



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery



Clinical Documentation Manual

2018 - 2019 Edition

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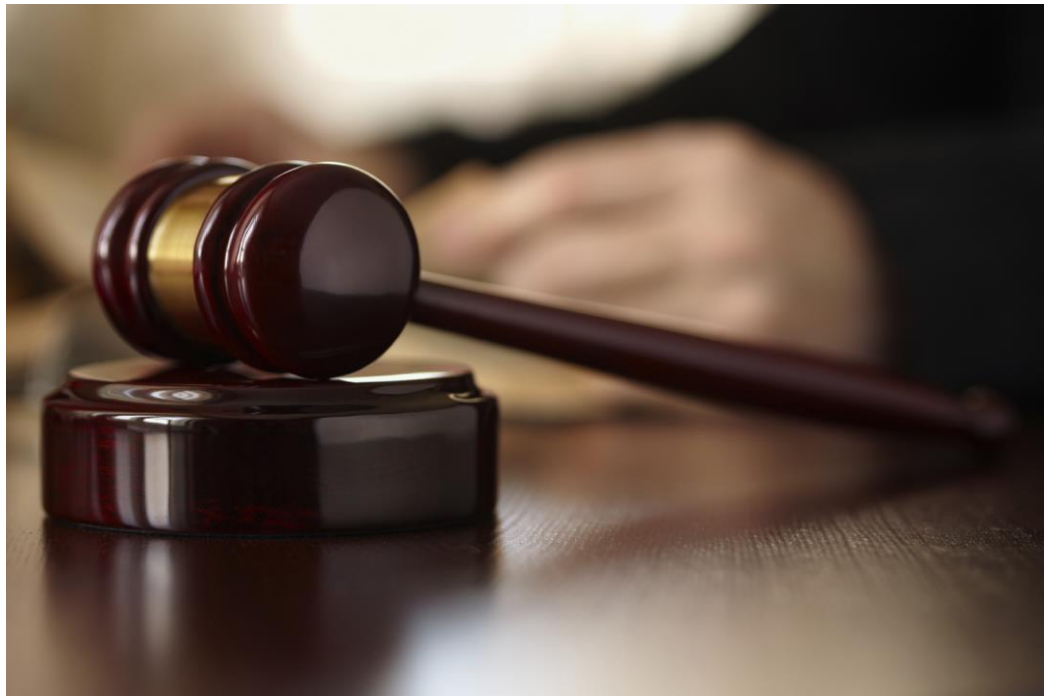
0.1 Reference Sources

The Clinical Documentation Manual was developed based on information gathered from the following sources:

- ✓ California Code of Regulations (Title 9)
- ✓ California Department of Health Care Services (DHCS) letters/notices
- ✓ California DHCS State Plan, Section 3, Supplement 3 to Attachment 3.1-A
- ✓ Behavioral Wellness policies and procedures
- ✓ Santa Barbara County Mental Health Plan

Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice NO.: 17-040, August 24, 2017. Retrieved from:

http://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_17-040_MHSUDS_Chart_Documentation_Information_Notice.pdf



Overview

0.2 Overview

The Santa Barbara County Department of Behavioral Wellness has authorized this document to serve as the official reference manual for all outpatient clinical behavior health documentation. The manual will be periodically updated and posted to the Department of Behavioral Wellness website.

This manual defines key concepts, explains documentation requirements per state laws and regulations, and provides instructions and guidance on how to correctly document various types of specialty mental health services provided to clients. All service providers strive to provide high-quality care to their clients, and documentation that is accurate, comprehensive and timely plays a crucial part in the process of delivering excellent care.

All documentation must follow a logical flow and be interconnected. To illustrate this concept, Figure 1.1 depicts *The Golden Thread*:



Figure 1.1 “The Golden Thread” of Clinical Documentation

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The concept of the “Golden Thread” captures the progression of services provided to the client and the accompanying documentation. Each service and the subsequent progress note documentation is linked back to the assessment, diagnosis and treatment plan.

Clinicians must remember to retain and support this connection throughout their documentation by:

- ✓ Clearly documenting **assessment** findings, including medical necessity for specialty mental health service through an included **diagnosis** and impairments in life functioning.
- ✓ Carrying medical necessity forward into the **treatment plan** and ensuring that the included diagnosis and impairments from the assessment inform the treatment goals, objectives and interventions.
- ✓ Documenting delivery of services in **progress notes**, specifically the application of the interventions originally identified in the treatment plan as well as the client’s response to those interventions.

Inevitably, situations will arise when staff have questions not answered here. In such cases, the Program Supervisor/Manager should be consulted. The Quality Care Management (QCM) team is also available to address questions concerning documentation at BWELLQCM@sbcbswell.org

Examples are illustrative, not exhaustive, and are not meant to replace clinical supervision or sound clinical judgment. Examples are not meant as a “cut and paste” one-size-fits-all solution.



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0.3 Cultural Competency

Health care professionals agree on the importance of capturing the impact that beliefs, culture and language can have on attitudes and access to mental health care. That is why the Department of Behavioral Wellness adheres to principles that demonstrate our commitment to cultural competence across all spectrums of care, including documentation practices and standards. As such, all cultural, racial, linguistic, religious/spiritual, physical abilities/challenges, sexual orientation, gender identify, socioeconomic and other relevant factors affecting service delivery must be documented in the intake, clinical assessment process, treatment plan goals/interventions, and in progress notes.

The inclusion of cultural perspectives and factors are critical so that perceived problems or issues are identified and placed in the appropriate cultural context.

For all clinical assessments, professionals must document evidence of:

- ✓ A discussion and exploration of culturally significant topics with the client and/or significant support persons.
- ✓ A discussion and exploration of relevant cultural issues that may pertain to the presenting mental health problem and which can be used in the development of a culturally appropriate treatment plan.
- ✓ Cultural and linguistic accommodations, including cultural adaptations to evidence-based practices (EBPs) and the utilization of qualified bilingual staff or interpreter services.

For information on who we serve and how we strive to provide equitable and culturally competent services to all beneficiaries, see the Departmental policies “[Accessing a Welcoming and Integrated System of Care and Recovery](#)” and “[Cultural and Linguistic Competency](#).”



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Embedded throughout the assessment template are the 16 questions from the *American Psychiatric Association's (APA) Cultural Formulation Interview*, a tool intended to help clinicians gather and organize culturally-relevant clinical information to inform diagnosis and treatment planning. These questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or other involved in the current problem). By posing the Cultural Formulation Interview questions throughout the assessment process, clinicians can gain meaningful insights on the following:

- ✓ The definition of the problem in the individual's own words and from their cultural standpoint
- ✓ Cultural perceptions of cause, context, and support
- ✓ Cultural factors affecting self-coping and past and current help seeking

The Cultural Formulation Interview can be used in *clinical encounters with all individuals and all clinicians*, not just with cultural minorities or in situations of obvious cultural difference between clinicians and the client. This is because all of us bring our own cultures, values, and expectations to the clinical encounter, including often invisible influences (i.e., implicit bias) on how we approach specific aspects of care.

