked to community interpreter resources when services were not available at the point of service, when applicable. • There must be evidence in the client medical record that a client who was visually impaired was offered treatment specific information in an alternative format, when applicable.
Medication Support Services	• The client record cannot contain an attestation by a clinician for medication consent in lieu of a client/legal representative signed medication consent form. • Medication consents must be specific for each medication prescribed.
Day Treatment Intensive & Rehab	• The service components for Day Treatment Intensive and Day Rehabilitation offered or provided must be by staff acting within their scope of practice. • Required staff must be present during services. • There must be documentation of client attendance (e.g. total number of minutes/hours a client actually attended the program). • There must be documentation in the client medical record of the reason a client was unavoidably absent and/or the total number of minutes/hours the client actually attended. • Service duration requirements were not met (for half day programs, a minimum of three hours of face-to-face service each day the program was open; for full-day programs, no less than 4 hours of face-to-face service each day the program was open).
TBS	• The TBS progress notes overall must clearly indicate that TBS was not provided solely for one of the following reasons: a) for the convenience of the family, caregivers, physician, or teacher; b) to provide supervision or to ensure compliance with terms and conditions of probation; c) to ensure the

Protocol Element	Components of the Element
	child's/youth's physical safety or the safety of others (e.g., suicide watch); or d) to address conditions that are not a part of the child's/youth's mental health condition. • The progress notes must clearly indicate that TBS was not provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility. • A plan for TBS must be documented.
Hospital Services	• The client must have a qualifying client diagnosis; • The client medical record must indicate why further psychiatric evaluation or medication treatment can only be provided in an inpatient psychiatric unit. • Documentation in the client medical record must support medical necessity criteria. • There must be documentation that mental health interpreter services in the client plan are being followed and the client medical record must indicate that mental health interpreter services are offered and the client's response to services must be documented. • There must be documentation in the client record that staff have screened, referred, or coordinated with other services the client needs and that other services contained in the client plan are being followed. • For clients requiring information in alternative formats (e.g. Braille, large print format), there must be documentation in the client medical record that clients receive information in the alternative format. • Correspondence must be in the client's preferred language. • The client medical record must document whether or not an advance directive has been executed by the client. • There must be a physician signature on the written client plan. • There must be documentation of a client plan being written by a physician prior to payment authorization approval by the utilization review committee or its designee. • There must be documentation of payment authorization by the hospital utilization review committee or its designee.

Protocol Element	Components of the Element
	• There must be documentation that a client was admitted to the hospital prior to the attending physician or staff physician writing a client plan of care.
ICC	• Medi-Cal cannot be reimbursed for Targeted Case Management when the following services are reimbursed, except on the day of admission: 1) Psychiatric Inpatient Hospital Services (e.g. Zuckerberg San Francisco General Hospital); 2) Psychiatric Health Facility Services (e.g. Langley Porter, McAuley); and 3) Psychiatric Nursing Facility Services (e.g. Skilled Nursing Facility); • Medi-Cal cannot be reimbursed for Targeted Case Management when services are reimbursed for an Institution of Mental Diseases (e.g. Skilled Nursing Facility) except for clients under age 21 years old that are receiving services under the direction of a physician in a psychiatric hospital or facility (42 CFR 440.160) and clients aged 65 and older receiving inpatient hospital services, nursing facility services, and intermediate care facility services in institutions for mental diseases (42 CFR 440.140); • TCM does not include and Medi-Cal cannot be reimbursed (42 CFR §441.169) when the TCM activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible client has been referred, including for foster care programs, services, such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(9)(c)); • Federal Financial Participation is available if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program, except for case management that is included in an individualized education program or individualized family service plan consistent with Sections 1902(a) (25) , 1905(c) and 1903(c) of the Social Security Act. • For members of the target group who are transitioning to a community setting, TCM services will be made available for up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days or less per hospitalization or inpatient stay prior to the discharge of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. • ICC may be provided solely for the purpose of coordinating placement of the child or youth on discharge from the hospital, psychiatric health facility, group home or psychiatric nursing facility, may

Protocol Element	Components of the Element
	be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning. • *Note: Service limitations and lockouts for Intensive Care Coordinator are equivalent to Targeted Case Management service limitations and lockouts.*
Intensive Home Based Services	• Mental health services (including IHBS) are not reimbursable when provided by day treatment intensive or day rehabilitation staff during the same time period that day treatment intensive or day rehabilitation services are being provided. Authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehabilitation services are provided. • IHBS may not be provided to children and youth in Group Homes. IHBS can be provided to children and youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits outside the Group Home setting. • Certain services may be part of the child or youth's course of treatment, but may not be provided during the same hours of the day that IHBS services are being provided to the child or youth. These services include: • Day Treatment Rehabilitative or Day Treatment Intensive; Group Therapy; TBS.

Section 28: Helpful Documentation Tips

Domain	Documentation Tip
Medical Necessity	Documenting your client's diagnosis is an important first step in the treatment process. It's equally important to document the relationship between the client's current, presenting behaviors and the ICD 10 diagnosis you have identified. Use the multiple sources of information available to you to make your diagnosis, from your client's own words and family members to other sources such as public systems that serve your client. Remember to always double check to make sure you have entered a client diagnosis in the medical record. If client diagnosis is not within your professional scope of practice, you cannot diagnose a client! When documenting proposed behavioral health interventions for the client plan, reflect on the reasons and aspects of your client's history and presenting/current problems that have resulted from his or her mental health disorder. What interventions are most likely to improve your client's functioning and why? What has worked or not worked in the past? Think of the clinical formulation process as the development of a mini client logic model or "your theory of change" for what would be most successful in improving the emotional wellness of your client. Medical necessity for proposed interventions is documented in the client plan, while medical necessity for actual interventions is supported through progress notes and other information contained in the client medical record. For example, if a qualifying diagnosis reflecting the client's current mental disorder or emotional disturbance is identified in the client medical record, a progress note does not need to duplicate/document Criterion #1: Diagnosis. Title 22 requirements referenced above generally require the same level of documentation as Title 9 services such as documenting that services are necessary to correct or improve mental disorders or emotional disturbances, are safe, are cost effective, and are not for the convenience of a client, family or service provider.

Domain	Documentation Tip
Client Assessment	In determining the annual anniversary date for a client reassessment: if the date a client was opened in Avatar on 2/1/2017, then the client anniversary date would be 2/1/2018. Licensed Professional Clinical Counselors (LPCC) are not permitted to assess or treat couples or families unless the LPCC has completed all of the required experience and course work on this subject (Source: CA Business and Professions Code §4999.20) which includes: 1) six semester/nine quarter units focused on theory; AND 2) no less than 500 hours of documented supervised experience working directly with couples, families, or children; AND 3) a minimum of six hours of continuing education specific to marriage and family therapy, completed in each license renewal cycle.
Client Plan	There must be written documentation/explanation when the client refused to sign the client plan or was unavailable to sign the client plan. As stated in DHCS' MHSUDS Information Notice #17-040, "Although not required, it is best practice to make additional attempts to obtain the beneficiary's signature and document the attempts in the client record. An outpatient mental health client with an admission date (the date opened in Avatar) of 2/1/2017 would have a client plan anniversary date of 2/1/2018.
Progress Notes	Avatar provides a report to allow staff to monitor whether all progress notes are finalized within five business days of the date a service was provided called the "Progress Notes in Draft Clinician" report. Progress notes should be brief, succinct, to the point, and avoid long narratives and lengthy descriptions. Progress notes should avoid jargon and use behaviorally specific descriptions.
Cultural and Linguistic Services	A refusal to accept interpreter services (client response) or client preference to use a family member or friend as the interpreter must be documented in the client medical record ***on every occasion!***

Domain	Documentation Tip
Rehabilitative Mental Health Services	If more than one staff person is claiming services, there must be documentation of each staff's contribution to the group. The difference between Collateral Family Counseling and Family Therapy is the focus of the treatment. The focus of Collateral Family Counseling is on the needs of the client in meeting the goals of the client plan, while the focus of Family Therapy is on the family system as a whole with attention to what goes on between individuals in the family rather than within one or more significant support persons. Contacts with significant support persons in the client's life must be directed exclusively to the mental health needs of the clients (Source: 9 CCR §1840.314). "Significant support person" means persons, in the opinion of the client or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to, the parents or legal guardian of a client who is a minor, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client (Source: 9 CCR 1810.246.1).
Medication Support Services	Even if no new medications are prescribed, medication consents for minors must be updated annually. There must be documentation in the client medical record that each of the elements of the consent form were discussed with the client; just checking boxes on a form is not sufficient.
Day Treatment Intensive	A weekly progress note summarizing the week's activities/interventions and client progress toward goals is still required if programs opt to use daily progress notes to document the dates of service during the week, the total duration the client was actually present each date of services, and the activities and interventions provided to the client.

Domain	Documentation Tip
Day Rehabilitation	Each date of service must be accounted for by the signature of a staff member who actually provided services on that date (i.e. more than one staff person may be required to sign the weekly progress note to cover all dates of service within the time period covered by the note). One staff signature is sufficient to cover multiple dates that staff provided services. While there is no State requirement to have sign-in sheets, sign-in sheets may be used to show evidence a client was present. If sign-in sheets are used, ensure that the date, client name, client/responsible adult signature or staff documentation for lack of signature, time of arrival, and staff name and signature/credentials verifying attendance. The presence of sign-in sheets does not negate the requirement for total duration of client presence within the program be documented on each daily progress note
Crisis Stabilization	Client time spent in the waiting room is not service time.
TCM	Monitoring does not include ongoing evaluation or check-in of an individual when all care plan goals have been met. Targeted Case Management is reimbursable when *solely* for the coordination of placement of a client on discharge from the hospital, psychiatric health facility or psychiatric nursing facility during the 30 calendar days immediately prior to the day of discharge for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility.
TBS	Start time is a required progress note element for TBS only.

Section 29: Reference Materials

The materials contained in Section 29 are summarized below:

#	Reference Name
A	ICD 10 Qualifying Mental Health Diagnoses (Info Notices #17-004, 1/26/2017 and #17-004E, 10/13/2017)
B	EPSDT Services & Supplemental Services (22 CCR § 51340)
C	P-I-R-P Format for BHS Progress Note
D	SFDPH-BHS Service and Staff Billing Privilege Matrix (Updated 7/1/2017)
E	DPH Service Definitions & Billing Codes Crosswalk
F	Policy 2.01-3 (Credentialing & Service/Billing Privileges in SMHS for MHRS & MHWs)
G	ICC, IHBS, TFC Resources
H	Memo (09/02/2016) Using the CBHS EHR to Track/Maintain Assessment/TPOC Timeliness (AOA version and CYF version)
I	Standard Abbreviations (from BHS Policy 3.10-11)
J	DHCS' Reasons for Recoupment for FY17-18 (Enclosure 4 from MHSUDS Info Notice# 17-050, published 9/29/2017)
K	Web-Based Resources

Reference A – ICD 10 Qualifying Mental Health Diagnoses (Info Notices #17-004, 1/26/2017 and #17-004E, 10/13/2017)

DHCS

JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

DATE: October 13, 2017

MHSUDS INFORMATION NOTICE NO.: 17-004E

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: INTERNATIONAL CLASSIFICATION OF DISEASES, TENTH REVISION (ICD-10) INCLUDED CODE SETS

REFERENCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES, CODE OF FEDERAL REGULATIONS, TITLE 45, SECTION 162.1002 (EFFECTIVE JANUARY 16, 2009)

The purpose of these errata to the Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 17-004 is to inform County Mental Health Plans about the ICD-10 diagnosis codes that are covered for specialty mental health inpatient and outpatient services effective October 1, 2017. This Information Notice updates and revises the ICD-10 diagnosis codes published as covered diagnoses for specialty mental health inpatient and outpatient services in previous MHSUDS Information Notices.[1] In addition, this Information Notice incorporates the Centers for Medicare and Medicaid Services annual update changes to ICD-10 diagnosis codes effective October 1, 2017, through September 30, 2018.

[1] MHSUDS Information Notices 15-030, 16-016, and 17-004.

Mental Health & Substance Use Disorder Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax: (916) 319-8219
Internet Address: www.dhcs.ca.gov

MHSUDS INFORMATION NOTICE NO.: 17-004E
October 13, 2017
Page 2

Enclosure 1 lists the ICD-10 diagnosis codes covered for specialty mental health **inpatient** services as of October 1, 2017. The table below indicates changes made to previously provided guidance.

CHANGES TO INCLUDED DIAGNOSES LIST FOR INPATIENT SERVICES

ICD-10 Diagnosis Code	Diagnosis Description	Change
F30		
F31		
F31		
F31		
F31		
F31		
F32		
F33		
F33		
F50		
F42.4	Excoriation Disorder	These 13 diagnosis codes, F42.4 through R15.9, and their corresponding diagnoses, were **OMITTED IN ERROR** from the inpatient list attached to MHSUDS Information Notice
F95.1	Chronic Motor or Vocal Tic Disorder	
F95.2	Tourette's Disorder	
F95.8	Other Tic Disorders	
F95.9	Tic Disorder, Unspecified	

THIS PAGE IS FOR INPATIENT HOSPITAL DIAGNOSES

F98.0	Enuresis Not Due to a Substance or Known Physiological Condition	17-004 and are **HEREBY REINSTATED**.
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition	
F98		
F98		
F98		
F98		
R15		
R15		
R69		
Z03.89	No Diagnosis	MHSUDS Information Notice 17-004 and are **HEREBY REINSTATED.** This diagnosis code and diagnosis should only be used when claiming for an assessment when that assessment resulted in no mental health diagnosis.

THIS PAGE IS FOR INPATIENT HOSPITAL DIAGNOSES

Enclosure 2 lists the ICD-10 diagnosis codes that are covered for specialty mental health **outpatient** services as of October 1, 2017. The table below indicates changes made to previously provided guidance.