Moreover, *treatment planning efforts* must take into account any cultural considerations and how they may influence progress towards goals.

When documenting delivery of services, clinicians must document *evidence-based practices (EBPs) and the cultural adaptation of EBPs* to better meet the cultural and personal needs of the client. This can include adaptations in time and location of service delivery, integration of religious and spiritual beliefs into treatment, and modification of EBPs to accommodate cultural, socioeconomic, educational, and linguistic factors.

Progress notes will also demonstrate continued cultural sensitivity, explanation of cultural adaptations for every encounter, and ongoing development of insights into the cultural needs of the client.

1.1 Scope of Practice for Licensed Mental Health Professionals

All specialty mental health services must be delivered by licensed mental health professionals (LMHPs) working within their scope of practice. [9 CCR §1840.314(d)] Please refer to appropriate professional licensing boards for specific information about scope of practice as well as any scope, supervision, or registration requirements set forth in the California Business and Professions Code or associated regulations.

The following LMHPs may provide and direct others in providing specialty mental health services, within their respective scope of practice and in accordance with the job duties as stated in their respective job classification:

- ✓ Physicians;
- ✓ Psychologists;
- ✓ Licensed Clinical Social Workers;
- ✓ Licensed Professional Clinical Counselors;
- ✓ Marriage and Family Therapists;
- ✓ Registered Nurses;
- ✓ Certified Nurse Specialists; and,
- ✓ Nurse Practitioners. [California State Plan, Section 3, Supplement 3 to Attachment 3.1-A, pages 2m-2o]

Waivered/registered mental health professionals may only provide services under the supervision of a LMHP in accordance with applicable laws and regulations governing the registration or waiver. [9 CCR §1840.314(e)(1)(F)] Providing services may include, but is not limited to, being the person directly providing the service on a treatment team, acting as a clinical driver for a case, or completion of assessments and approval of client treatment plans. The LMHP supervising the waivered/registered mental health professional assumes ultimate responsibility for the specialty mental health service provided.

1.2 Scope of Practice for Other Mental Health Professionals

Specialty mental health services may be provided by mental health professionals who are credentialed by the Department according to state requirements, or non-licensed providers who agree to abide by the definitions, rules, and requirements for specialty mental health services established by DHCS, to the extent authorized under state law.

The following types of providers must be licensed in accordance with applicable State of

California licensure requirements, and, in addition, must work “under the direction of” a licensed professional operating within his or her scope of practice:

- ✓ Licensed Vocational Nurses;
- ✓ Licensed Psychiatric Technicians;
- ✓ Physician Assistants (under the direction of a Physician only); and,
- ✓ Pharmacists (under the direction of a Physician only).

Additional providers who may operate under the direction of a LMHP include:

- ✓ Mental Health Rehabilitation Specialist
- ✓ Other Qualified Providers (e.g., Case Workers, Recovery Assistants)

The DHCS State Plan permits the provision of services by “Other Qualified Providers,” defined as, “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.” Mental Health Services (excluding Therapy), Targeted Case Management, Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential and Crisis Residential Treatment services may be provided by any person determined by the Department of Behavioral Wellness to be qualified to provide the service, consistent with state law. State law requires these “Other Qualified Providers” to provide services under the direction of a LMHP within their respective scope of practice. [9 CCR §1840.344]

1.3 Medical Necessity Criteria

The term *medical necessity* encompasses a set of criteria that are used to determine whether specialty mental health services are reasonable, necessary, and/or appropriate. Mandated by the California Code of Regulations (9 CCR §1930.205) and regulated by the DHCS, establishing medical necessity is crucial to (1) substantiate the need for services and (2) ensure that any service rendered is reimbursable by Medi-Cal.

Medical necessity criteria have 3 components: diagnosis, impairment, and interventions. These components, along with explanations and sub-components, are detailed below.

Establishing Medical Necessity

In order to be eligible for specialty mental health services, an individual must:

1. Have an included mental health diagnosis as listed in Section 1.6 of this manual
2. Have an impairment (A, B, or C below):
 - A. A significant impairment in an important area of life functioning.
 - B. A probability of significant deterioration in an important area of life functioning.
 - C. A reasonable probability that a child (under 21) will not progress developmentally as individually appropriate.
3. Need an intervention (A, B, and C below must be true):
 - A. The focus of the proposed intervention is to address the included diagnosis or impairments.
 - B. The interventions will (at least on one of the following must be true):
 - Significantly diminish the impairment
 - Prevent significant deterioration in functioning
 - Allow the child to progress developmentally as appropriate
 - B. The condition would not be responsive to physical health care based treatment.
4. Will benefit from specialty mental health services

NOTE: Full scope Medi-Cal beneficiaries under 21 may qualify under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) regulations if they have the probability of deterioration as a result of a condition that could lead to a mental health disorder that specialty mental health services can correct or ameliorate, even if current impairment criteria are not met.

1.4 Determining the Level of Impairment and Level of Care

Severe and Persistent Mental Illness. The Department of Behavioral Wellness has a contract with DHCS to provide treatment to adults with Severe and Persistent Mental Illness (SPMI). This means that in order for an adult to meet clinic level criteria, they **MUST** have a **moderate** to **severe** impairment.

For children to meet criteria for clinic level services, the assessment must prove that the child is at risk of developing moderate, and severe impairment without treatment, or have the probability of deterioration if not offered/provided services.

Determining the Level of Impairment: A functional impairment is defined as a significant problem in an important area of life functioning. Some examples of areas of functioning in various domains are: work/education, legal, relationships, housing, placement (STRTP/group home, foster care, psychiatric hospitalization), and community. It is up to the clinician that has clinical experience and training assessing the client to determine if the client has a significant problem in an important area of functioning that is caused by the client's mental health. Some things to consider when making this decision:

- ✓ Does the client report that they perceive the issue as a problem? Document the client's perspective. Do they want to work but feel unable to do so because of their mental health symptoms or would they rather not work?
- ✓ Are there negative consequences to the problem? Does the client struggle to pay their bills? Even if the client doesn't feel that they have a problem with work but they continue to have financial problems because of their mental health symptoms, the client could have a financial impairment.
- ✓ Some clients struggle with reporting their symptoms or impairments due to lack of insight or because of their mental health condition. In these instances, it is important for the clinician to use their own observations and/or collateral sources to gather information about how their symptoms may be impacting their life.
- ✓ Are there negative consequences in the community to where a person is unable to function due to their mental health symptoms and a client is coming across multiple law enforcement contacts due to poor insight? Is a child removed or unenrolled from community events or social groups due to their mental health symptoms; such as boys and girls club or the Y.

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- ✓ It is imperative to document the length of time/intensity and onset of the symptoms/impairments. The onset and duration/intensity of the symptoms help determine differential diagnosis.

If the client or collateral source does not report the issue as a problem AND there are no negative consequences (either from the client's perspective or others'), it is likely not a severe impairment.

Level of Care. Medi-Cal stipulates that clients are to be served at the lowest level of care possible. Staff should be constantly evaluating the client's progress to determine when it would be beneficial for the client to transition to a lower level of care. See the [LOCRI memo for Adult services](#).

In order to refer clients to a lower level of care, they must still meet "medical necessity" for mild to moderate impairment which means they do not continue to meet criteria for "severe" impairments. It is required that the referral process include continuity of care to where a client is kept open until they are linked.

If clients do not meet medical necessity (i.e. no diagnosis and/or no impairment) they do not need mental health treatment from the county or from other Medi-Cal providers.

Did you know?

A client should not be transferred to a different level of care without an active assessment and without [care coordination planning](#). Clients are matched to the appropriate level of care based on their needs, which are determined by measuring their current impairments. **The level of impairment on the assessment determines the level of care needed.** If a team suspects a client's impairments have increased or decreased and benefit from a change in level of care, they should conduct an assessment (an updated assessment might be sufficient) to make this determination.

1.5 Formulation of a Diagnosis

Formulation of a diagnosis requires a clinician, working within their scope of practice, to be licensed, a registered intern, waived Psychologist that is under the direction of a LMHP in accordance with California State law. [MHSUDS Info Notice No. 17-040]

Per Departmental discretion, this may include graduate students who are in their second year in graduate school or later. All assessment and diagnostic documentation completed by graduate students require review and co-signature by the assigned Team Supervisor or other assigned LMHP.

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Diagnosis is in the scope of practice for the following provider types:

- ✓ Physicians;
- ✓ Psychologists;
- ✓ Licensed Clinical Social Workers;
- ✓ Licensed Professional Clinical Counselors;
- ✓ Licensed Marriage and Family Therapists; and,
- ✓ Advanced Practice Nurses, in accordance with the Board of Registered Nursing and Title 9. This includes a master's level registered nurse, nurse practitioners, and certified nurse specialists.
- ✓ Associate Clinical Social Workers;
- ✓ Professional Clinical Counselor Intern;
- ✓ Associate Marriage and Family Therapist.

A diagnosis with qualifiers such as “Rule-Out” or “R/O,” “versus,” “provisional” or “by history” do not qualify as a diagnosis. These cannot be entered for primary, secondary or any other diagnosis provided by a clinician.

A client must qualify with an included primary diagnosis for specialty mental health services to be opened for ongoing services. If a client has an excluded diagnosis as their primary diagnosis, a clinician will need to consider closing and referring out to the most appropriate service. Please consult with your supervisor or manager.

If the primary diagnosis is not an included diagnosis in the assessment phase, then medical necessity is not met for specialty mental health services. Clinicians will provide a “Z03.89 - No diagnosis” code for those who do not meet medical necessity for specialty mental health services, the clinician should close out the case, and provide the client with an NOABD. Only clients that have Medi-Cal would be provided a NOABD.

When using the R69 “Deferred Diagnosis” code, it is limited only to the following scenarios:

- ✓ Crisis evaluations for individuals not previously open to the system.

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- ✓ When providing outreach and engagement services [e.g., Homeless Outreach, Assertive Outreach Treatment (AOT)] for individuals not yet open to the system and prior to completing an assessment.

Individuals who are found to meet medical necessity for specialty mental health services and are opened to an outpatient program may not be assigned a R69 or Z03.89 code. Instead, staff are to input an included diagnosis that most closely matches the individual's disposition and initial clinical impressions. For example, if an individual potentially meets criteria for a mood disorder diagnosis, the applicable diagnostic code will be entered into ShareCare and Clinician's Gateway. This diagnosis is subsequently updated following the completion of the comprehensive assessment.

1.6 Included DSM-5/ICD-10 Diagnoses

The included DSM-5/ICD-10 Diagnoses are listed on the DHCS website. The current links are:

- ✓ http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notice%20s/MHSUDS_17-004.pdf
- ✓ http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notice%20s/MHSUDS_17-004_Enc1.pdf
- ✓ http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notice%20s/MHSUDS_17-004_Enc2.pdf

1.7 Documentation of Diagnoses: Clinician's Gateway

Making a diagnosis requires documentation of the DSM-5 diagnostic symptoms.

The diagnosis and supporting symptoms may be documented in one of the Assessment templates approved by the Department of Behavioral Wellness and implemented in Clinician's Gateway.

Secondary diagnoses, especially diagnoses of Substance Use Disorders (SUD), must be captured on all clients presenting with SUD issues. Although SUD cannot be the focus of treatment, Clinicians and psychiatrists are responsible for ensuring these diagnoses are captured in Clinician's Gateway assessments. Considering that co-occurring disorders (COD) are the expectation and not the exception, secondary SUD diagnoses are vital to provide treatment planning that addresses COD issues.

1.8 Documentation of Diagnoses: ShareCare

All primary and secondary diagnoses for all open admissions must be recorded in ShareCare on the day of the assessment. In addition, any Substance Use Disorder diagnoses must be entered in ShareCare. The ICD-10 code must be entered in ShareCare.

Clinicians must ensure that diagnoses inputted into ShareCare also match Clinician's Gateway most recent assessment exactly, meaning what is listed in Clinician's Gateway as the primary, secondary and tertiary diagnoses, the clinician must click the radio buttons to designate which diagnoses are primary, secondary and tertiary in ShareCare.

Each outpatient program providing specialty mental health services is responsible for establishing and maintaining a system to ensure that this requirement is met. Team based care is an effective process to ensure the diagnosis are matching and the [appropriate way of documenting care coordination](#).

DSM-5 diagnoses do not always align exactly with the ICD-10 codes. Staff will use the ICD-10 code that matches closely with the DSM-5 diagnosis given on the assessment and is the most clinically appropriate.

1.9 Team Approach to Diagnoses

The initial diagnosis is made by the clinician that is completing the Initial or Comprehensive Assessment.

The diagnosis or diagnoses will be discussed at a clinical team meeting, or as per arrangement of the team members. This discussion will aid in the confirmation of the diagnosis originally determined by the diagnosing clinician. Clinical team members may recommend different or additional diagnoses when indicated. However, the diagnosing clinician - who conducted the face-to-face assessment and is interacting with the client directly - will need to agree to any changes and update the documented diagnosis accordingly.

Based on information gathered in the course of treatment, it may be appropriate to modify or augment the diagnostic formulation.

If a diagnosis made by a psychiatrist is different than that made by a clinician, then the diagnoses will become the topic of a team discussion. The clinician and psychiatrist may also engage in a 1:1 consultation. Potential outcomes are that one diagnosis replaces the other, or that both diagnoses are valid. Ultimately, there must be only one primary diagnosis. The primary diagnosis must always be the diagnosis that is the focus of primary treatment.

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What is important to note is that physician interventions are just as much part of the golden thread as the interventions prescribed by the clinician conducting the assessment. The clinician and physician must work together to:

- ✓ Ensure proper assignment of diagnoses as primary and secondary.
- ✓ Formulate a treatment plan that aligns with the primary and secondary diagnoses.
- ✓ A Clinician should not add a diagnosis that is by history and that will not be addressed in treatment. All diagnosis listed will be addressed and have added interventions in corresponding treatment plans. The diagnoses that are listed as the focus of treatment are outlining current functioning.
- ✓ Psychiatric interventions must be included in treatment plans as integrated plans and not separate treatment plans.