MHSUDS INFORMATION NOTICE NO.: 17-004E
October 13, 2017
Page 4

CHANGES TO INCLUDED DIAGNOSES LIST FOR OUTPATIENT SERVICES

ICD-10 Diagnosis Code	Diagnosis Description	Change
F50.89	Other Specified Eating Disorder	This diagnosis code and its corresponding diagnosis were **CHANGED** to F50.82, Avoidant/Restrictive Food Intake Disorder, effective October 1, 2017.
F64.1	Dual Role Transvestism	This diagnosis code and its corresponding diagnosis were **CHANGED** to F64.0, Transsexualism, effective October 1, 2017.
F98.0	Enuresis Not Due to a Substance or Known Physiological Condition	These 15 diagnosis codes, F98.0 through R15.9, and their corresponding diagnoses, were **OMITTED IN ERROR** from the outpatient list attached to MHSUDS Information Notice 17-004 and are **HEREBY REINSTATED**.
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition	
F98.21	Rumination Disorder of Infancy	
F98.29	Other Feeding Disorders of Infancy and Early Childhood	
F98.3	Pica of Infancy and Childhood	
F98.4	Stereotyped Movement Disorder	
G21.0	Neuroleptic Malignant Syndrome	
G21.11	Neuroleptic-Induced Parkinsonism	
G24.4	Idiopathic Orofacial Dystonia	
G25.1	Drug-Induced Tremor	
G25.70	Drug-Induced Movement Disorder, Unspecified	
G25.71	Medication-Induced Acute Akathisia	
G25.9	Extrapyramidal and Movement Disorder, Unspecified	
R15.0	Incomplete Defecation	
R15.9	Full Incontinence of Feces	

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October 13, 2017
Page 5

ICD-10 Diagnosis Code	Diagnosis Description	Change
R69	Diagnosis Deferred	This diagnosis code and its corresponding diagnosis were **OMITTED IN ERROR** from the outpatient list attached to MHSUDS Information Notice 17-004 and are **HEREBY REINSTATED.** This diagnosis code and diagnosis should only be used when claiming for services provided during the assessment period when no diagnosis has as been assigned.
Z03.89	No Diagnosis	This diagnosis code and its corresponding diagnosis were **OMITTED IN ERROR** from the outpatient list attached to MHSUDS Information Notice 17-004 and are **HEREBY REINSTATED.** This diagnosis code and diagnosis should only be used when claiming for an assessment when that assessment resulted in no mental health diagnosis.

Questions regarding the content of this MHSUDS Information Notice or its enclosures may be directed to the DHCS Mental Health Services Division, County Support Unit Liaison for your county. A current list of county assignments can be found at http://www.dhcs.ca.gov/services/MH/Pages/CountySupportUnit.aspx.

Sincerely,

Original signed by

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health & Substance Use Disorder Services

Enclosures

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: January 26, 2017

MHSUDS INFORMATION NOTICE NO.: 17-004

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.

SUBJECT: INTERNATIONAL CLASSIFICATION OF DISEASES, TENTH REVISION (ICD-10) INCLUDED CODE SETS

REFERENCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES, CODE OF FEDERAL REGULATIONS, TITLE 45, SECTION 162.1002 (EFFECTIVE JANUARY 16, 2009)

SUPERCEDES: MHSUDS INFORMATION NOTICE 15-030

The purpose of this Information Notice is to inform County Mental Health Plans about the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes that are covered for specialty mental health inpatient and outpatient services effective October 1, 2016. The list of ICD-10 covered diagnoses have been updated. First, the Centers for Medicare and Medicaid Services (CMS) released an updated list of ICD-10 diagnosis codes that are effective October 1, 2016. Some of the ICD-10 diagnosis codes that the Department of Health Care Services (DHCS) published as covered diagnoses for specialty mental health inpatient and outpatient services in the Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 15-030 have been removed and new diagnosis codes have been added. Second, DHCS is adding ten diagnosis codes to the existing list of covered diagnoses. This Information Notice contains two enclosures that display the covered diagnoses for specialty mental health inpatient and outpatient services.

Mental Health & Substance Use Disorder Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax: (916) 319-8219
Internet Address: www.dhcs.ca.gov

Enclosure 1 lists the ICD-10 diagnosis codes that are covered for specialty mental health inpatient services and are effective October 1, 2016. The following two ICD-10 diagnosis codes have been removed from the list of covered diagnoses for specialty mental health inpatient services:

- F34.8 (Other Persistent Mood (Affective) Disorders);
- F42 (Obsessive-Compulsive Disorder).

The following twelve diagnosis codes have been added to the list of covered diagnoses for specialty mental health inpatient services:

- F20.89 (Other Schizophrenia);
- F31.0 (Bipolar I Disorder, Single Manic Episode Without Psychotic Features, Unspecified);
- F34.81 (Disruptive Mood Dysregulation Disorder);
- F34.89 (Other Specified Persistent Mood Disorder);
- F42.2 (Mixed Obsessional Thoughts and Acts);
- F42.3. (Hoarding Disorder);
- F42.8 (Other Obsessive-Compulsive Disorder);
- F42.9 (Obsessive Compulsive Disorder, Unspecified);
- F43.29 (Adjustment Disorder with Other Symptoms);
- F50.81 (Binge Eating Disorder);
- F50.89 (Other Specified Eating Disorder);
- F91.8 (Other Conduct Disorder).

Enclosure 2 lists the ICD-10 diagnosis codes that are covered for specialty mental health outpatient services and are effective October 1, 2016. The following three diagnosis codes have been removed:

- F32.8 (Other Depressive Episodes);
- F34.8 (Other Persistent Mood (Affective) Disorder);
- F42 (Obsessive-Compulsive Disorder).

Diagnosis Code 64.1 was renamed from Gender Identity Disorder in Adolescence and Adulthood to Dual Role Transvestism.

The following seventeen diagnosis codes have been added to the list of covered diagnoses for specialty mental health outpatient services:

- F20.89 (Other Schizophrenia);
- F31.0 (Bipolar I Disorder, Single Manic Episode Without Psychotic Features, Unspecified);
- F32.89 (Other Specified Depressive Episodes);
- F34.81 (Disruptive Mood Dysregulation Disorder);

- F34.89 (Other Specified Persistent Mood Disorder);
- F42.2 (Mixed Obsessional Thoughts and Acts);
- F42.3 (Hoarding Disorder);
- F42.4 (Excoriation Disorder);
- F42.8 (Other Obsessive-Compulsive Disorder);
- F42.9 (Obsessive-Compulsive Disorder, Unspecified);
- F43.29 (Adjustment Disorder with Other Symptoms);
- F50.81 (Binge Eating Disorder);
- F50.89 (Other Specified Eating Disorder);
- F80.82 (Social (Pragmatic) Communication Disorder);
- F80.9 (Developmental Disorder of Speech and Language, Unspecified);
- F90.8 (Attention Deficit/Hyperactivity Disorder, Other Type);
- F91.8 (Other Conduct Disorder).

Questions regarding the content of this Information Notice or its enclosure may be directed to the Mental Health Services Division County Customer Services Section at MedCCC@dhcs.ca.gov or 916-650-6525.

Sincerely,

Original signed by

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health & Substance Use Disorder Services

Enclosures

SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES

Enclosure 2

ICD-10 COVERED DIAGNOSIS TABLE

Diagnosis Code	Description
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressv disord, single epsd, sev w/o psych features
F32.3	Major depressv disord, single epsd, severe with psych features
F32.4	Major depressv disorder, single episode, in partial remis
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other Specified Depressive Episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressv disorder, recurrent severe without psych features
F33.3	Major depressv disorder, recurrent, severe with psych symptoms
F33.40	Major depressive disorder, recurrent, in remission, unsp
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.0	Cyclothymic disorder
F34.1	Dysthymic disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F39	Unspecified Mood Disorder
F40.00	Agoraphobia, unspecified
F40.01	Agoraphobia with panic disorder
F40.02	Agoraphobia without panic disorder

SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES
ICD-10 COVERED DIAGNOSIS TABLE

Enclosure 2

Diagnosis Code	Description
F40.10	Social phobia, unspecified
F40.11	Social phobia, generalized
F40.210	Arachnophobia
F40.218	Other animal type phobia
F40.220	Fear of thunderstorms
F40.228	Other natural environment type phobia
F40.230	Fear of blood
F40.231	Fear of injections and transfusions
F40.232	Fear of other medical care
F40.233	Fear of injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of bridges
F40.243	Fear of flying
F40.248	Other situational type phobia
F40.290	Androphobia
F40.291	Gynephobia
F40.298	Other specified phobia
F40.8	Other phobic anxiety disorders
F41.0	Panic disorder without agoraphobia
F41.1	Generalized anxiety disorder
F41.3	Other mixed anxiety disorders
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-compulsive Disorder, Unspecified
F43.0	Acute stress reaction
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F43.20	Adjustment disorder, unspecified
F43.21	Adjustment disorder with depressed mood
F43.22	Adjustment disorder with anxiety
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F43.24	Adjustment disorder with disturbance of conduct
F43.25	Adjustment disorder w mixed disturb of emotions and conduct

SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES
ICD-10 COVERED DIAGNOSIS TABLE

Enclosure 2

Diagnosis Code	Description
F43.29	Adjustment Disorder with Other Symptoms
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.4	Conversion disorder with motor symptom or deficit
F44.5	Conversion disorder with seizures or convulsions
F44.6	Conversion disorder with sensory symptom or deficit
F44.7	Conversion disorder with mixed symptom presentation
F44.81	Dissociative identity disorder
F44.9	Dissociative and conversion disorder, unspecified
F45.0	Somatization disorder
F45.1	Undifferentiated somatoform disorder
F45.22	Body dysmorphic disorder
F45.41	Pain disorder exclusively related to psychological factors
F45.42	Pain disorder with related psychological factors
F45.8	Other somatoform disorders
F45.8	Other somatoform disorders
F48.1	Depersonalization-derealization syndrome
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.81	Binge Eating Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating disorder, unspecified
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.9	Personality disorder, unspecified
F63.0	Pathological gambling

SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES
ICD-10 COVERED DIAGNOSIS TABLE

Enclosure 2

Diagnosis Code	Description
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania
F63.81	Intermittent explosive disorder
F63.9	Impulse disorder, unspecified
F64.1	Dual Role Transvestism
F64.2	Gender identity disorder of childhood
F64.9	Gender identity disorder, unspecified
F65.0	Fetishism
F65.1	Transvestic fetishism
F65.2	Exhibitionism
F65.3	Voyeurism
F65.4	Pedophilia
F65.50	Sadomasochism, unspecified
F65.51	Sexual masochism
F65.52	Sexual sadism
F65.81	Frotteurism
F65.9	Paraphilia, unspecified
F68.10	Factitious disorder, unspecified
F68.11	Factitious disorder with predominantly psychological signs and symptoms
F68.12	Factitious disorder with predominantly physical signs and symptoms
F68.13	Factitious disorder with combined psychological and physical signs and symptoms
F80.82	Social (Pragmatic) Communication Disorder
F80.9	Developmental Disorder of Speech and Language, Unspecified
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified
F90.0	Attention-deficit/hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit/hyperactivity disorder, Predominantly Hyperactive Type

SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES
ICD-10 COVERED DIAGNOSIS TABLE

Enclosure 2

Diagnosis Code	Description
F90.2	Attention-deficit/hyperactivity disorder, combined type
F90.8	Attention Deficity/Hyperactivity Disorder, Other Type
F90.9	Attention-deficit/hyperactivity disorder, Unspecified Type
F91.1	Conduct disorder, childhood-onset type
F91.2	Conduct disorder, adolescent-onset type
F91.3	Oppositional defiant disorder
F91.8	Other Conduct Disorder
F91.9	Conduct disorder, unspecified
F93.0	Separation anxiety disorder of childhood
F93.8	Other childhood emotional disorders
F93.9	Childhood emotional disorder, unspecified
F94.0	Selective mutism
F94.1	Reactive attachment disorder of childhood

Page 7 of 7

Reference B : EPSDT Services & Supplemental Services (22 CCR § 51340)

CCR Title 22, § 51340. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services.

(a) EPSDT screening services as defined in Section 51184(a)(1) are a program benefit when provided through the Child Health and Disability Prevention program in accordance with Title 17, California Code of Regulations, Sections 6800 et seq. EPSDT screening services as defined in Sections 51184(a)(2) and (a)(3) are covered when provided by a certified Medi-Cal provider meeting the requirements of this chapter, if such services are otherwise reimbursable under the program.

(b) EPSDT diagnosis and treatment services as defined in Section 51184(b) are covered subject to the provisions of this chapter.

(c) Unless otherwise specified in this Chapter, EPSDT supplemental services are covered subject to prior authorization if the requirements of subsections (e) or (f), as appropriate, are met. The Department shall review requests for services resulting from EPSDT screening services for compliance with this section whether the screen was performed by a Medi-Cal provider or a non-Medi-Cal provider.

(d) Requests for prior authorization for EPSDT supplemental services pursuant to subsection (c) shall state explicitly that the request is for EPSDT supplemental services, and shall be accompanied by the following information:

(1) The principal diagnosis and significant associated diagnoses.

(2) Prognosis.

(3) Date of onset of the illness or condition, and etiology if known.

(4) Clinical significance or functional impairment caused by the illness or condition.

(5) Specific types of services to be rendered by each discipline with physician's prescription where applicable.

(6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.

(7) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care.

(8) Any other documentation available which may assist the Department in making the determinations required by this section.

(e) EPSDT supplemental services must meet one of the following standards, as determined by the Department:

(1) The standards and requirements set forth in Sections 51003 and 51303, and any specific requirements applicable to a specific service that are based on the standards and requirements of those sections other than the service-specific requirements set forth in Section 51340.1.

(2) The service-specific requirements applicable to EPSDT Supplemental Services set forth in Section 51340.1.

(3) When the standards set forth in paragraph (e)(1) or (e)(2) are not applicable to the services being requested, all of the following criteria, where applicable:

(A) The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services as defined in subsection (a) of this section.

(B) The supplies, items, or equipment to be provided are medical in nature.

(C) The services are not requested solely for the convenience of the beneficiary, family, physician or another provider of services.

(D) The services are not unsafe for the individual EPSDT-eligible beneficiary, and are not experimental.

(E) The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary's appearance.

(F) Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

(G) The services to be provided:

1. Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence, consisting of well designed and well conducted investigations published in peer-review journals, and, when available, opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.

2. Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the beneficiary.

(H) The predicted beneficial outcome of the services outweighs potential harmful effects.

(I) Available scientific evidence, as described in paragraph (e)(3)(G)1., demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.

(f)(1) Notwithstanding subsection (e), EPSDT case management services as specified in paragraph (j)(3) may be covered for the EPSDT-eligible beneficiary when accompanied by the information described in subsection (d) if the Department determines that both of the following criteria are met:

(A) The service to which access is to be gained through case management is medically necessary for the EPSDT-eligible beneficiary. For purposes of this subsection, medical necessity is established if the service meets the criteria set forth in subsection (e)(1), (e)(2), or (e)(3).

(B) The EPSDT-eligible beneficiary has a medical or mental health condition or diagnosis.