After a team discussion and/or consultation, the clinician and psychiatrist with differing diagnoses must document the following in separate notes or addenda:

- ✓ The team discussion and/or consultation regarding the differing diagnoses.
- ✓ If the original diagnosis is changed, the clinician and psychiatrist must provide clinical justification that demonstrates the client was assessed for and meets all required criteria for the decided diagnosis. This will be captured in an addendum to the original clinical assessment.

Following any changes in diagnosis, the assigned clinician must update the client treatment plan to ensure goals and interventions target the newest diagnosis.

1.10 Communicating Changes to Other Treatment Providers

To ensure the accuracy of documented [care coordination](#) and diagnoses across treatment providers, assigned clinicians are responsible for verifying this information at updated assessments with all known providers, including other Department programs/clinics, community-based organizations (CBOs) and primary care physicians within (3) business days of the change.

Contracted CBOs are responsible for communicating changes in diagnosis to Department clinicians within three (3) business days of the change.

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2.1 Assessment

An **assessment** is a service activity that evaluates the current status of a client's mental, emotional, or behavioral health. The "golden thread" begins with the assessment, which in turn informs the individualized goals and interventions of the client treatment plan. By gathering and analyzing historical information, observing behaviors, and interviewing the individual and his or her significant others, a clinician can formulate a comprehensive view of an individual's strengths and needs.

Information gathered in an assessment must include, but is not limited to, the following: **Current presentation and functioning**; mental status determination; client's clinical history; analysis of relevant cultural issues identified and history; client's strength and resources; developmental history; history of trauma or adverse life events; assessment of any current risk; diagnosis; and the use of testing procedures. [9 CCR §1810.204]

Assessments must be completed face-to-face in order to assign a diagnosis. When needing to gather additional assessment information, the information may be gathered by telephone, and may involve family members or significant parties without the client. For example, sensitive family and development history may be better collected in a separate session with the parent of a young child rather than with the child present.

The consent for treatment must be completed prior to commencing the assessment or any other services. Within the consent for treatment, the limits of confidentiality, patient rights, risks/benefits of treatment and Department of Behavioral Wellness policies pertaining to standards of care are explained before commencing the assessment process. Repeat as necessary to ensure that all parties involved in treatment understand the issues involved. Signature on the informed consent form must be obtained to document that the client/legally responsible person understands and agrees to participate in treatment. The Consent for treatment must be completed annually.

2.2 Assessment Types

There are five types of assessment templates in Clinician's Gateway.

- ✓ **Access Form/Screening** - This will be used for routine, urgent, and crisis contacts with the Access Line, walk-ins to clinics, and outreach programs. Typically, QCM access screeners are the ones who will complete the Screening Sheet tab within the Access Form in its entirety. All staff will use the Contact Sheet tab in order to log all access. After staff complete the Contact sheet, they will finalize the Access template, and then move on to complete one of the other assessment templates

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listed in this section or the crisis evaluation template. Walk-in clinics are **not** to use the screening template for face to face assessments.

- ✓ **Initial Assessment** - This is an in-person assessment that focuses primarily on medical necessity determination and assesses for risks. This template should be used by outreach and for clinic walk-ins. If the client is found to meet medical necessity on the Initial Assessment, a Comprehensive Assessment is scheduled. If the client is not found to meet medical necessity with the Initial Assessment, the client can be closed according to the Department's discharge policy and continuity of care needs to be employed. The Initial Assessment can be skipped if staff believe that a client is likely to meet criteria and prefer to conduct a Comprehensive Assessment without doing the Initial Assessment. (Remember, in either case, the Access Contact Sheet tab will also need to be completed if not already done by the QCM screeners).
- ✓ **Comprehensive Assessment** - This is the full clinical assessment and evaluates presenting problems that include the current status of a client's mental, emotional, or behavioral health. The Comprehensive Assessment establishes medical necessity and leads to the development of the treatment plan goals.

The Comprehensive Assessment is completed when a client meets one of the following criteria:

- ✓ The client has never had, or currently does not have an open admission to an outpatient mental health program.
- ✓ The client has been receiving outpatient mental health services for the past three (3) years, and a new Comprehensive Assessment is now due.
- ✓ The client's case was closed, and at some point following discharge experiences significant life changes, or his/her condition has worsened significantly, and as a result returns to the outpatient mental health program. Regardless of the time that has lapsed since discharge, the client will be considered "new" and a Comprehensive Assessment must be completed as soon as possible following the client's return. Comprehensive Assessment and treatment plan completion deadlines for new clients will apply.

In order to receive services, **every ongoing client must have a current Comprehensive Assessment**. Assessment compliance reports track due dates for the comprehensive assessment only.

Additionally, Clinicians must use the Comprehensive Assessment template when an assessment is scheduled by Access, when an existing client's assessment is due, or when it is obvious that a new

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client meets medical necessity. Remember, if Access has completed a phone screening and referred the client for a Comprehensive Assessment, the Comprehensive Assessment must be completed; an Initial Assessment is not sufficient since the medical necessity determination has already been completed by the screener.

NOTE: no additional time from the subsequent meetings should be added back into the Comprehensive Assessment template; this is considered double billing).

Assessment Update

An Assessment Update must be completed for every client receiving specialty mental health services when one of the following occurs:

- ✓ When a clinician determines that there is a reasonable probability that significant clinical information in the existing Comprehensive Assessment may not be currently accurate and the updated assessment still compliments the comprehensive assessment.
- ✓ To reflect significant changes in some aspect of the client's life and/or condition (i.e. updated documentation to ensure the diagnosis matches the documentation within the comprehensive assessment and/or functional impairments, housing or vocational status) since the previous assessment was completed.
- ✓ When a client requires a higher or lower level of care and the current Comprehensive Assessment does not reflect this needed level of care.

Due to frequent and ongoing changes in condition, placement and developmental milestones, children and adolescents under the age of 18 may require more frequent Assessment Updates.

When warranted, the Assessment Update will result in modification to the client's treatment plan goals and interventions to ensure parity with the conditions and impairments evaluated and documented in the Assessment Update.

Outpatient Progress Note: Assessment

The Outpatient Progress Note: Assessment template is used:

- ✓ When a Comprehensive Assessment takes more than one session to complete. The Comprehensive Assessment template will be used for the first face-to-face meeting with the client and any information gathered in that meeting. The Outpatient Progress Note: Assessment would be used for any additional time or meetings held to gather assessment information (NOTE: no additional time from the subsequent meetings should be added back into the Comprehensive Assessment template; this is

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considered double billing). The time claimed in the Outpatient Progress Note: Assessment would include the time spent the gathering assessment information and the documentation time for that note.

- ✓ Between triennial (i.e., every 3 years) Comprehensive Assessments for gathering general assessment updates and information. If information gathered will lead to a change in level of care, the Assessment Update template should be used instead, if significant changes are made, the comprehensive assessment should be completed.