(2) Requests for EPSDT case management services shall not be approved if the Department determines that EPSDT case management services appropriate to the EPSDT-eligible beneficiary's needs can reasonably be obtained through the use of family, agency, or institutional assistance that is typically used by the general public in assuring that children obtain necessary medical, social, educational, or other services. In making the determination described in this paragraph, the Department may take into account the following factors:

(A) Whether or not the beneficiary has a complicated medical condition, including a history of multiple or complex medical or mental health diagnoses, frequent recent hospitalizations, use of emergency rooms, or other indicators of medical or mental health conditions resulting in significant impairment.

(B) Whether or not the beneficiary has a history of one or more environmental risk factors, including:

1. parent, guardian, or primary care-giver mental retardation or mental illness, physical or sensory disability, substance abuse, under age 18 years, prolonged absence, or

2. other environmental stressors, which may result in neglect, abuse, lack of stable housing, or otherwise compromise the parent's, guardian's, or primary caregiver's ability to assist the beneficiary in gaining access to the necessary medical, social, educational, and other services.

(g) If reimbursement is being sought on a “by report” basis, a description of the service, the proposed unit of service, and the requested dollar amount shall be included with the request for authorization. A “by report” service or item is any service for which a maximum allowance has not been established because the item is rarely billed to the Medi-Cal program or because the service is unusual, variable or new.

(h) EPSDT supplemental services requested as a result of EPSDT screening services are exempt from the benefit limitations in Section 51304, and may be covered subject to prior authorization as defined in Section 51003 if the requirements of subsection (e) of this section are met.

(i) Regardless of the source of the referral for the service, requests for EPSDT diagnostic and treatment services and EPSDT supplemental services pursuant to the requirements of this chapter shall be reviewed pursuant to this section.

(j)(1) Requests for EPSDT case management services shall not be authorized where the Department has determined that appropriate case management services may be obtained through a targeted case management (TCM) provider under contract with a participating local governmental agency that has elected to provide case management services pursuant to Section 14132.44 of the Welfare and Institutions Code, or where TCM services are available pursuant to Section 14132.48 of the Welfare and Institutions Code.

(2) Where the Department determines that EPSDT case management services are not provided or available pursuant to paragraph (j)(1), requests for EPSDT case management services may be referred to the unit within the Department designated by the Director.

(3) Where the Department determines that EPSDT case management services are not provided or available pursuant to paragraph (j)(1) or (j)(2), the Department may authorize EPSDT case management services through an EPSDT case manager described in Section 51184(h)(4).

(k) For members of Medi-Cal managed care plans, the Medi-Cal managed care plan shall determine whether EPSDT case management services are medically necessary based on subsection (f). If the plan determines EPSDT case management services are medically necessary, the plan shall refer the members to an appropriate EPSDT case manager described in paragraph (h)(1) or (h)(2) of Section 51184. Services shall first be sought pursuant to paragraph (j)(1). If services are not available pursuant to paragraph (j)(1), the plan shall provide, or arrange and pay for, the EPSDT case management services. For purposes of this subsection, Medi-Cal managed care plan means any entity that has entered into a contract with the Department to provide, or arrange for, comprehensive health care to enrolled Medi-Cal beneficiaries pursuant to Chapter 8 or Articles 2.7, 2.8, 2.9 and 2.91 of Chapter 7 of Part 3, Division 9, of the Welfare and Institutions Code.

(l) The Department shall not approve an EPSDT supplemental service pursuant to this section if the Department determines that the service to be provided is accessible and available in an appropriate and timely manner as an EPSDT diagnostic and treatment service.

(m) The Department shall not approve a request for EPSDT diagnostic and treatment services or EPSDT supplemental services in home and community-based settings if the Department determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total costs incurred by the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

Reference C – P-I-R-P Format for BHS Progress Note

Problem This is the problem (from the treatment plan) that you focused on in the session.	**Intervention** This is the intervention (from the treatment plan) you provided in the session.	**Response** This is the response of the client to your intervention.	**Plan** These are the next steps of you and the client to achieve treatment plan goals.
When you document the "Problem," use a clear and complete notation or description regarding the client's current complaint(s), condition(s), assessment of client and/or reason(s) presented during the session. Use behavioral terms, and include an assessment of the client. This is not a statement of diagnosis but rather a statement of why this session is necessary. • Why this session is necessary? • Is progress being made? • Any remaining impairments? • Is the diagnosis still valid?	When you document the "Intervention," use descriptive sentence(s) about your interventions (i.e., what you did). Identify the skills used to cope-adapt-respond-problem solve. Reinforce new behaviors, strengths. Identify specific skills that are taught-modeled-practiced. The Interventions elements of the progress note shall describe the following: • Clinician's interventions • Clinician's assessment (including risk assessment when needed) • Document advice and recommendations given to client and family	When you document the "Response," use descriptive sentences about the client's response to the staff's intervention; describe the response to the intervention in behavioral terms and include the client's progress or lack of progress. Intermittently document the client's progress or lack of progress towards the Plan of Care goals. The Response may also include a description of other significant changes in client status. Any new assessment findings? If there is a lack of improvement: • Explain the reasons for lack of improvement • Obtain consultation, if needed, to verify the diagnosis or TPOC • Explain the need for additional treatment due to Medical Necessity • Include outcome measures in documentation, as appropriate.	When you document the "Plan," include the clinical decisions regarding the TPOC, 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. • Document if any new goals are needed • Document that the treatment goals remain appropriate or revise as needed • Consider treatment titration and plan for discharge

Reference D – SFDPH-BHS *Service and Staff Billing Privileges Matrix* (Updated 7/1/2017 for Peer Specialist)

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

SFDPH-BHS: Mental Health Staffing Qualifications for Service and Billing Privileges

Updated 07/01/2017-v2Peer

Name of Service	Licensed Practitioner of the Healing Arts (LPHA)								LPHA-Registered/Waivered					Non-LPHA Nurses, Psychiatric Technicians & Pharmacist				Mental Health Rehab Specialist (MHRS)	Mental Health Worker (MHW) and Peer Specialist	Graduate Students (Enrolled in School; Unlicensed)		
	MD	NP	CNS	LCSW	LMFT	LPCC	Licensed PhD	Licensed PsyD	ASW	MFTI	PCCI	Waivered PhD	Waivered PsyD	RN (BA or AA)	LVN	Psych Tech	Pharmacist			MSW Student	MA Counseling	Doctoral Psychology
Assessment	90792 Psychiatric Diagnostic w/Medical Service	90792 Psychiatric Diagnostic w/Medical Service	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	No Priv. *(see Exception in Notes field below)*	No Priv. *(see Exception in Notes field below)*	No Priv. *(see Exception in Notes field below)*	No Priv.	ASMT1 (Cannot establish Diagnosis; LPHA must co-sign)	No Priv.	ASMT1 (LPHA must co-sign)		
Plan Development	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	No Priv. *(see Exception in Notes field below)*	No Priv. *(see Exception in Notes field below)*	No Priv. *(see Exception in Notes field below)*	No Priv.	H0032 (LPHA must co-sign)	No Priv.	H0032 (LPHA must co-sign)		
Individual Psycho-therapy	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	INDTPY (LPHA must co-sign)		
Group Psycho-therapy	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	GRPTPY (LPHA must co-sign)		
Individual Rehabilitation	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	No Priv.	IREHAB	IREHAB (LPHA or MHRS must co-sign)	IREHAB (LPHA must co-sign)		
Group Rehabilitation	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	No Priv.	GREHAB	GREHAB (LPHA or MHRS must co-sign)	GREHAB (LPHA must co-sign)		
Collateral	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL (LPHA or MHRS must co-sign)	ICOLL (LPHA must co-sign)		
Targeted Case Management	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017 (LPHA or MHRS must co-sign)	T1017 (LPHA must co-sign)		
Crisis Intervention	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS (LPHA or MHRS must co-sign)	CRISIS (LPHA must co-sign)		
TBS Assessment; TBS Plan Development	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A (LPHA must co-sign)	H2019A (LPHA must co-sign)	H2019A (LPHA must co-sign)	No Priv.	H2019A (LPHA must co-sign)	No Priv.	H2019A (LPHA must co-sign)		
TBS Direct Service	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	No Priv.	H2019	No Priv.	H2019 (LPHA must co-sign)		
TBS Collateral	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	No Priv.	H2019C	No Priv.	H2019C (LPHA must co-sign)		
Medication Support	E/M Code or H0034, as appropriate	E/M Code or H0034, as appropriate	H0034	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	H0034	H0034	H0034	H0034	No Priv.	No Priv.	No Priv.		
Group Meds	GMEDS	GMEDS	GMEDS	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	GMEDS	GMEDS	GMEDS	GMEDS	No Priv.	No Priv.	No Priv.		

Notes: (1) No Priv. = staff member has no privileges to provide the service; (2) Exception for RN/LVN/PsychTech = if a staff member also meet MHRS criteria, then the staff may deliver assessment and plan development using same MHRS restrictions; (3) this version of the document (07/01/2017-v2Peer) introduced new information (added "Peer Specialist" and corrected "90792 Psychiatric Diagnostic"); (4) Staff Contact: SFDPH Compliance and Privacy Affairs Unit (415-255-3914)

2018-Service-Billing-Privileges-Matrix-PEER-Added-07-01-2017-v2.xlsx

Reference E – DPH Service Definitions & Billing Codes Crosswalk

This crosswalk is currently under revision (9/25/17).

Reference F – Policy 2.01-3 (Credentialing & Service/Billing Privileges in SMHS for MHRS & MHWs)

BHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor
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POLICY/PROCEDURE REGARDING: **Credentialing and Service/Billing Privileges in Specialty Mental Health Services for Mental Health Rehabilitation Specialists & Mental Health Workers**

Issued By: Kavoos Ghane Bassiri, LMFT, LPCC
Director of Behavioral Health Services

Effective Date: July 1, 2017

Manual Number:2.01-3

References: CCR Title 9, Chapter 11; CCR Title 9, §532.6, §630 and §1810.435; California State Plan Amendment 12-025; Mental Health Plan Implementation Plan (2017)

New Policy

This policy communicates an official change in the credentialing criteria for two categories of Specialty Mental Health Services (SMHS) providers in the CBHS Mental Health Plan (MHP): (a) Mental Health Rehabilitation Specialist (MHRS) and (b) Mental Health Worker (MHW; formerly known as "Mental Health Advocate").

Background

The establishment of provider selection criteria is a required activity of County MHPs (CCR, Title 9, §1810.435). MHPs are authorized to establish additional requirements "as part of a credentialing or other evaluation process" [§1810.435(b)(6)].

This memo clarifies and specifies the required credentials for MHRS and MHW (formerly, "Mental Health Advocate") that currently appear in the BHS Policy 6.00-01 (*CBHS Electronic Signatures*), Appendix 3 (*Staffing Qualifications for Service Delivery and Documentation)*.

Policy

BHS uses CCR Title 9 §630 criteria for credentialing MHRS staff and uses the State Plan Amendment (SPA # 12-025; "Qualification of Providers") for credentialing MHW staff. These definitions appear below. In instances where guidance/authority is vague, BHS provides clarification and specification to ensure providers meet compliance and quality standards.

> *Mental Health Rehabilitation Specialist: A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post associate arts clinical experience*

may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting (CCR, Title 9, §630).

Other Qualified Provider: An individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department (SPA # 12-025; "Qualification of Providers").

BHS Policy Clarification- MHRS Definition (CCR, Title 9, §630)

BHS clarifies the following:

1. The **Baccalaureate degree** described in §630 does not specify or limit the degree to a particular field, like psychology, or type, like a bachelor's of science.
    a. BHS adopts the same criteria and does not specify or limit the Baccalaureate degree.
2. The **four years of experience** described in §630 does not specify the type (paid vs. volunteer), amount (full time vs. part time) or tasks (working with clients vs. file clerk).
    a. BHS is obligated to verify candidates' education and professional experiences and thus, requires the following clarifications to §630:
        i. "*Experience*" is defined as verifiable experience, either paid/unpaid, including "practicum" experiences gained in professional training programs.
        ii. "*Experience*" is defined as full-time or full-time equivalence.
        iii. "*Specialist*" is defined as a role primarily working with/providing services to clients.
3. The **graduate professional education** which is substituted for experience (described in §630) does not specify a particular field or type.
    a. BHS clarifies that the requirement is graduate professional education in a clinical professional field: Social Work (MSW), Marriage Family Therapy (MFT), Clinical Counseling (LPCC), Psychology (PhD/PsyD), etc.
    b. BHS adopts the criteria of "up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis."
4. The **two years of post associate arts clinical experience** described in §630 requires a sequence where first, an Associate degree is obtained and second, clinical experience is obtained.
    a. BHS adopts the same criteria. Staff who have an Associate degree may substitute clinical experience (up to two years) accrued after the completion of the Associate.
    b. BHS requires the following clarifications to the "clinical experience"
        i. "*Experience*" is defined as verifiable experience, either paid/unpaid, including "practicum" experiences gained in professional training programs.
        ii. "*Experience*" is defined as full-time or full-time equivalence.
        iii. "*Clinical Experience*" is defined as a role primarily working with/providing services to clients.

5. The **Associate degree** described by DHCS[i] in its clarification of §630 does not specify or require a particular field, like psychology, or type, like an Associate of science.

    a. BHS adopts the same criteria. Staff may qualify for the MHRS criteria with an Associate degree;

BHS Policy Clarification-MHW Definition (SPA # 12-025; "Qualification of Providers")

BHS specifies the following:

1. **The "determined to be qualified"** language in SPA# 12-025 is not further defined.

    a. BHS clarifies that staff are "determined to be qualified" when the program provides and documents:
        i. a specific plan of supervision and
        ii. at least 20 hours of in-service training per year for the employee to ensure the ongoing qualifications of the individual to perform the job[ii].
    b. BHS will continue to specify the frequency, content and other details of the supervision and training requirements for MHW qualifications.

BHS Policy Clarification-Service, Billing & Documentation Privileges for MHRS and MHW

DPH Compliance & Privacy affairs publishes the *Mental Health Staffing Qualifications for Service and Billing Privileges* matrix and the document has been updated to reflect the information described in this Memo. The table below summarizes the core guidance for MHRS and MHW staff.

Domain	MHRS (within scope of practice)	MHW (within scope of practice)
Service/Billing Privileges	*INTENT: the educational and work requirements equip the MHRS staff to identify and intervene with a client's basic mental health needs and behaviors.* Assessment & Plan Development: MHRS staff have limited privileges. They may contribute through the collection of data, creation of documents, but LPHA staff signature is required for the Assessment and TPOC documents. Mental status examination and diagnosis is not in the scope of practice for an MHRS. Therapy: therapy is legally restricted to specific professions. MHRS staff are not permitted to deliver or bill for any type of psychotherapy; Collateral, Rehabilitation, Targeted Case Management: MHRS staff are permitted to provide these services; Crisis Intervention: MHRS staff are permitted to provide portions of this "bundled service" that are commensurate with their scope of practice, including 5150 detainment given staff/site certification. However, the formal lethality assessment activities (i.e., danger to self; danger to others) should be conducted by LPHA staff; Day Treatment (Rehabilitation, Intensive), Adult Residential, Crisis Residential & Crisis Stabilization-Urgent Care: MHRS staff may deliver this service.	*INTENT: MHW staff are equipped to implement activities under the direction of an MHRS and/or LPHA staff including: monitoring/supervising clients, basic behavioral interventions and skills development, service brokering/linking, and collection of basic, historical, non-clinical information for assessment and care planning;* Assessment & Plan Development: MHW staff are not permitted to conduct clinical behavioral health assessment and/or care planning activities. Mental status examination and diagnosis is not in the scope of practice for an MHW. Therapy: same as MHRS; Collateral, Rehabilitation, Targeted Case Management: When under the direction of an MHRS and/or LPHA staff, an MHW may provide these services; Crisis Intervention: When under the direction of an MHRS and/or LPHA, the MHW may deliver the non-clinical components of this service (e.g., monitoring behaviors for safety and 5150 detainment given staff/site certification); Day Treatment (Rehabilitation, Intensive), Adult Residential*, Crisis Residential* & Crisis Stabilization-Urgent Care: When under the direction of an MHRS and/or LPHA, the MHW may deliver this service.
Documentation Privileges in Outpatient Services	Documents/Forms: MHRS may create SMHS Assessment and TPOC document/form if a LPHA staff member signs the document/form; Progress notes when appropriately authored by an MHRS, progress notes do not require a signature by LPHA. This includes Assessment, Plan Development, Rehabilitation, Collateral, Targeted Case Management, Crisis Intervention, Day Treatment (Weekly Summary/Daily Note), Adult Residential (Weekly Summary), Crisis Residential (Daily Note), Crisis Stabilization (Daily Note, per hour of service).	Documents/Forms: MHWs are not permitted to create SMHS Assessment or TPOC documents/forms; Progress notes MHW staff work under the direction of an MHRS and/or LPHA and thus, must have the signature of the MHRS and/or LPHA who directs the services. This includes Rehabilitation, Collateral, Targeted Case Management, Crisis Intervention, Day Treatment (Weekly Summary/Daily Note), Adult Residential (Weekly Summary), Crisis Residential (Daily Note), Crisis Stabilization (Daily Note, per hour of service).

* If a non-hospital program provides 24-hour-based, bundled services, with an interdisciplinary team, then MHW staff can collect basic, historic client information that will contribute to the assessment and care planning processes. This practice standard is appropriate given the nature of this level of care and setting. However, the LPHA staff who finalizes the assessment and treatment plan of care documents is ultimately the responsible party, accountable for the contents & the processes through which the information was collected and documented.

BHS Tools & Technical Assistance:

1. Summary Table of MHRS Criteria (Title 9 & BHS)

Element of MHRS Criteria (from CCR, Title 9, §630 and/or DHCS)	Area Requiring Clarification	BHS Mental Health Plan (MHP) Clarification
Baccalaureate degree	§630 does not specify or limit the type/focus of the degree (e.g., BA vs. BS in Psychology vs. Sociology)	As with §630, BHS does not specify or limit the type/focus of the degree
Four years of experience	§630 does not specify the type, amount or tasks of "experience"	BHS must be able to verify education and experience—the following clarifications are made for "experience" and "specialist": • Paid or unpaid work • Full-time or FTE • Direct work with clients
Graduate professional education	§630 does not specify a particular field or type of education	BHS clarifies the following for "graduate professional education": • No requirement to have a degree conferred/granted; • Professional clinical service delivery education (e.g., social work, counseling, marriage/family therapy, clinical/counseling/school psychology, etc.).
Two years of post associate arts clinical experience	§630 requires a sequence for education/experience, but does not specify the type, amount or tasks of "experience"	As with §630, BHS requires a sequence for education (first) and experience (second). BHS clarifies "experience" as paid or unpaid work, full-time/FTE and direct work with clients
Associate degree	DHCS does not specify or limit the type/focus of the degree (e.g., AA vs. AS)	As with DHCS, BHS does not specify or limit the type/focus of the Associate degree

2. Frequently Asked Questions (FAQ) for MHRS/MHW: an initial list of questions and answers appears below.

Question about MRHS	Answer
Can the Bachelor's or Associate degree be in any area (e.g. Biology, Literature, etc.)?	Yes, the Bachelor's or Associate degree could be from any discipline. Title 9 does not specify the content area of the Bachelor's degree or Associate degree. Note, however, that BHS has specified the content area of professional graduate education.
Does it matter if the staff member accrued experience before obtaining a degree (or vice-versa)? Does the sequence of education and experience determine if a staff member can qualify?	Title 9 specifies one scenario where a sequence of events is required for qualification. Scenario: • Staff member only has an Associate degree • Staff has six or more years of experience Required Sequence of Events: • Staff member obtains Associate degree • Staff member accrues two years of experience after the degree;
Can you give an example of a staff member who does not qualify for the MHRS role because of the sequence of education?	Example: • Staff member obtained a high school diploma (age 20); • Staff member works in an adult residential treatment program for 20 years (age 40) • Staff member completes an Associate degree (age 42) • Staff member applies for MHRS criteria (age 42) The staff member cannot be credentialed because she/he/they need to obtain 2 years of work experience after the Associate degree. That means the staff member will be eligible for the MHRS credential after 2 years of work (i.e., at age 44)
Can you give an example of a staff member who does qualify for the MHRS role with an Associate degree and six years of experience?	Yes, if a staff member uses an Associate degree to qualify, then the following must be true: 1. The staff member has at least six years of experience 2. Two of the six years of experience must be accrued after the Associate degree was conferred 3. The remaining four years of experience could have been obtained before or after the date the Associate degree was conferred

Question about MRHS	Answer
If a staff member has a Bachelor's degree and 2 years of professional graduate education, how many years of experience are required to qualify as an MHRS?	A staff member who has a Bachelor's degree and two years of professional graduate education will meet MHRS criteria if they have 2 years of experience. Remember—a Bachelor's level staff person needs to have ***4*** years of experience, but Title 9 allows you to substitute graduate professional education. In this example 2 years experience + 2 years graduate education = ***4***
Regarding the experience requirement, will BHS follow Title 9 description (i.e., "fields of physical restoration, social adjustment, or vocational adjustment")	Yes, BHS accepts experience in the fields of physical restoration, social adjustment or vocational adjustment. Note, however, that BHS requires those experiences to be "primarily working with/providing services to clients." Example: Prior experience as a file clerk in a vocational rehabilitation program does not meet the BHS standard because the role is not directly providing services to clients. In contrast, providing vocational rehabilitation services to a client meets the BHS standard because of the client-level interaction and involvement.
Has the BHS credentialing form (*Certification and Verification for Staff ID: Attestation for Non-Licensed Staff*) been updated?	Yes, the *Certification and Verification for Staff ID: Attestation for Non-Licensed Staff* form has been updated to reflect these criteria.
Is it sufficient for a staff/program to simply attest that the criteria are met?	No, it is not sufficient to simply attest that the requirements are met. Programs and agencies must verify the staff member's education and experience prior to submitting the credentialing form to BHS. Programs and agencies must maintain this verification and documentation in the event of an audit or review. However, programs and agencies are not required to submit the verification information.
Will BHS provide additional information about the expectations for training and supervision of MHW staff?	BHS plans to provide further guidance on this and to identify basic standards & expectations for initial/ongoing training as well as supervision (in consultation with DHCS, as needed). However, it is the expectation & understanding that the training and supervision activities provided by each agency/organization, and/or obtained through other professional entities/institutions, would already be at the level to meet this general standard as well as be documented for review/verification.

[i] http://www.dhcs.ca.gov/services/MH/Pages/SMART-ScopeOfPracticeFAQs.aspx
[ii] Based on CCR Title 9 §532.6

Contact Person:

Director, Adult & Older-Adult System of Care

Director, Children, Youth and Families System of Care

Distribution:
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City and County of San Francisco
Office Of COMPLIANCE

1380 Howard St., 2nd Fl.
San Francisco, CA 94103

Certification and Verification for Staff ID

Attestation for Non-Licensed Staff

Legibly **PRINT OR TYPE** responses. Your request will **not** be processed without an NPI number, supporting documentation, and both staff and supervisor signatures. Please submit your request two (2) weeks in advance.
NO BILLING IS ALLOWED until verification and credentialing is finalized.
NO RETROACIVE BILLING WILL BE ALLOWED:

NEW REQUEST fax to: **IT Accounts Coordinator:** at 415-252-3008
UPDATE fax directly to: **DPH COMPLIANCE OFFICE** at 415- 252-3032

☐ New ☐ Update **Personal** Info ☐ Update **Program** Info

If updating information, please include your Staff ID #: _____ Date **of Hire:** _____

Personal Information:

Last: _____ First: _____ MI: ____ Suffix: _____ (Sr., Jr.)

SSN:_____-_____-_____ DOB: _____/_____/_____ Gender: _____ Ethnicity_____

NPI number: _____ **Taxonomy Code:** _____

Program Information : ☐**Mental Health** ☐**Substance Abuse**

Program Name: _____ RU/Program Code #_____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Agency Phone: _____ Agency Fax: _____

Languages (other than English)	Provide Services	Certified Interpreter

☐ **Peer Specialist:** ☐**Admin Staff:**

☐For **Mental Health Graduate Student Trainee** (e.g. individual participating in a field intern/trainee placement while enrolled in an accredited Masters in Social Work (MSW), Masters of Art (MA)/Masters of Science (MS) Counseling, PhD/PsyD training program.) *I attest that* _____ *(student) is a Graduate Student Trainee from* _____, *an accredited higher education institution, who began interning at our agency on* ____/____/____ *(date). Internship will expire on* ____/____/____

☐ **Mental Health Rehabilitation Specialist (MHRS) (see page 2 for full MHRS Criteria)**
I attest that _____ *(staff) meets the requirements for an MHRS because of one of the following situations.*
☐ Graduate professional education in a mental health field (who is NOT waivered/registered/licensed) *See Substitution **OR**
☐ Bachelor's Degree & four (4) years' experience in fields of physical restoration, social adjustment, or vocational adjustment **OR**
☐ Associate Arts Degree & six (6) years' experience in a appropriate setting (2 years of the 6 years must be post AA Degree)
[*for staff with an AA/BA/BS, but insufficient experience, substitute up to 2 years of graduate professional education (year for year) experience]

☐ **Mental Health Worker (MHW) (see page 2 for full MHW criteria)**
I attest that _____ *(staff) has graduated from High School or possess a GED. This staff person will be under my supervision and I will be responsible for oversight of their required clinical training and their clinical work at the agency.*

Substance Abuse Counselors who are not licensed, certified, or registered
Provide start date ____/____/____ *Staff/ trainee must obtain registration from a recognized accrediting body within six (6) months of their start date*

Signatures and Contact Information: (**by signing below you are attesting that all information provided is true and correct**)

Employee Signature: _____ Date: _____

Employee Phone: _____ Employee E-mail: _____

Supervisor Name: _____ Supervisor Signature: _____ Date: _____

Supervisor Phone: _____ Supervisor E-mail: _____

Other staff to be notified of employee's Staff ID# : _____ E-mail: _____

Revised: April 2017 **Effective 7/1/17** **Page 1 of 2**

City and County of San Francisco
Office Of COMPLIANCE

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San Francisco, CA 94103

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NO BILLING IS ALLOWED until verification and credentialing is finalized.
NO RETROACIVE BILLING WILL BE ALLOWED:

NEW REQUEST fax to: **IT Accounts Coordinator:** at 415-252-3008
UPDATE fax directly to: **DPH COMPLIANCE OFFICE** at 415- 252-3032

Mental Health Rehabilitation Specialist (MHRS) and Mental Health Worker (MHW) Definitions and Guidelines

MHRS Definition and Clarifications:

CCR Title 9 §630: A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two (2) years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two (2) years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four (4) years' experience in a mental health setting.

1. Educational Degree: Minimum education attainment is an Associate Degree (any type).

2. Experience: Defined as full-time equivalent, verifiable, either paid or unpaid, primarily working with/providing services to clients:
   a. If a staff member only has an Associate Degree, then six (6) years of experience are required.
      i. Two (2) years of the experience MUST have been accrued after obtaining the Associate Degree.
   b. If a staff member has a Bachelor's Degree, then four (4) years of experience are required.

3. Substitutions: A portion of the experience requirement can be met by substituting years of graduate professional education (defined as clinical professional education in MSW, MFT, PCC, PhD/PsyD).
   a. Up to two (2) years of experience can be substituted for education;
   b. The substitution of education for experience is done on a year-for-year basis

MHW Definition and Clarifications

1. State Plan Amendment # 12-025: An "Other Qualified Provider" is an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the County Mental Health Plan

2. Supervision Requirements: There must be a specific plan of supervision of the MHW's work activities by a License Practitioner of the Healing Arts (LPHA) and/or MHRS

3. Minimum Annual Training: There must be a specific plan of in-service training to the MHW totaling at least twenty (20) hours per year.

Reference G – ICC, IHBS, TFC Resources

ICC Service Component Examples

Assessing • Assessing client's and family's needs and strengths • Assessing the adequacy and availability of resources • Reviewing information from family and other sources • Evaluating effectiveness of previous interventions and activities	CFT members, including the TBS worker, teacher, coach, parents, older sister, Parent Partner and Youth Partner, discussed the circumstances and situations where John's physically aggressive behavior takes place at school, identifying potential environmental triggers, including adults physically leaning too close to help when he is struggling with school tasks. It is noted that John is much calmer when support comes in the form of reminders about steps he can take that have been pre-planned, and the adult is at least four feet away during the conversation
Service Planning/Implementation • Developing a plan with specific goals, activities and objectives • Ensuring the active participation of the client and individuals involved, and clarifying the roles of the individuals involved • Identifying the interventions/course of action targeted at the client's and family's assessed needs	The ICC coordinator, behavior specialist, John, John's parents, the child welfare worker, and the teacher's aide discussed potential strengths that could form the basis of positive intervention strategies that John can use to manage his anxiety when he is feeling stressed and frustrated by his school work: ➢ John can tell that he is getting frustrated before he lashes out; he is able to communicate his frustration to his teacher with an agreed upon signal. ➢ John can read and could use a list of reminders of what to do when he's frustrated. ➢ The teacher's aide in the classroom recognizes that, when John's leg jiggles fast, he is getting agitated. When the teacher's aide reminds John to breathe slowly, John does it and settles down. All present agreed that the behavior specialist will work with the teacher's aide to develop a list of coping strategies that John can use when he is becoming agitated. The teacher's aide will track the number of times that he notices John is agitated and how many of those times John is able to use his strategies to calm down. The CFT members will evaluate at the next CFT meeting.