Sample client assessment timelines:

Example 1: Client calls Access > QCM completes Access Contact sheet and Screening tool on the Access template, determines client needs further assessment, and schedules an assessment for client at the clinic > clinic clinician completes Comprehensive Assessment and it is determined client meets medical necessity for clinic level services. The client can begin receiving ongoing treatment. The initial assessment template should not be used.

Example 2: A Client who is difficult to link is referred to Crisis Services following discharge from the PHF > Crisis Services staff complete the Contact sheet on the Access template > Due to the acuity of the client, begin the Comprehensive Assessment; it is determined client meets medical necessity for clinic level services. > The client will be served by Crisis Services for up to 30 days while the client is linked to the outpatient clinic > The client is then transferred to the outpatient clinic. The clinic clinician will base treatment on the Comprehensive Assessment done by Crisis Services staff.

Example 3: Client walks in to a clinic requesting routine services > a clinician completes the Contact sheet on the Access template > and the Initial Assessment and determines client meets medical necessity. The client is scheduled for a Comprehensive Assessment > A clinician completes the Comprehensive Assessment and it is determined client meets medical necessity for clinic level services. The client can begin receiving ongoing treatment. Best practice is to complete the assessment as soon as possible, but must be completed within 60 calendar days (up to 60 calendar days for initial openings only; this timeframe does not apply to assessments for transferring clients). Assessments that take up to 60 calendar days to complete tend to be complex and especially challenging cases.

Example 4: Client walks in to a clinic requesting routine services > the clinician completes the Contact sheet on the Access template > and Based on what is known about this client (from what client or others are reporting or if client was previously open), the clinician determines it is highly likely that client will meet medical necessity and the clinician chooses to schedule the Comprehensive Assessment without first doing the Initial Assessment.

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Example 5: Client is currently open to a Behavioral Wellness clinic and has been receiving services for 3 years; during the last 3 years, staff have periodically documented on the Outpatient Progress Note: Assessment to capture general assessment information > Clinician will now complete the Comprehensive Assessment prior to or on the date the assessment is due and determines client continues to meet medical necessity. > After one year of services following the Comprehensive Assessment, the clinician observes that the client has had significant changes in their symptoms and needs to evaluate the current level of care. The clinician completes the Assessment Update to determine if client continues to be served best by the current level of care.

2.3 Elements of a Comprehensive Assessment

Area	Description	Example
Special Needs	Describe any disabilities or limitations relating to vision, hearing, mobility, written/verbal language, etc.	Clients reports being diagnosed with dyslexia in 4 th grade. He believes he may have other learning disabilities but did not receive further testing.
Military History	Capture any military history, including dates, durations and geographic locations of deployments as well as occupation and rank during each, circumstances of discharge, and discharge date.	Client reports no military history.
Identifying Current Functioning During Assessment	Document client's current presentation Describe reason for assessment Document what client states they would like help with Document onset, frequency, duration and severity of the symptoms/impairments	Client is dressed appropriately in jeans and a T-shirt. Client was referred to Behavioral Wellness by the Probation Department. The client is on probation for repeated arrests for trespassing at businesses. Probation reports seeing the client responding to possible auditory hallucinations. Client reports they would like help with managing thoughts of self-harm.
Presenting Symptoms and Impairments	Document response to Questions 1-3 of the Cultural Formulation Interview.	
Risk Assessment	SUICIDE: Indicate presence of ideation, plan, imminence, and any other information, as applicable. HOMICIDE: Indicate presence of ideation, plan, imminence, and any other information, as applicable. GRAVE DISABILITY: Indicate if the client, due to the presence of a mental disorder, is unable or unwilling to provide for his or her basic personal needs for food, clothing, or shelter. Indicate risk level.	Client denies any current thoughts of self-harm or harm to others. Client is not at risk for grave disability this day, as evidenced by client reporting he is eating twice a day and is oriented to place and time. Client was evaluated for grave disability 2 months ago when he was refusing to eat anything that was not canned. Client was found not to meet criteria for hospitalization at that time. Last year client had a woman who claimed to be his girlfriend and moved

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	<p>Other things to consider regarding client risk:</p> <ul style="list-style-type: none"> 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); 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.) 	<p>into client's home. This woman lived in client's home without paying any rent and the current provider believed that client allowed the woman to misuse his funds due to mental health impairments. Client would state that he didn't like the woman to stay at his home and spend his money. Eventually, the client was able to take legal action and have the woman removed. Client is at risk of being victimized in this way.</p>
Mental Health History	<p>For the first Comprehensive Assessment, provide a timeline of the continuum of care that the client received, when, where, by whom, treatment received, names of previous therapists/psychiatrists, and progress made or lack thereof. Document responses to Questions 4-5 of the Cultural Formulation Interview. For the Assessment Update, focus on the client's level of participation and progress since the last assessment. Do not copy/paste from previous assessments. Do not add mental health history under current functioning status.</p>	<p>Client began receiving services at Behavioral Wellness three years ago. Previously, client was not receiving any mental health service. Client reports that he has not felt services have helped him but that he continues to participate in psychiatry appointments and weekly groups.</p>
Developmental History	<p>Elicit the developmental milestones from a parent or caretaker perspective; i.e. when the child achieved the expected milestones or difficulties with them. Ask for prenatal issues (toxemia, premature birth, fetal alcohol, etc.) and infectious diseases, illnesses, childhood trauma or losses</p>	<p>Client stated that he reached all developmental milestones on time except for talking. He did not start with complete sentences until he was three and a half years old. He also had a period of enuresis when he started elementary school. He also noted that his mother told him she consumed alcohol while pregnant.</p>
Physical Health Status and History	<p>Elicit what significant illnesses, injuries, hospitalizations (and the dates) the client has experienced.</p> <p>Always ask about allergies and adverse reactions to medications and check the appropriate boxes.</p> <p>Document current Primary Care provider and date of last physical. Makes sure to document if a referral is needed to link to primary care if a client has no PCP.</p>	<p>Client reports a history of ulcers. Client's PCP is Dr. Cone and his last saw the doctor in October.</p>
Current Medication	<p>If the client is not taking any medication, state so in the Physical Health section and write "Not Applicable" in the Current Medications box.</p>	<p>Pepcid 25 mg, PRN, taking since 2005.</p>