Monitoring & Adapting • Monitoring to ensure that identified services and activities are progressing appropriately • Changing and redirecting actions targeted at the client's and family's assessed needs, not less than every 90 days	Discussed Susie's level of participation and progress at the Boys and Girls (B&G) Club for the past month; what she likes about going there; and what is not going as well. Susie reports that she likes the art activities, but that she does not want to go back because two girls are bullying her and calling her names. The ICC coordinator suggested strategies to increase support at the B&G Club to observe and coach Susie to respond to the girls and/or to talk to an adult. Susie agreed, so the client plan was refined and will be reviewed in two weeks. Assignment made to behavior specialist to support Susie on Tuesday and Thursday for the next month.
Transition • Developing a transition plan for the client and family to foster long-term stability, including the effective use of natural supports and community resources.	CFT participants, including the ICC coordinator, IHBS provider, Susie's parents, Susie, and Susie's teacher, reviewed the client's and family's gains and progress, along with their personal strengths and external resources, in order to better assist the client's transition away from formal supports. The CFT members identified the presence and effectiveness of their natural supports, which include Susie's church youth group, soccer team, and B&G Club leadership group, and address ways of maximizing community resources and activities in order to ensure long-term stability for Susie and her family.

Examples of ICC Documentation of Service Components and Activities

- Active Listening during a CFT Meeting

  Example 1: Clinician attends a CFT meeting and learns from the school counselor that Sam recently grabbed the arm of another student because he was not passing the ball to the client in P.E. class. Based on this shared information, clinician will work to develop and strengthen Sam's active problem-solving skills in order to help him consider alternative solutions to anger- provoking situations.

- Multiple staff during a CFT Meeting

  Example 2: During the CFT meeting, the client's IHBS worker learns from the ICC coordinator that Sam continues to display isolative behaviors during recess because his peers do not like how he acts (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let him play with them. The IHBS worker and ICC coordinator review with the family different interventions to apply. Based on this information and discussion, the IHBS worker will focus

interventions to strengthen Sam's pro-social behaviors while playing with peers by teaching, modeling, and reinforcing behaviors such as listening rather than interrupting, waiting his turn, playing more gently and appropriately, and initiating social interaction with peers. The IHBS worker and ICC coordinator each claim (to ICC) for the actual amount of time they each participated during the CFT meeting, including active listening time. Each staff may claim up to the length of the meeting plus documentation and travel time. Any participation time claimed, which may include active listening time, must be supported by documentation showing what information was shared and how it can/will be used in planning for client care or services to the client (i.e., how the information discussed will impact the Client Plan).

- Example 3: During the CFT meeting, the team discusses the effectiveness of various interventions intended to diminish Noah's isolative behaviors during recess at school. Noah's IHBS worker coaches Noah to talk about how he has been practicing to wait his turn, and otherwise actively listens and learns how things have been going for Noah from the perspective of his teacher and his mom. The ICC coordinator shared that information when she spoke to the recess monitor, and the recess monitor reported that Noah goes off by himself when his peers do not like how he acted (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let the client play with them. Mrs. T is upset because she feels that the school staff does not follow through with the support that they promised for Noah. The Parent Partner agrees to meet with her the following day and to help Mrs. T plan exactly what she would like the school staff to do, and how she will make that request. The IHBS worker and ICC coordinator review with the family the different interventions to apply and how they will keep track of Noah's progress. Based on this information and discussion, the IHBS worker will focus interventions to strengthen client's pro- social behaviors while playing with peers by: teaching, modeling and reinforcing behaviors such as listening, rather than interrupting; waiting his turn; playing more gently and appropriately; and initiating social interaction with peers.

Sample ICC Progress Note

APPENDIX D

SAMPLE PROGRESS NOTES

SAMPLE 1: ICC PROGRESS NOTE

Date: 01/10/17	Staff Service Duration: :40	Travel Durations: :15	Documentation: :09
Telephone Contact: ☐ Y ☒ N	Other Staff Duration: :40	Travel Durations: :15	Documentation: :00
Procedure Code:	T1017:HK		
Service:	Intensive Care Coordination		
Location of Service:	Client's Home		

Goal: John will increase replacement behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder to reduce client's kicking and punching siblings and peers, from 5x per day to 1x per week.

John reported no angry outbursts at school for the last 5 days. John has been playing basketball with peers after school. John also shared that he was invited to a classmate's birthday party on Saturday, and is looking forward to going to the party.

John's mother and grandmother reported his progress in self-regulation at home and school. With encouragement and prompting from his maternal grandmother, John is able to complete his homework and has been taking care of his hygiene. He has been taking his prescribed medications from his mother, without resistance. Mother is pleased with client's behavioral improvement.

Parent Partner informed team that Mrs. T continues to participate in school conferences and IEP meetings, which has helped Mother better understand the context of John's behavior. Parent Partner also reported fewer altercations between client and Mother, because of improved communication styles between the two. The ICC Coordinator led a discussion regarding potential of IHBS worker decreasing amount of sessions at the home, but continuing to reinforce anger management plan. John smiled at the idea of the IHBS worker coming less. When the ICC Coordinator prompted John to share why he was smiling, client stated "it makes me feel like I am getting better." Mother was supportive of the idea, but asked if the IHBS worker could still come every week. The IHBS worker shared that she thought working on other ways to express feelings might be helpful to the John and his family.

Parent Partner acknowledged Mother's appropriate communication skills, and discussed with Mother importance of consistency in dealing with John's outbursts. Parent Partner will assist Mother in developing a plan to support and recognize appropriate behavior and social interaction. IHBS worker will meet with John, reinforce his anger management plan, and teach alternative ways in expressing feelings.

Mrs. T. reported feeling much more confident in her own response when John is struggling and indicated that she understands the importance of her response to John in helping John to stay calm.

Signature & Discipline:	Date:	Co-signature & Discipline:	Date:

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Sample IHBS Progress Note

SAMPLE 2: IHBS PROGRESS NOTE

Date: 01/13/17	Staff Service Duration: :40	Travel Durations: :20	Documentation: :09
Telephone Contact: ☐ Y ☒ N	Other Staff Duration: :00	Travel Durations: :00	Documentation: :00
Procedure Code:	H2015:HK		
Service:	Intensive Home Based Services		
Location of Service:	Client's Home		

Goal: John will reduce aggressive behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder, including kicking and punching siblings, from 5x per day to 1x per week and will increase use of pro-social replacement behaviors.

IHBS worker met with Mother and Aunt to identify situations and triggers at home that contribute to client's angry outbursts. Family reported that client has been throwing tantrums, kicking and punching his siblings. When they start playing and teasing each other, John's behavior escalates and gets out of hand.

IHBS worker assessed home situation and assisted Mother in identifying situations that lead to John's angry outbursts. IHBS worker and family discussed alternative ways to deal with John's frustration, such as talking to client in a firm but calm tone of voice, and suggesting alternative options. IHBS worker also assisted Mother in gaining a better understanding of client's behavior, as well as the need to recognize the behavior she wants to see at least once every 5 minutes, from both boys, so that they know what they should do.

Also, John agreed that he will take a short client time out when becoming angry. If he becomes violent towards self/family members, he will go to his room for a 15-minute period to calm himself. IHBS worker will continue to assist Mother in identifying when the interaction is likely to become out of control, so that she can intervene early, as well as modeling appropriate responses to client's outbursts.

Signature & Discipline:	Date:	Co-signature & Discipline:	Date:

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TFC Service Model Sample Progress Note Template

APPENDIX E

TFC SERVICE MODEL SAMPLE PROGRESS NOTE TEMPLATE AND INSTRUCTIONS

TFC SERVICE MODEL SAMPLE PROGRESS NOTE TEMPLATE

Child's/Youth's Name and other required information

Service Date _____
1. Presentation *Observations of the child's/youth's behavior(s) for the day. Include the target behavior(s), as well as appropriate behaviors and interactions the child engaged in.*
2. Target behavior(s) *Behaviors identified in the client plan*
3. Intervention(s) utilized? *What strategies were used to address the target behavior, based on proposed interventions identified in the client plan?*
4. Childs response to intervention(s) *Was the intervention effective? How did the child/youth practice coping strategies? Did the child/youth remember coping strategies/think about the strategies before or after the behavior? Can the child/youth think of what could have gone better? Identify other coping solutions? How did the child/youth respond to strategies utilized?*

TFC Parent Signature/Date:	**LMHP/WRMHP Co-Signature/Date:**

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instructions for TFC Progress Note Template

INSTRUCTIONS FOR COMPLETING TFC SERVICES PROGRESS NOTE TEMPLATE

The Licensed Mental Health Professional (LMHP) or Waivered or Registered Mental Health Professional (WRMHP) directing the TFC parent(s) in providing this service should use this document to assist the TFC parent in completing the TFC Daily Progress Note. This document contains instructions, explanations, and examples that are intended to aid the TFC parent in completing a progress note that is in compliance with Medi-Cal documentation requirements.

I. **Service Date:** TFC Parent to provide the date that the service being claimed was performed.

II. **Client Plan:** Use the client plan developed with the CFT as a reference to identify the target behavior(s) and/or planned intervention(s).

III. **Progress Note:**

1. **Presentation**
   a. Brief narrative of how the child's/youth's day went.
   b. Include the target behavior(s), as well as appropriate behaviors and interactions the child/youth engaged in.
2. **Target behavior(s)**
   a. Identify the target behaviors identified in the client plan that the child/youth engaged in that day.
   b. Be specific
3. **Intervention(s) utilized**
   a. What strategies were used to prevent the target behavior, or promote the desired behavior, based on proposed interventions identified in the client plan?
   b. How did you respond when the child/youth engaged in the target behavior?
   c. How did you utilize interventions identified in the client plan?
4. **Child's response to the intervention**
   a. Describe how the child /youth reacted to your intervention? How did the child/youth respond to strategies utilized?
   b. How did the child/youth practice coping strategies? Did child/youth remember coping strategies/think about the strategies before or after the behavior?
   c. Can the child/youth think of what could have gone better? Identify other coping solutions?
   d. Describe whether the child's/youth's reaction was positive or negative. (Not all interventions will have the desired result). This helps guide future treatment planning and interventions.
   e. Include quotes from the child/youth, whenever possible.
5. **Signature/Date of TFC Parent and Co-Signature/Date of LMHP/WRMHP**

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Examples of potential target behaviors, including, but not limited to:

- Noncompliance with house rules
- Refusing to get out of bed
- Refusing to go to school
- Refusing to eat meals
- Interrupting—repeatedly cutting off foster mother as she tried to have a conversation with her friend

Examples of desirable behaviors, including, but not limited to:

- Child/youth does not throw tantrums
- Child/youth does not destroy property
- Child/youth follows instructions appropriately
- Child/youth used his/her coping skills to navigate a difficult issue

Possible ways to debrief with the child at the end of the day:

- Explore with the child/youth his/her response to the intervention(s) and if he/she found it helpful.
- Explore with the child/youth possible preferred parental approaches to target behaviors.
- Be mindful of the child's/youth's current mood state at the time of debriefing in order to have a successful interaction.

Reference H: Memo (09/02/2016) Using the CBHS EHR to Track/Maintain Assessment/TPOC Timeliness (*AOA version and CYF version*)

City and County of San Francisco
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San Francisco Health Network
1380 Howard Street, 5th Floor
San Francisco, CA 94103-2614
Phone: 415-255-3400; Fax: 415-255-3567

Edwin Lee
Mayor

MEMORANDUM

Date: September 2, 2016

To: Adult/ Older Adult System of Care Providers

From: Irene Sung, MD; Edwin Batongbacal, LCSW; Joe Turner, PhD

Re: Using the CBHS electronic health record (Avatar) to track and maintain Assessment and Treatment Plan of Care (TPOC) timeliness.

This Memo serves to clarify the DHCS and CBHS compliance and timeliness guidelines for the Assessment and Treatment Plan of Care (TPOC) for all providers of Medi-Cal funded Specialty Mental Health Services (SMHS). Providers should use the CBHS electronic health record (Avatar) as one method to ensure that Assessment and TPOC documents are completed on time.

Please review this document and attachments with your staff to ensure they understand and comply with the DHCS and CBHS documentation standards. Note that "Anniversary Date" as used here refers to the Anniversary Date of the client's Episode Opening.

Background: Per CBHS guidelines, all newly admitted clients must have both an Assessment and a TPOC finalized in Avatar (within 60 days of episode opening for Outpatient, but no later than the first planned service; within 72 hours for Residential). The annual Assessments and TPOCs must be finalized in Avatar by the Anniversary Date of the Episode Opening.

CBHS allows providers to finalize the annual Assessment and TPOC documents in Avatar up to 30 days in advance of the Anniversary Date (remember that these documents must reflect the client's current mental health needs and functional impairments). This enables providers to submit finalized documents to PURQC and receive treatment authorization by the Anniversary Date. An Assessment and/or TPOC that is finalized and appropriately signed within these 30 days is considered to be valid for the subsequent period.

In the rare situation when the annual Assessment and TPOC needs to be finalized in Avatar more than 30 days prior to the Anniversary Date, the provider must document the reason in the Assessment narrative and also in a progress note. But under no circumstances will the annual Assessment and TPOC be finalized in Avatar more than 60 days prior to the Anniversary Date.

CBHS' Core Criteria for Valid Assessments and TPOCs

Assessments and TPOCs are considered to be valid if all of the following are true:

1. The Assessment/TPOC has been finalized in Avatar in accordance with the specified guidelines and timelines for initial and annual Assessments and TPOCs;

2. The Licensed Practitioner of the Healing Arts (LPHA) staff on the case has appropriately signed and dated the Assessment and TPOC documents;

3. The client (or legal representative) has appropriately signed and dated the TPOC document;

4. If the client (or legal representative) has not yet signed the TPOC, the staff member documents the refusal/unavailability of the client and ongoing attempts to obtain the signature in a progress note(s). The staff member will write the date(s) of those progress note(s) on the TPOC in the field labelled "If no client signature, document reason in progress notes(s) dated."

CBHS is currently making enhancements to Avatar so that all Assessment and TPOC records are electronically signed when the staff member finalizes the document. This will involve the inclusion of a statement that appears in the clinician's signature line on the printed finalized Assessment and TPOC that the documents been electronically signed. This will also involve inserting a "Draft" into the signature line if a draft document is printed. Electronic signatures functionality is already in place for Progress Notes that are finalized in Avatar.

Avatar TPOC "Plan Effective Date" and "Plan End Date" Fields

- CBHS Standard: Providers will define the exact begin and end dates of a TPOC through the use of two date fields in Avatar: *Plan Effective Date* and *Plan End Date*. A TPOC record that has been appropriately finalized and meets all other DHCS and CBHS requirements will be considered valid for the period specified in *Plan Effective Date* and *Plan End Date* fields.

- Guidance:

    - Initial TPOC: for an initial TPOC, enter the Avatar expected finalized date into the "Plan Effective Date" and enter the annual Anniversary date into the "Plan End Date."
    - Annual TPOC: for an annual TPOC, enter the current Anniversary date into the "Plan Effective Date" and the next Anniversary date into the "Plan End Date." Appendix A provides examples as well as guidelines for problem scenarios.

Timelines for Draft and Final Annual Documents

- CBHS Standard: Assessments and TPOCs reflect the client's current mental, emotional or behavioral health, the current diagnosis and the current functional impairments.

- Guidance: To ensure that annual documents are completed on time and reflect the client's current status, providers must finalize the annual Assessment and TPOC documents in Avatar no later than the Anniversary Date, and no earlier than 30 days before the Anniversary date. Appendix A provides examples as well as guidelines for problem scenarios.

Other Dates Associated with the TPOC

- CBHS Standard: The Avatar fields labelled "Plan Effective Date" and "Plan End Date" define the TPOC coverage period. For an annual TPOC, the "Plan Effective Date" is the current Anniversary Date. CHBS allows staff to finalize annual documents 30 days before the Anniversary date (which means the date of finalization can be up to 30 days before the "Plan Effective Date") to ensure the PURQC review can be completed.

  Staff cannot create annual TPOC records where the finalized date is after the "Plan Effective Date" (e.g., I finalize the TPOC on Wednesday, but say it's effective on Monday). In the event the TPOC is finalized late (i.e., after the Anniversary Date), then Plan Effective Date that you enter for that late TPOC must be the expected date of finalization in Avatar.

  All other dates associated with the TPOC must be completed correctly.

- Guidance:

  - Avatar Finalized Date: the computer automatically assigns the date when a user saves the record as "final." This date cannot be changed. Logically, the TPOC finalized date must come before the Anniversary date, and before the client date of signature, etc.
  - Staff Signature Date: if a staff member provides a "wet" signature on the TPOC (i.e., using ink), they write the date of that signature.
  - Client Signature Date: when the client provides a "wet" signature on the TPOC, they write the date of that signature.

Appendix A: Examples and Guidance for Using CBHS' Electronic Health Record (Avatar) for Assessment and TPOC timeliness

1. Screenshots for using Avatar's TPOC "Plan Effective Date" and "Plan End Date" Fields:

*Figure 1: **Initial** TPOC for Example Client (Episode Opening on 7/1/2016)*

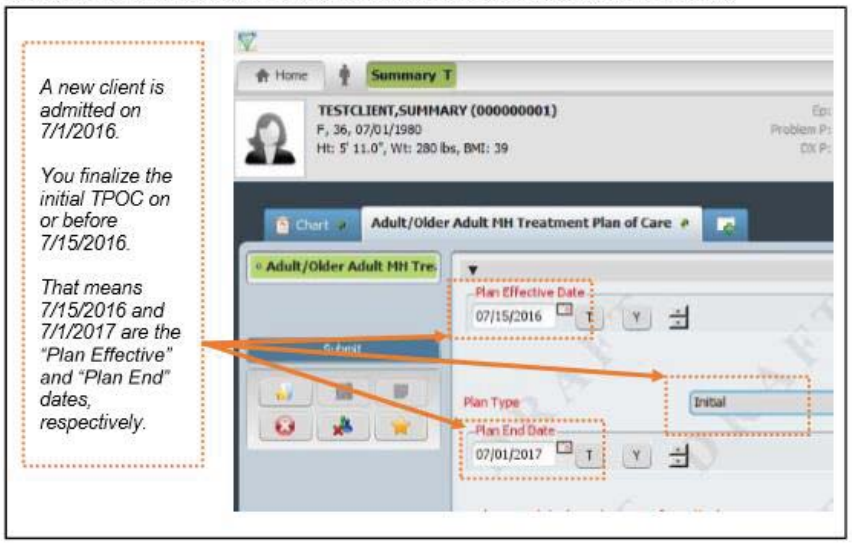
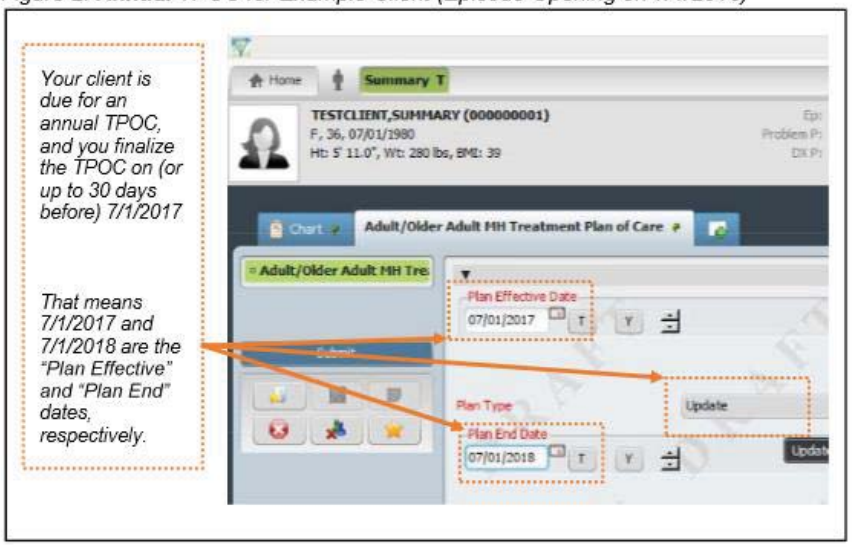


*Figure 2: **Annual** TPOC for Example Client (Episode Opening on 7/1/2016)*



Page 4 (CBHS Memo-09/02/16-Assessment & TPOC Timeliness)

2. Flowchart for Aligning Episode Opening Anniversary Date and Annual Assessments/TPOC:

Figure 2: Four Years of Assessment and TPOC Cycles (Episode Opening on 7/1/2016)

YEAR #1: 7/1/16 to 7/1/17	**YEAR #2:** 7/1/17 to 7/1/18	**YEAR #3:** 7/1/18 to 7/1/19	**YEAR #4:** 7/1/19 to 7/1/20
Initial Assessment:	**Annual Assessment:**	**Annual Assessment:**	**Annual Assessment:**
Finalized on 7/15/2016	*Finalized on 6/6/2017*	*Finalized on 6/18/2018*	*Finalized on 6/25/2019*
Expires on 7/1/2017	*Expires on 7/1/2018*	*Expires on 7/1/2019*	*Expires on 7/1/2020*
Initial TPOC:	**Annual TPOC:**	**Annual TPOC:**	**Annual TPOC:**
Finalized on 7/20/2016	*Finalized on 6/20/2017*	*Finalized on 6/19/2018*	*Finalized on 6/25/2019*
Expires on 7/1/2017	*Expires on 7/1/2018*	*Expires on 7/1/2019*	*Expires on 7/1/2020*

3. Troubleshooting Problem Scenarios:

Problem Scenario	Troubleshooting to Maintain Compliance
I did not complete my annual TPOC on time—it was due on 7/1/16, but I didn't complete it until 7/15/16.	If the annual TPOC is due on 7/1/16, but you did not complete it until July 15th, then you should immediately create a TPOC and use that day as the "Plan Effective Date" and 7/1/17 as the Plan End date. You cannot backdate the Effective date. You must have a LPHA and client signature with dates on the TPOC.
I never obtained a client signature **&/or** there is no documentation of my attempts to obtain the client signature.	If you did not obtain the client signature or clearly document your attempts to obtain the signature, then the TPOC is not valid. You must create a valid TPOC with the correct Plan Effective and Plan End Dates (remember, you cannot change the "Effective Date" after you save the record in draft status). You must have a LPHA and client signature with dates on the TPOC.
I need to finalize my annual Assessment and/or TPOC earlier than 30 days before the Anniversary date.	If there is a specific reason (e.g., client is incarcerated), then you should document the reason (both in the Assessment narrative as well as a progress note) why you need to finalize the annual documents earlier than 30 days before the Anniversary date. You are not permitted to finalize your annual Assessment TPOC process earlier than 60 days before the Anniversary date.
I forgot to finalize the TPOC in Avatar and I've been working off a draft record.	If you did not finalize the TPOC record in Avatar, then the TPOC is not valid. At a minimum, you must create and finalize a new TPOC, data-entering as the correct "Plan Effective Date" the date you expect to finalize the TPOC. (Remember, you cannot change the "Effective Date" after you save the record in draft status). You must have a LPHA and client signature with dates on the TPOC.
There is a clinical crisis and I need to create a new TPOC before the Anniversary date.	DHCS states that TPOCs are "updated at least annually and/or when there are significant changes in the beneficiary's condition." In this type of situation, you would create and finalize a new TPOC record to address the clinical crisis. The Plan Effective date would be the expected finalized date, and the Plan End date would still be the Anniversary date of the Episode Opening. You must have a LPHA and client signature with dates on the TPOC.
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To: Child, Youth and Family System of Care Providers

From: Irene Sung, MD; Kenneth Epstein, LCSW, PhD; Joe Turner, PhD

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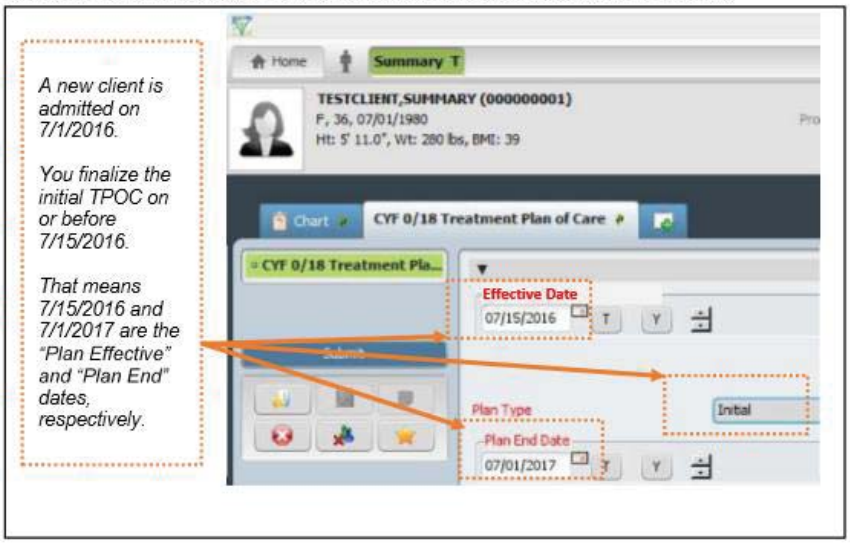

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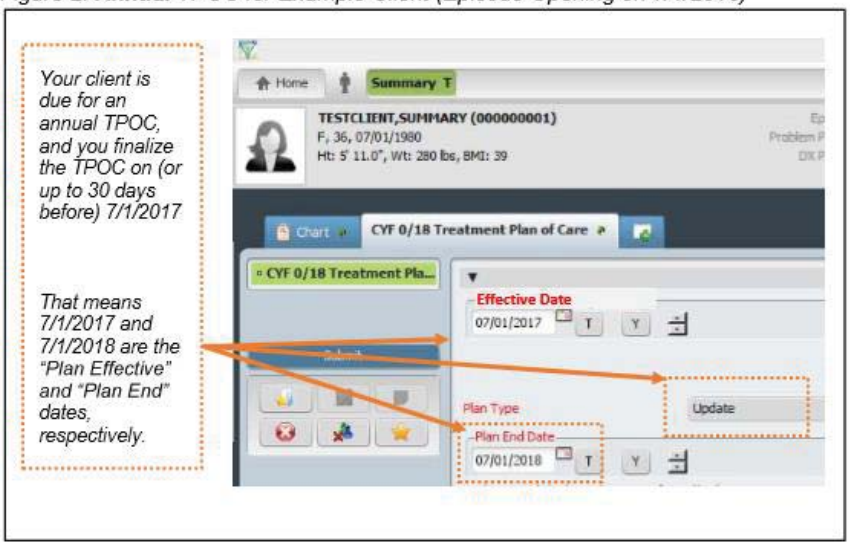

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Reference I: Standardized Abbreviations (from BHS Policy 3.10-11)

Attachment 1

Community Behavioral Health Services
Standardized Abbreviations

Abbreviation	Definition
24/7	24 Hours A Day/Seven Days A Week
Ā	
ā	Before
@	At
A/H	Auditory Hallucinations
A/O	Alert & Oriented
AA	Alcoholics Anonymous
ABD	Abdomen
ACT	Assertive Community Treatment Team
AD	Alzheimer's disease
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
ADM	Admission
ADP	California State Office of Alcohol and Drug Programs
ADU	Acute Diversion Unit
ADMIN	Administrative
ADOL	Adolescent
ADV DIR	Advance Directive
AIDS	Acquired Immune Deficiency Syndrome
AKA	Also Known As
ALOC	Altered Level Of Consciousness
AM	Morning
AMA	Against Medical Advice or American Medical Association
AMPHET	Amphetamines
AMS	Acute Mental Status (on emergency room records)
AMT.	Amount
ANSA	Adult Needs and Strength Assessment
A/OA	Adult/Older Adult Services
AOD	Alcohol and Other Drugs
A/P	Assessment / Plan
APA	American Psychiatric Association
APP	Aid Paid Pending
APPROP	Appropriate(ly)
APPT	Appointment
APROX	Approximate(ly)
APS	Adult Protective Service

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ASA	Aspirin
ASAM	American Society of Addiction Medicine
ASAP	As Soon As Possible
ASI	Addiction Severity Index
ASSESS	Assessment
ASW	Associate of Social Work (registered with Board)
ATOD	Alcohol, Tobacco, and Other Drugs
ATTN	Attention:
AVG	Average
Ax	Auxiliary
AWOL	Absence With Out Leave
B	
BA	Bachelor of Arts
BAC	Blood Alcohol Content
B&B	Bowel & Bladder
B&C	Board & Care
BDI	Beck Depression Inventory
BDZ	Benzodiazepine
BEH	Behavior
BF	Boyfriend
BHAC	Behavioral Health Access Center
BHBIS	Behavioral Health Billing Information Systems
BHVP	Bayview Hunters Point Mental Health
BIB	Brought in By
BIBA	Brought In By Ambulance
bid	Twice a day
Bipolar	Bipolar Affective Disorder
BM	Bowel Movement
BOCC	Business Office Contract Compliance
BP	Blood Pressure
BPD	Borderline Personality Disorder
bro	Brother
b/t	Between
Bup	Buprenorphine
Bup/nx	Buprenorphine/Naloxone (Subonoxe)
BX	Behavior
C	
$\overline{c}$	with
C/O	Complains of
CA	Cancer
CAADAC	California Association of Alcoholism and Drug Abuse Counselors
CAAP	County Adult Assistance Program
CAADE	California Association of Alcohol and Drug Educators
CAD	Coronary Artery Disease