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NOTE: This section CANNOT be left blank; Clinician's Gateway will not allow you to progress further without a minimum of 3 characters in this field.		
Legal and Forensic	Elicit the client's history of arrests and convictions, if any, including current status. State if client is on probation, what kind of probation, the name of the Probation Officer, and the conditions and expiration of probation.	Client has had involvement with the legal system since he was a teenager. Client is currently on probation for repeated arrests of trespassing at businesses.
Victim-related Trauma	If client reports no trauma history, select none. If you select any trauma, explain in detail in the box provided. "Abuser" trauma refers to the act of violence towards others. This is an extremely traumatic event and should be included in this section. Also note if the client's victim needed medical attention.	Client reports physical abuse from his father from the ages 8-10. Client reports sexual abuse by a neighbor from the ages 12-14. Client reports initiating fights several times per year when he was 17-22. In one of these instances, the victim had to have stitches.
Cultural and Social Factors and Functioning	Ask the client questions about his or her social and cultural background, such as : Would you describe yourself for me—both how you see yourself and how you think others see you? What were/are the values upheld by your family and community? How has your upbringing affected your worldview? What was it like to grow up as a girl/boy in your family of origin? What were the expectations for you in your culture of origin? What does it mean for you to be (definitions given by client) living in the USA?	Client reports being socially isolated, is impatient with others and will "yell" at them. Has no social support system. Feels useless and unmotivated. Born in California to Mexican immigrants and denies acculturation issues. Identifies as having a low socioeconomic status (SES). Reports past gang affiliation.
School/Work	Document schools attended, dates, issues, and behavior. If client is or was enrolled in special education classes, state timeframe and the date the last Independent Educational assessment done. Make sure to ask if a child has social issues at school-ability to make and keep friends. For adult clients, a brief timeline of jobs/occupations. Include here any government benefits the client is receiving and how much.	Client is a high school graduate. States he is a poor reader. Reports that he has had "many, many jobs. I was a bus boy, a short order cook, I worked for Parks and Recreation as a parking attendant, and I have done some apprenticing as a mechanic." Client has not had a job in the last year and receives social security disability. Client indicates he has had difficulty maintaining a current job due to ongoing MH issues.
Family History	Describe childhood and adolescence in the context of the family of origin. Elicit parent's history, including clinically significant information related to	Both parents deceased. Mother had a history of depression and committed suicide when she was diagnosed with breast cancer in 1979.

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	<p>medical, mental health, and substance abuse history.</p> <p>Record relevant information about siblings, spouses, and other family, including present relationships, conflicts, and mental health/ substance abuse history.</p> <p>Do not use their names or other identifying information.</p>	<p>Has one sister in Oaxaca, Mexico. Has not had contact with her for last 15 years. No mental health problems reported.</p> <p>Was married for 4 years. Wife left "because I couldn't work".</p> <p>Does not know whereabouts of other family members and has no contact.</p>
Family or Support Group's Strengths and Resources, and Consumer's Strengths	<p>Document client's response to questions provided focusing on context, resources, supports, and resilience.</p> <p>Document the client's recent self-coping for the problem. Document how client had been successful in the past.</p> <p>Document if client has any family or close family friend that lives in the area or has no supports.</p>	<p>Client utilized the food bank to supplement his groceries in the past. Client attended a drum circle at the beach once a month and used to engage in social interactions.</p> <p>Client used to use positive self-talk strategies to ignore auditory hallucinations.</p> <p>Client is interested in working on rebuilding these social outlets and developing new coping skills.</p>
Mental Status Exam	<p>When a box is checked other than "normal," describe the client's current presentation.</p> <p>Capture information that reflects their presentation the day of the assessment, not what was reported in the past.</p>	<p>Client's movements were slow and he made poor eye contact. He had prolonged speech latency (delayed responses) and spoke in a soft, low voice.</p>
Presenting Impairments 1 & 2	<p>Write the most significant presenting problems (functional impairments and symptoms) identified in this assessment. Minimum of two impairments. These will be summarized at the end of the assessment to then populate into the treatment plan. If the services are to be provided by an outreach program, there should be a minimum of one presenting problem/impairment for outreach/short-term programs. Do not add more than one in each box.</p>	<p>Presenting Problem #1: Client has had difficulty keeping housing.</p> <p>Presenting Problem #2: Client has an employment impairment.</p>
Treatment Recommendations	<p>Describe the recommendations for treatment and level of care. This is where the clinician outlines service necessity.</p>	<p>Client could benefit from monthly therapy and weekly rehabilitation to assist client in learning coping skills and symptom management. Client's impairment is severe and he qualifies for clinic level services. For children, if the level of care is wraparound (spirit), then the service necessity would be family, individual rehab/therapy, and collateral supports totaling up to 2-3x week, and may include TBS for up to 3 months.</p>

2.4 Claiming and Coding Requirements

If more than one assessment service is claimed, the reason for each subsequent assessment service must be clearly explained in the progress note for each service. The number of assessment sessions and total time for the assessment must be reasonable and supported by the documentation contained in the progress notes. The amount of time a clinician codes should be actual day and time spent with the client/family including documentation time.

If a clinician sees a client on Monday and finishes the paperwork on Tuesday (when client is not present), the time spent on paperwork is added to the actual day you did the write up and the time you spend on the service is added to the day you saw the client in a separate note. The write up is an important part of the assessment process, and it is a separate assessment service. It is important to have the time spent on your time card match the time you actually worked.

2.5 When a Client Transfers or Leaves Treatment

If a *client transfers or is opened to a new program*, the clinician may use one of the following options:

- ✓ Complete a new Comprehensive Assessment, if indicated.
- ✓ Accept the prior Comprehensive Assessment (if satisfactory) as long as it is current. This is only acceptable when the Comprehensive Assessment is from an outpatient program. Inpatient assessments and diagnoses may not be used for outpatient programs.
- ✓ Accept the prior Comprehensive Assessment, but if sections are incomplete, the clinician must complete these sections as soon as possible in an Outpatient Progress Note: Assessment. An additional 60 days is not allowed for existing open clients.
- ✓ If a client is transferring from a community-based organization (CBO) to a Behavioral Wellness outpatient clinic, a Comprehensive Assessment must be completed if indicated.

If a *client leaves treatment and returns*, the episode of care can be reopened within 60 calendar days of the closing based on the most recent assessment as long as the information is current and was previously completed less than one year ago. However, if the client had an inpatient hospitalization, incarceration or other major change in life circumstances during the time the case was closed, a new or updated assessment may need to be completed.

2.6 Updating an Assessment

An Assessment Update must be completed for every client receiving specialty mental health services when one of the following occurs:

- ✓ When a clinician determines that there is a reasonable probability that significant clinical information in the existing Comprehensive Assessment may not be currently accurate.
- ✓ To reflect significant changes in some aspect of the client's life and/or condition (i.e. changes in levels of care and/or functional impairments, housing or vocational status) since the previous assessment was completed.

Due to frequent and ongoing changes in condition, placement and developmental milestones, children and adolescents under the age of 18 may require more frequent Assessment Updates.

All Assessment Updates will result in modification to the client's treatment plan goals and interventions to ensure parity with the conditions and impairments evaluated and documented in the Assessment Update.

A new Comprehensive Assessment shall be completed every three (3) years for every client receiving continuous specialty mental health services. All required elements must be reevaluated and documented as part of the Comprehensive Assessment. Stating that there has been no change or "see previous assessment" is not acceptable.



3.1 Treatment Plans

The *client treatment plan* is the guiding force behind the delivery of care. Per the golden thread, treatment plans are linked to several components in the client's assessment (e.g. DSM diagnosis, functional impairments, and service necessity) that in turn inform the client's goals, strengths, obstacles, objectives, and interventions. All treatment planning activities must be documented through the Plan Development code on a separate progress note. This progress note must include the client's involvement, agreement or disagreement with the goals developed.

3.2 Initiating a Treatment Plan

Initial treatment planning occurs during three circumstances:

Initial Admission

Initial treatment planning must be completed within *60 days of admission* for all *new clients*. An initial admission means the client is newly opened to specialty mental health services. If the client is transferring to another program within Behavioral Wellness / from or to a CBO, that is not considered a new or initial admission.

Interim Client Treatment Plan

An Interim Client Treatment Plan is completed within a short period of time of the client coming into the system or program in order to quickly begin providing services that cannot be provided without a treatment plan. An Interim Client Treatment Plan *can be completed in both short- and long-term programs*, especially for clients that are difficult to engage. However, the Assessment must have been started and may be in progress, and all treatment plan requirements must be met for an Interim Client Treatment Plan.

At a minimum, the Interim Client Treatment Plan must include:

- ✓ Specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis;
- ✓ Proposed type(s) of intervention/modality;
- ✓ Detailed description of the intervention to be provided;
- ✓ Proposed frequency and duration of intervention(s);

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- ✓ Interventions that focus and address the identified functional impairments as a result of the mental disorder and are consistent with the client plan goal; **and must be**
- ✓ Consistent with the qualifying diagnoses; and
- ✓ Be signed (or electronic equivalent) by the required staff.
- ✓ And must document effort made to engage or encourage client to sign the treatment plan.

Transferring to a New Program

In order to claim for services provided by the new program, a treatment plan must be in place and include the specific interventions that that new program will be providing. Whenever possible, staff will plan ahead for the transfer and have the treatment plan in place prior to the client entering the new program. A new treatment plan may be necessary to match the level of care the client will be receiving. No additional time or extension will be granted for updating a treatment plan upon a client's transfer (there is a common misconception that an additional 60 calendar days for transfer is granted, which is incorrect). In this situation, the treatment plan and Assessment follows the client within the EHR. This means you may need to open the client to the new fac/prog prior to closing out the existing program.

For more information on the treatment planning process, [refer to Policy CL-8.101, Mental Health Client Treatment Plans](#).

3.3 Elements of a Treatment Plan

The treatment plan's structure is comprised of the identification of **presenting impairments** along with the impairment's associated **client goal, strengthens, obstacles, objective, service modality, and intervention**.

As the clinician develops each corresponding section (client goal, strengthens, obstacles, etc.), **the information in each section must be directly linked to the presenting impairment**. In other words, if the presenting impairment is associated with depression, all information that follows has to be about depression. The majority of clients served may have several presenting impairments, some of which will be the focus of the treatment plan while others can ameliorate over time.

With the exception of short-term outreach programs (e.g., Justice Alliance, RISE, Homeless Outreach), best practice for longer-term programs is to list at least **two (2) presenting impairments** in the treatment plan. For each presenting impairment, staff are encouraged to list

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at least **two (2) interventions**. Short-term programs may list just one (1) presenting impairment and one (1) intervention.

The following grid breaks down the various components of the treatment plan along with brief descriptions and documentation examples. All areas are required for a treatment plan to be considered complete as required by the Department of Health Care Services (DHCS).

Note: The information in the “Area” column reflects the layout of the Clinician’s Gateway Treatment Plan template. The grid does not capture all components of a treatment plan and instead focuses on areas that need further clarification or are commonly documented incorrectly.

Area	Description	Examples
Presenting Impairment	<p>A presenting impairment is a significant impairment in an important area of life functioning (social, vocational, educational, community, etc.) as a result of a mental disorder.</p> <p>During the assessment process, in cooperation with the client, the staff may identify several presenting impairments. From those presenting impairments, staff are encouraged to work with the client to select at least two (2) presenting impairments to be the focus of the treatment plan [short-term programs may list just one (1) presenting impairment]. The selected presenting impairments may be the most severe directly associated with the client’s diagnosis and/or the area in which the client is most motivated or willing to work on as their goal.</p> <p>The presenting impairments listed in the treatment plan should be similar to the presenting impairments documented in the assessment.</p> <p>Note that presenting impairments will auto-populate from the Comprehensive Assessment or Assessment Update template into the Treatment Plan template.</p>	<p>Presenting Impairment #1: Inability to maintain employment as a result of depression.</p>

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Client Goal	Ask the client to state their goal as it relates to the identified presenting impairment. The goal must be documented in the client's own words and can be written as a direct quote. Demonstrate that the client participated in developing the goal. Client goals must be directly tied to the presenting impairments listed in the Treatment Plan and Assessment. For each presenting impairment, list only one (1) of the client's goals.	Client reports, "I would like to be able to work so I can pay my bills."
Strengths	Identify the client's strengths that would help them achieve their stated goal. Ask the client what strengths have helped them be successful in the past. While the client may have various strengths, only list the strengths that will directly assist the client in achieving the previously stated goal as it relates to the impairment.	Client is motivated to begin working full time and indicated that he has been able to do this when he had a lot of family support a year ago.
Obstacles	Identify obstacles that would keep the client from achieving the stated goal. While the client may be facing various obstacles, only list the obstacles that would directly impede or prevent the client from achieving the previously stated goal that is related to this impairment.	Client reports having an inability to manage depression to where it is difficult for him to get out of bed on a daily basis. Client explained how hard it is to manage daily depression symptoms in order to be able to maintain job.
Objective	<p>The objective must focus on the symptoms or impairments as a result of the client's mental health diagnosis. This section summarizes the client's goal into observable and measurable language that has a baseline and a target.</p> <p>The objective cannot be focused on clients taking medications or attending appointments, as these are interventions. As with all other sections, the objective must address the presenting impairment previously stated.</p>	Client will increase getting out of bed and leaving his house to attend work from 0 days a week to 4-5 days a week.

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Integrated Psychiatric Intervention	<p>Select <i>Integrated Psychiatric Intervention</i> when a client is being treated by a psychiatrist. This emphasizes that treatments are provided with a team-based care approach and that Medication Support Services are not a separate isolated service. The <i>Integrated Psychiatric Intervention</i> counts as a second intervention.</p> <p>If the staff selects that the treatment plan is NOT an <i>Integrated Psychiatric Intervention</i>, it means that the client will not be seen by a psychiatrist; in this case, no intervention needs to be entered. This is usually the case for children's programs.</p>	<p>The psychiatrist will provide a psychiatric assessment and provide the client with psychoeducation to help manage symptoms of depression.</p> <p>Medication support staff will provide psychoeducation and follow up with vitals to help monitor side effects.</p> <p>Medication support staff will monitor efficacy of medications to reduce symptoms of depression.</p>
Interventions	<p>Describe the modality and what interventions staff will provide to assist the client in reducing impairments. With the exception of short-term programs, at least two (2) interventions should be documented for each presenting impairment. State <u>only one (1) intervention per field box</u> and add more field boxes for each intervention. Staff should add additional intervention field boxes to ensure all interventions and provider's roles are completely and accurately reflected in the treatment plan.</p>	<p>Case worker will provide rehabilitation through education and coaching on utilizing coping skills to help manage symptoms of depression.</p> <p>Rehabilitation specialist will provide skill-building tools to assist with job retention.</p> <p>Therapist will provide psychotherapy to assist client with feeling identification, cognitive distortions, and thought stopping techniques.</p>
Duration	<p>Period of time during which intervention/services listed in the treatment plan will be provided.</p> <p>The default duration is 12 months. It is recommended that the duration for all interventions be 12 months and that any</p>	<p>12 months</p>