CADC I / II	Certified Alcohol and Drug Counselor
CADE	Certified Alcohol and Drug Educator
CAFAS	Child and Adolescent Functional Assessment Scale
CAGE	Alcoholism Screening Tool
CalOMS	California Outcome Measurement System
CANS	Children and Adolescent Needs and Strengths Assessment
CAP	Capsule
CAUC	Caucasian
CBC	Complete Blood Count
CBHS	Community Behavioral Health Services
CBO	Community Based Organization
CBT	Cognitive Behavioral Therapy
CBZ	Carbamazepine
CCBADC	California Certification Board of Alcohol and Drug Counselors
CCDC	Chinatown Child Development Center
CCISC	Comprehensive, Continuous, Integrated System of Care
CCS	Comprehensive Crisis Services (umbrella organization for Child Crisis, Crisis Response, and Mobile Crisis)
CCSF	City and County of San Francisco
CD	Chemical Dependency
CDC	Center for Disease Control
CDTA	Contract Development and Technical Assistance
CDTA PM	Contract Development and Technical Assistance Program Manager
CERT	Certification
CHEMO	Chemotherapy
CHF	Congestive Heart Failure
CHP	Community Health Programs
CHN	Community Health Network
CIGS	Cigarettes
CIR	Critical Incident Review
CIWA	Clinical Institute Withdrawal Assessment
CLT	Client
CM	Case management
CMS	Center for Medicare & Medicaid Services
CNS	Central Nervous System
CP	Community Programs
CTF	Community Treatment Facility
CTNB	Chinatown North Beach
COD	Co Occurring Disorders
COLL	Collateral

COMPASS	Co-Morbidity Program Audit Self-Survey
CONC	Concentrate
CONS	Conserved / Conservatorship
CON REP PROG	Conditional Release Program
cont.	Continuously
COORD	Coordinate
COPD	Chronic Obstructive Pulmonary Disease
COPE	Centralized Opiate Placement Evaluation
CORRESP	Correspondence
CPR	Cardiopulmonary Resuscitation
CPS	Children Protective Services
CPT	Current Procedural Terminology Code (billing)
CQI	Continuous Quality Improvement
CRDC	Cost Report Data Collection
Crisis Res.	Crisis Residential
CRS	Crisis Response Service
CRT	Crisis Resolution Team
CRAFFT	Substance Abuse Screening Tool For Child And Youth
CSA	Client Service Authorization
CSAT	Center for Substance Abuse Treatment
CSI	Computerized Screening Incorporated
CSOC	Children's System of Care
CSU	Crisis Stabilization Unit
CT or CAT	Computerized Tomography
CVA	Cerebrovascular Accident
CWW	Child Welfare Worker
Cx	Crisis
CXR	Chest X-Ray
CYF	Child, Youth, and Family
D	
DA	Dopamine
DAU / DTR	Daughter
DAY TX	Day Treatment
DBT	Dialectic Behavior Therapy
D/C	Discharge
DC	Discontinue
DHCS	Department of Health Care Services
DD	Developmentally Disabled
dec	Decanoate
DEL	Delusions
DETOX	Detoxification
DIFF	Differential
DIR	Director
DISPO	Disposition
DIV	Divorce

DM	Diabetes Mellitus
DME	Durable Medical Equipment
DMC	Drug MediCal
DMH	Department Of Mental Health
DMV	Department of Motor Vehicles
DNR	Do Not Resuscitate
DO	Doctor of Osteopathic Medicine/Physician
d.o.a	Date of Admission
DOB	Date of Birth
d.o.e.	Date of Entry
d.o.s	Date of Service
DPH	Department of Public Health
Dr	Doctor
DSM	Diagnostic & Statistical Manual
DT's	Delirium Tremens
DUI	Driving Under the Influence
DUR	Drug Utilization Review
DV	Domestic Violence
Dx	Diagnosis
Dz	Disease
E	
EAP	Employee Assistance Program
ECG	Echocardiogram
ECT	Electro Convulsive Therapy
ED	Emergency Department
EDUC	Educate / Education
EEG	Electroencephalogram
EENT	Eyes, ears, nose, and throat
e.g.	(L. exempli gratia) for example
HER	Electronic Health Record
EKG & ECG	Electro cardiogram
Elix.	Elixir
EMDR	Eye Movement Desensitization Reintegration
EMT	Emergency Medical Technician
EPS	Extrapyramidal Side Effects
EPSDT	Early Periodic Screenings & Diagnostic Testing
EQRO	External Quality Review Organization
ER	Emergency Room
ESP	Especially
ETA	Estimated Time of Arrival
EtOH	Alcohol
Ext.	Extract
EVAL	Evaluation
E.W.	Eligibility Worker
F	
F/U	Follow Up

fa	Father
FAS	Fetal Alcohol Syndrome
FBS	Fasting Blood Sugar
FCMHP	Foster Care Mental Health Program
Fe	Iron
FG	Fasting Glucose
FL	Fluid
FMP	Family Mosaic Project
FNP	Family Nurse Practitioner
FOI	Flight of Ideas
FQHC	Federally Qualified Health Center
FREQ	Frequent
FSA	Family Service Agency
Fx	Fracture
FY	Fiscal Year
G	
GA	General Assistance
GABA	Gamma Aminobutyric Acid
GAD	General Anxiety Disorder
GAF	Global Assessment of Functioning
GD	Gravely Disabled
GERD	Gastro Esophageal Reflux Disease
Gfa / GF	Grandfather
G/F	Girlfriend
GHB	Gamma Hydroxybutyrate
GI	Gastrointestinal
GLBTQQ	Gay, Lesbian, Bisexual, Transgendered, Queer, Questioning
glu	Glucose
gm	Gram
Gmo / GM	Grandmother
GP	General Practitioner
Gr	Grains
Group Tx	Group Therapy
GRP(s)	Group(s)
G/W	Glucose and Water
GSW	Gunshot Wound
gtt.	Drop
GU	Genitourinary
GYN	Gynecology
H	
H	Heroin
HA	Headache
H2O	Water
H&P	History and Physical
Hal / Halluc	Hallucinations

5 HT	Serotonin
5HT2	Serotonin 2 Receptor
h.s.	Hour of sleep/bedtime
H/I	Homicidal Ideation
HBP	High Blood Pressure
HBV	Hepatitis B
Hct	Hematocrit
HCV	Hepatitis C
HF / HC / HW	Healthy Families/ Healthy Children/ Healthy Workers
HEENT	Head, ears, eyes, nose & throat
Hep	Hepatitis
Hgb	Hemoglobin
HIE	Health Information Exchange
HIM	Health Information Management
HIPAA	Health Insurance Portability & Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HOH	Hard of Hearing
Hosp	Hospital / Hospitalized
HPI	History of Present Illness
HPV	Human Papilloma Virus
hr.	Hour
HR	Human Resources
H.R.	Heart Rate
HRSA	Health Resources and Services Administration
HAS	Human Services Agency
ht.	Height
HTN	Hypertension
HUH	Housing Urban Health
HUSB	Husband
HV	Home Visit
Hx / H/O	History / History of
I	
I & O	Intake and Output
IAPC	Interagency Placement Committee
ICD	International Classification Disorder
ICU	Intensive Care Unit
IDDM	Insulin Dependent Diabetes Mellitus
IDDT	Integrated Dual disorder Treatment
IEP	Individual Education Plan
IISC	Interagency Intensive Services Committee
ILSA	Integrated Longitudinal Strength-Base Assessment
IM	intramuscular
IMD	Institute of Mental Disease

Incont.	Incontinent
IN-PT	Inpatient
IPT	Intensive Placement Team
ISC	Integrated Service Center
IT	Information Technology
ITWS	Information Technology and Web Services
IV	Intravenous
IVDU	Intravenous Drug Use
J	
JCAHO	Joint Commission on Accreditation of Health Care Organizations
JC	Junior College
JJC	Juvenile Justice Center
JPS	Jail Psychiatric Services / Juvenile Probation Services
JUV	Juvenile
K	
K+	Potassium
Kcal	Kilo Calorie
Kg.	Kilogram
L	
LAB	Laboratory
LANG	Language
LT	Left
LB or lb.	Pound
LCR	Lifetime Clinical Record
LCSW	Licensed Clinical Social Worker
LD	Learning Disability
LDL	Low Density Lipoprotein
L-Fac	Locked Facility
LFU	Legal Entity File Update
LG	Large
$LiCo_3$/Li	Lithium Carbonate
LLE	Left Lower Extremity
LLQ	Left Lower Quadrant
LMFT	Licensed Marriage and Family Therapist
LMP	Last Menstrual Period
LOA	Leave of Absence
LOC	Loss of Consciousness
LOCUS	Level of Care Utilization System
LOS	Length of Stay
LP	Lumbar Puncture
LPN	Licensed Practical Nurse
LPT	Licensed Psychiatric Technician
LPPI	Langley Porter Psychiatric Institute
LPS	Lanterman-Petris-Short

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LSD	Lysergic Acid Diethylamide
L-SNF	Locked Skilled Nursing Facility
LTC	Long Term Care
LUE	Left Upper Extremity
LUQ	Left Upper Quadrant
LVN	Licensed Vocational Nurse
M	
MAOI	Monoamine Oxidase Inhibitors
M	Male
MA	Masters of Arts or Medical Assistant
MAA	MediCal Administrative Activities
Marital Status	D Divorced M Married S Single W Widowed
MAST	Michigan Alcohol Screening Test
MAT	Medication Assisted Treatment
MAX	Maximum
MCAH	Maternal Child Adolescent Health
MCTT	Mobile Crisis Treatment Team
Mcg	Microgram
MCI	McAuley Adolescent Institute or Mild Cognitive Impairment
MD	Medical Doctor/Physician
MDD	Major Depressive Disorder
MDMA	Methylenedioxymethamphetamine (Ecstasy)
MDO	Mentally Disordered Offender
MEDI-MEDI	MediCal and Medicare
mEq	Milliequivalents
MED HX	Medical History
Meds	Medications
MFT	Marriage & Family Therapist
MFTI	Marriage & Family Therapist Intern
mg	Milligram
M GR	Maternal Grandmother
MH	Mental Health
MHA	Mental Health Assistant
MHP	Mental Health Plan
MHRC	Mental Health Rehabilitation Center
MHRS	Mental Health Rehab Specialist
MHSA	Mental Health Services Act or Prop 63
MHSIP	Mental Health Statistics Improvement Program
MHTC	Mental Health Treatment Center
MHW	Mental Health Worker
MI	Myocardial Infarction or Motivational Interviewing

	or Motivational Incentives
MIDAS	Mental Illness Drug and Alcohol Screening
MIN	Minutes
Mission ACT	Mission Assertive Community Treatment
Mission PPN	Mission Private Provider Network Clinic
MJ	Marijuana
ml	Milliliter
MMPI	Minnesota Multiphasic Personality Inventory
MMSE	Mini-Mental State Exam
MMT	Methadone Maintenance Treatment
mo	Mother
MOCD	Mayor's Office of Community Development
MOM	Milk of Magnesia
MOW	Meals On Wheels
MRI	Magnetic Resonance Imaging
MRS	Monitoring Report Summary
MSE	Mental Status Exam
M.S.	Master of Science Degree
MSG	Message
MST	Multisystemic Therapy
MSW	Masters of Social Work (not registered with Board) or Medically Supervised Withdrawal (detox) or Medical Social Worker
MTG	Meeting
MVA	Motor Vehicle Accident
N	
N/A	Not Applicable
NA	Narcotics Anonymous
Na	Sodium
NAC	Neighborhood Alternative Center
NAMI	National Alliance for the Mentally Ill
NARC	Narcotic
NAS	No Added Salt or Neonatal Abstinence Syndrome
NASW	National Association of Social Workers
N/C	No Complaints
NCADA	National Council on Alcoholism and Drug Addiction
NCCA	National Commission for Certifying Agencies
NEG	Negative
NEURO	Neurological
NGP or TPNGP	Northgate Point (Turning Point Northgate Point)
NGRI	Not Guilty by Reason of Insanity
NIAAA	National Institute of Alcoholism and Alcohol Abuse
NIDA	National Institute of Drug Abuse

NIDDM	Non Insulin Dependent Diabetes Mellitus
NIH	National Institute of Health
NIMH	National Institute of Mental Health
NKA	No Known Allergies
NKDA	No Known Drug Allergies
NMS	Neuroleptic Malignant Syndrome
NOA	Notice Of Action
NOC	Night
NOS	Not Otherwise Specified
NPI	National Provider Identifier
NPO	Nothing by Mouth
NPPES	National Plan and Provider Enumeration System
NREPP	National Registry of Evidence-based Programs and Practices
NS	No Show
NSG	Nursing
NSH	Napa State Hospital
NTP	Narcotic Treatment Program
NTE	Not to Exceed
NV	Nausea & Vomiting
O	
O_2	Oxygen
O	Oral
OB	Obstetrics
OBIC	Outpatient Buophrenorphine Induction Clinic
OBOT	Office-Based Opiate Treatment Services
OBS	Organic Brain Syndrome
OCC	Occasionally
OCD	Obsessive Compulsive Disorder
OD	Overdose
O.D.	Ocular Dexter (Right Eye)
ODD	Oppositional Defiant disorder
OINT	Ointment
OMI	Oceanview, Merced Heights and Ingleside
OOB	Out of Bed
OP	Outpatient
OPG	Office of Problem Gambling
O/R	Own Recognizance
OTC	Over the Counter
Ox4	Oriented times 4
Outpt	Outpatient
Oz	Ounce
P	
p	After

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p.c.	After Meals
p.r.n.	As Needed
P/C	Phone Call
P=	Pulse is
PADs	Preventive Aggression Devices
PAP	Papanicolaou Test
PC	Primary Care
P.C.	Penal Code
PCN	Penicillin
PCP	Phencyclidine
PCP/PMD	Primary Care Provider
PD	Plan Development
PDD	Pervasive Developmental Disorder
PDR	Physician's Desk Reference
PE	Psychiatric Exam
PERRL	Pupils Equal, Round, Reactive to Light
Per	By / Through
PES	Psychiatric Emergency Services
PFU	Provider File Update
PG	Public Guardian
PhD	Doctor of Philosophy
Ø barb	Phenobarbital
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHN	Public Health Nurse
PIN	Provider Identification Number
PM	Program Manager
pm	Afternoon
PMA	Psychomotor Agitation
PMR	Psychomotor Retardation
PN	Psychiatric Nurse
PO	Probation Officer
po	By Mouth
POS	Point of Service
POST OP	After Operation
PPD	Purified Protein Derivative for Tuberculosis Test
PREG	Pregnant
PRE OP	Before Operation
PREP	Preparation
PROB	Problem
PROG	Progress
PSW	Psychiatric Social Worker or Protective Services Worker
PsyD	Doctor of Psychology
pt	Patient
P/T	Part Time

PTSD	Post Traumatic Stress Disorder
P/U	Pick Up
PURQC	Program Utilization Review Quality Committee
PVC's	Premature Ventricular Contractions
Px	Physical
Q	
q	Every
q2h	Every 2 hours
QA	Quality Assurance
qam	Every Morning
qh	Every Hour
QIC	Quality Improvement Coordinator/Committee
qid	Four Times a day
qs	Quantity Sufficient
qt	Quart
R	
R	Respiration
R&R	Re-Assessment & Re-Authorization Plan
R/O	Rule-Out
R=	Respirations Are
RAMS	Richmond Area Multi-Service Inc.
RBC	Red Blood Count
RD	Right Deltoid
REC'D	Received
RE	Regarding
REC	Recommend
REG	Regular
REHAB	Rehabilitation
REL	Relationship
REL Of INFO or ROI	Release of Information
REM	Rapid Eye Movement
RESP	Respiratory
REV	Review
RFP	Request for Proposals
RFQ	Request for Qualifications
R/L	Right/Left
RLE	Right Lower Extremity
RLQ	Right Lower Quadrant
RN	Registered Nurse
RES TX CNTR	Residential Treatment Center
ROM	Range of Motion
ROS	Review of Systems
R or rt	Right
RTC	Return to Clinic

RU#	Reporting Unit Number
RUE	Right Upper Extremity
RUQ	Right Upper Quadrant
Rx	Prescription
Rxn	Reaction
S	
S	Without
SA	Substance Abuse
SACPA	Substance Abused Crime Prevention Act (Prop 36)
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIZ	Schizophrenia
SCUT	Schizophrenia, Chronic Undifferentiated Type
SDI	State Disability Insurance
SDMC	Short-Doyle MediCal
SE	Side Effects
SECFTC	South East Child & Family Therapy Center
SED	Severely Emotionally Disturb
SLP	Supported Living Program
S&R	Seclusion & Restraint
S/S	Signs and Symptoms
S/A	Suicide Attempt
SBO	School Based Outpatient
SFGH	San Francisco General Hospital
SFMHP	San Francisco Mental Health Plan
SFUSD	San Francisco Unified School District
SGOT	Serum Glutamic-Oxaloacetic Transaminase
SGPT	Serum Glutamic-Pyruvic Transaminase
S/I	Suicide Ideation
SIB	Self Injurious Behavior(s)
sib	Sibling
sis	Sister
SMAST	Short Michigan Alcohol Screening Test
SNF	Skilled Nursing Facility
SOB	Shortness of Breath
SOC	System of Care
SOC Hx	Social History
SOC PM	System of Care Program Manager
SOC-QIC	System of Care Quality Improvement Committee
S/O	Significant Other
S/P	Status Post
SPMD	Serious and Persistent Mental Disorder
SPY	Special Programs for Youth
SRS	Session Rating Scale
SSA	Social Security Administration

SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
SSRI	Selective Serotonin Reuptake Inhibitor
Staph	Staphylococcus
STAT	Immediately
STD	Sexually Transmitted Disease
Strep	Streptococcus
SUBJ	Subject
SUBQ	Subcutaneously
SUD	Substance Use Disorder
SVP	Sexually Violent Predator
SW	Social Worker
Sx	Symptoms
Sz	Seizures
T	
TAY	Transitional Age Youth
TA	Technical Assistance
TC	Therapeutic Community
T/C	Telephone Call
T/O	Telephone Order
T= or Temp	Temperature is
Tab	Tablet
TAP	Treatment Access Program
TV	Television
TB	Tuberculosis
TBI	Traumatic Brain Injury
TBS	Therapeutic Behavioral Services
Tbsp.	Tablespoon
TCA	Tri-Cyclic Antidepressants
TCM	Targeted Case Management
TCN	Tetracycline
TCON	Temporary Conservatorship
TCPC	Treatment Center Program Coordinator
TD	Tardive Dyskinesia
TEDS	Treatment Episode Data Set
TIA	Transient Ischemic Attack
tid	Three Times A Day
tinct.	Tincture
TIP	Treatment Improvement Protocol
TANF	Temporary Assistance to Needy Families
THC	Tetrahydrocannabinol (active ingredient to MJ)
TPR	Temperature, Pulse, Respirations
TAR	Treatment Authorization Request
TRO	Temporary Restraining Order
TSH	Thyroid-Stimulating Hormone
tsp.	Teaspoon

Tox	Toxicology
Tx	Treatment
TRH	Thyroid releasing hormone
TVS	Therapeutic Visitation Services
TYS	Transitional Youth Services
U	
U/A	Urinalysis
UCI	Unique Client Identifier
UCSF	University of California San Francisco
U.A.	Unauthorized Absence
UCSFMC	University of California San Francisco Medical Center
UOS	Unit of Service
UDS	Urine Drug Screen
ULQ	Upper Left Quadrant
UGI	Upper Gastrointestinal Series
UM	Utilization Management
UMDAP	Uniform Method for Determining Ability to Pay
UNG	Ointment
UNK	Unknown
UR	Utilization Review
URI	Upper Respiratory Infection
URQ	Upper Right Quadrant
UTI	Urinary Tract Infection
Utox	Urine Toxicology Screen
V	
VA	Veterans Administration
VD	Venereal Decease
VDRL	Test for syphilis
V/H	Visual Hallucinations
VM	Voice Mail/ Voice Message
V/O	Verbal Order
V/S	Visions South
VOC REHAB	Vocational Rehabilitation
Vol	Voluntary
VPA	Valproic Acid/Valproate
VS	Vital Signs
VSS	Vital Signs Stable
W	
W	White
W&I	California Welfare and Institutions Code
WIC	Women's, Infants & Children
W/C	Wheelchair
w/o	Without
w/	With
W/D	Withdrawal

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WD/WN	Well-Developed, Well-Nourished
WBC	White Blood Cell Count
WK	Week
WNL	Within Normal Limits
Wt.	Weight
X	
X	Multiplied by/times
Y	
YGC	Youth Guidance Center
Y/O	Years Old
YR	Year
Z	
Zn	Zinc
Symbols	
Ψ	Psychiatric/ Psychiatrist/Psychology
≤	Less Than or Equal To
≥	Greater Than or Equal To
↑	Increase
↓	Decrease
♀	Female
♂	Male
1°	Primary
2°	Due to; Secondary to
#	Number
%	Percent
+	Plus, positive, yes
-	Minus, negative, no
1:1	One to one
"	Inches
'	Feet
?	Unknown
&	And
@	At
=	Equal
5150	WIC 72 hour hold for mental health evaluation
5250	WIC 14 day hold

Reference J: DHCS' Reasons for Recoupment (FY17-18; Non-Hospital Services)

Enclosure 4

REASONS FOR RECOUPMENT
FOR FY 2017/2018
(CCR, title 9, section 1810.380(b); Mental Health Plan (MHP) contract)
NON-HOSPITAL SERVICES

MEDICAL NECESSITY

1. Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, section 1830.205(b)(1)(A-R).

   CCR, title 9, sections 1830.205(b)(1)(A-R); 1830.210(a)(1), 1810.345(a) and 1840.112(b)(1)(4); Mental Health Plan (MHP) Contract; MHSUDS Information Notice 17-040

2. Documentation in the medical record does not establish that, as a result of a mental disorder listed in CCR, title 9, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

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

   CCR, title 9, sections 1830.205(b)(2)(A – C), 1830.210(a)(3), 1810.345(a) and 1840.112(b)(1)(4)

3. Documentation in the medical record does not establish the expectation that the claimed intervention(s) will do, at least, one of the following:

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

   CCR, title 9, sections 1810.345(a); 1830.205(b)(3)(B), 1830.210(a)(3); and 1840.112(b)(4); MHP Contract

Enclosure 4

REASONS FOR RECOUPMENT FOR FY 2017/2018

CLIENT PLAN

4. No documentation of beneficiary or legal guardian participation and agreement with the client plan or written explanation of the beneficiary's refusal or unavailability to sign as required in the Mental Health Plan (MHP) Contract with the Department.

CCR, title 9, sections 1810.440(c) and 1840.112(b)(5); MHP Contract; MHSUDS Information Notice 17-040

5. Services that cannot be claimed without a Client Plan in place were claimed either:
   a) Prior to the initial Client Plan being in place; or
   b) During the period where there was a gap or lapse between client plans; or
   c) When there was no client plan in effect

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

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

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

PROGRESS NOTES

6. No progress note found for service claimed

   a) No progress note found

   b) Progress note provided does not match the claim in terms of
      1) Specialty Mental Health Service and/or Service Activity claimed. For example, the progress note should indicate the SMHS, such as TCM, Medication Support, Crisis Intervention, etc.; and/or, the specific service activity when applicable, such as assessment, plan development, individual/group/family therapy, collateral, and rehabilitation, which would be claimed as Mental Health Services.
      2) Date of service, and/or
      3) Units of time.

Enclosure 4

REASONS FOR RECOUPMENT
FOR FY 2017/2018

The exception below pertains to 6. b) 3):

- If everything in a progress note matches the claim except that the units of time documented in the progress note *are greater than* the units of time claimed, this will *not* result in a disallowance but will be a Plan of Correction (POC). If however, the units of time documented in the progress note *are less than* the units of time claimed, this will result in a disallowance.

The exceptions below pertain to 6. b) 1):

- If in review of a progress note one of the following is determined to be the case, the MHP will be allowed to void and replace the claim as long as all other progress note requirements are met.

  The Specialty Mental Health Service and /or Service Activity was:

  (1) Claimed inaccurately by those entering/submitting claims information for the MHP, or
  (2) Documented inaccurately in the progress note by the provider of service.

  If either of the above occurs, the MHP will be required to submit proof of the void and replace to the department for verification and a Plan of Correction will be required with evidence showing how the MHP will correct the identified problem and prevent future occurrences.

  NOTE: *This is expected to be the exception not the rule. If this is identified as a significant or repetitive finding it may result in disallowances.*

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

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

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

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

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

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

9. The progress note indicates that the service provided was solely for one of the following:

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

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

10. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present.

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

11. Progress notes for group activities involving two (2) or more providers did not clearly document the following:

a) The specific involvement of each provider in the context of the mental health needs of the beneficiary;
b) The specific amount of time of involvement of each group provider in providing the service, including travel and documentation time if applicable; ***and***
c) The total number of group participants,

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

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

MHP Contract; MHSUDS Information Notice 17-040

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REASONS FOR RECOUPMENT FOR FY 2017/2018

13. No service provided:

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

(***NOTE:*** *If there is a progress note in which the provider documents that they conducted chart review in preparation for a service, and documents that the beneficiary was a no-show for the service, the time spent to review the chart in preparation for the beneficiary's appointment is reimbursable as plan development*)

CCR, title 9, section 1840.112(b)(3); title 22, section 51470(a); MHSUDS Information Notice 17-040

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

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

DAY TREATMENT INTENSIVE / DAY REHABILITATION (DTI / DR)

15. On a day where the beneficiary was present for at least 50% of the scheduled DTI/DR program time, but was not in attendance for the full hours of operation for that day, there is no documentation of the reason for an "unavoidable absence" which clearly explains why the beneficiary could not be present for the full program on the day claimed.

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;

16. The actual number of hours and minutes the beneficiary attended the DTI/DR program (e.g., 3 hours and 58 minutes) is not documented and for this reason it cannot be established that the beneficiary was present for at least 50% of the program time for the day reviewed.

DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;

17. Documentation reviewed, including the written weekly schedule for DTI/DR along with the progress notes, reflects that the program does not meet the time requirements for a half-day or full-day program as follows:

a) Breaks and/or meal times were counted in order to meet the time requirements,

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REASONS FOR RECOUPMENT
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b) Half day program was less than 3 hours (requirement is for 4 hours or less, but a minimum of 3 hours)
c) Full day program was 4 hours or less (requirements is for more than 4 hours)

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

18. Required DTI/DR documentation was not present as follows:

a) There was not a clinical summary present for Day Treatment Intensive Services for the week of the service reviewed
b) There was not a daily progress note present for Day Treatment Intensive Services for the day of the service reviewed
c) There was not a weekly progress note present for Day Rehabilitation Services for the week of the service reviewed

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

HOSPITAL SERVICES

MEDICAL NECESSITY

19. Admission
a) Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).
b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.
c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:
- Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
- Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function

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Reference K: Web-Based Resources

Resource	URL
Centers for Medicare & Medicaid Services	www.cms.gov
California Department of Health Care Services (DHCS)	www.dhcs.ca.gov
DHCS Main Medi-Cal Web Page	www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx
DHCS Providers & Partners Web Page	www.dhcs.ca.gov/provgovpart/Pages/default.aspx
DHCS Medi-Cal Bulletins & Manuals Web Page	http://files.medi-cal.ca.gov/pubsdoco/Bulletins_menu.asp http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp
DHCS Forms, Laws & Regulations Web Page	www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx
DHCS Bulletins, Information Notices and Letters	www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx
DHCS SMHS Waiver, Contract, and State Plan	http://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx http://www.dhcs.ca.gov/formsandpubs/laws/Document/09-004_advPkg/pdf
DHCS Medi-Cal Billing Manual	http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Mental%20Health%20Medi-Cal%20Billing%20Manual_POSTED_1_28_14doc.pdf
Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services:	http://www.dhcs.ca.gov/services/Documents/Medi-cal_manual_9-22-16.pdf
California Department of Social Services (CDSS)	www.cdss.ca.gov
BHS Policies and Procedures	https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSmnuPolyProc.asp
BHS Documentation Manual	https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/default.asp
Avatar User Support	https://www.sfdph.org/dph/comupg/oservices/mentalHlth/BHIS/avatarUserDocs.asp
BHS Outpatient Mental Health Billing Codes	https://www.sfdph.org/dph/comupg/oservices/mentalHlth/BHIS/avatarUserDocs.asp

For more information about mental health documentation requirements, please contact:

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https://www.sfdph.org/dphcomupg/oservices/mentalHlth/CBHS/CBHSQualityMgmt.asp