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	<p>changes to duration be made as needed throughout the year. If a staff selects time frames under 12 months, the treatment plan will expire sooner than the 12 months.</p>	
Frequency	<p>Enter the frequency that most accurately reflects the amount of services that will be offered based on level of care needs. The frequency on the treatment plan should match the services that are actually provided and documented in the client's electronic health record.</p> <p>Staff may state a range of frequency for services.</p>	<p>Therapy services will be provided 1-2 time monthly.</p> <p>Rehabilitation services will be provided 1-2 times weekly.</p> <p>Medication support services will be provided 1 time monthly.</p>
Authorization	<p>Check the appropriate boxes and select staff names to indicate who is responsible for authorizing if the staff completing the treatment plan is not a LMHP. A psychiatrist only co-signs treatment plans for Medicare clients. All other treatment plans can be finalized without a psychiatrist's review.</p>	
Participation	<p>Check the appropriate boxes identifying those that are responsible for providing the services that will be part of the treatment team as stated in the treatment plan and participated in developing the treatment plan. This section reflects the team-based care model of collaboration and support from a multidisciplinary team.</p> <p>Staff must also check the boxes and document in a separate Plan Development note that: (1) indicates the client was included in the collaboration process of developing the treatment plan goals, (2) the client was offered a copy of the treatment plan, and (3) the client agreed with the goals/interventions.</p>	

3.4 Measurable Objectives

In the treatment planning process, objectives provide a path for the client to achieve their goals. All objectives must address symptoms or impairments resulting from an included mental health diagnosis that were originally identified during the assessment process. The key to a clear and strong objective is developing a statement in *observable and measurable terms* that describe what the client will accomplish as a result of the interventions applied by staff.

Do not confuse objectives with interventions, such a client taking their medication or attending appointments.

Objectives checklist:

- ✓ Does the objective clearly address a mental health impairment (or symptom) that is based on the included diagnosis?
- ✓ Is there a baseline (often the client is engaging in, or has an occurrence of, a specific behavior or symptom)?
- ✓ Is there a measurable target/outcome (a clear way to measure if the goal is met)?
- ✓ What is a reasonable target that the client can achieve?

3.5 Formulating Interventions

Interventions must describe the modality and actual interventions that staff will implement with the client and how they will help client meet the treatment plan goal. *Interventions cannot be copy and paste or definitions of bill codes.*

Do not use “Ad Hoc” or “as needed” as a frequency of interventions. Instead, make a reasonable estimate for frequency of sessions/services. Staff may also indicate a range of frequency (e.g. “2x-4x per week”). If staff consistently use more time than listed in the treatment plan, revise the treatment plan to better match actual use and level of care.

Medication support services should be linked to the mental health goal by adding additional interventions to the goal that are called *Integrated Psychiatric Interventions*. Examples include “Reduce Frequency/Intensity of Symptoms by....,” and “provide psychoeducation regarding medication side effects.”

Interventions Checklist:

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- ✓ Is the modality outlined? Each staff providing services must have an intervention they can document to for their specific class level (i.e., job classification/title). For example, non-LMHPs may not document on therapy services or clinical evidence-based practices that are outside their scope of practice.
- ✓ Is the intervention individualized? It is unique for this client?
- ✓ Does the intervention link to a symptom or impairment (describe how this intervention will help client meet goals)?
- ✓ Does the intervention relate to the diagnosis?
- ✓ Is the intervention realistic and a focus of treatment?

3.6 Updating a Treatment Plan

All treatment plans must be updated annually from the anniversary date of the last “New” treatment plan (i.e. the date it was signed by the client, or signed by only the staff when documentation demonstrates the reason the client was not able to sign the treatment plan). The treatment plan anniversary is **one year from the first day of the month**. For example, if a client is admitted on August 15, the annual treatment plan update must be completed by August 1 of the following year.

Additionally, treatment plans must be updated whenever clinically indicated. This means the LMHP has updated the assessment to capture a significant life event that potentially changes the client’s mental status, diagnosis or treatment direction, or any other major life stressor. This information is then reflected in the updated treatment plan.

When updating treatment plans, clinicians have the following 2 action options:

- ✓ **NEW** - used to complete a completely new treatment plan annually. Choosing *New* establishes a new treatment plan anniversary date.
- ✓ **REVISE** - used when the existing treatment plan continues to meet the client’s needs, and only a minor revision to reflect new goals or interventions is necessary, or when a client is transferred to or moved to a different level of care. Choosing *Revise* **does not** change the treatment plan anniversary date. Additionally, if the treatment plan anniversary date passes and the treatment plan was not renewed, the option to revise will no longer be available.

3.7 Interim Treatment Plan

An Interim Treatment Plan is a plan completed within a short period of time of the client coming into the system or program in order to quickly begin providing services that cannot be provided without a treatment plan. An Interim Treatment Plan can be completed in both short- and long-term programs, especially for clients that are difficult to engage. However, all treatment plan requirements must be met for an Interim Treatment Plan.

At a minimum, the Interim Treatment Plan must include:

- ✓ Specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis;
- ✓ Proposed type(s) of intervention/modality;
- ✓ Detailed description of the intervention to be provided;
- ✓ Proposed frequency and duration of intervention(s);
- ✓ Interventions that focus and address the identified functional impairments as a result of the mental disorder and are consistent with the treatment plan goal; *and must be*
- ✓ Consistent with the qualifying diagnoses; and
- ✓ Be signed (or electronic equivalent) by the required staff (see Section 3.8 for more information).

[MHSUDS Info Notice No. 17-040, p. 14]

3.8 Signatures

Staff Signatures

A treatment plan must be signed (or electronic equivalent) and dated by either:

- ✓ The person providing the services;
- ✓ A person representing a team or program providing services; or
- ✓ A person representing the Mental Health Plan (MHP) providing the services.

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In addition to a signature by one of the above, the treatment plan must be co-signed by one of the following providers if the treatment plan indicates that some services will be provided by a staff member *under the direction* of one of the categories of staff listed below, and/or the person signing the treatment plan is not one of the categories of staff listed below:

- ✓ A physician;
- ✓ A licensed/waivered psychologist;
- ✓ A licensed/registered/waivered social worker;
- ✓ A licensed/registered/waivered marriage & family therapist;
- ✓ A licensed/registered/waivered professional clinical counselor; or
- ✓ A registered nurse, including but not limited to nurse practitioners and clinical nurse specialists. [MHSUDS Info Notice No. 17-040, p. 9; 9 CCR §1810.440 (c)]



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Client Signatures

The client's signature or the signature of the client's legal representative is required on the treatment plan when:

- ✓ The client is expected to be in long-term treatment as defined by the Mental Health Plan (MHP); and,
- ✓ The treatment plan provides that the client will be receiving more than one (1) Specialty Mental Health Service (SMHS). [MHSUDS Info Notice No. 17-040, p. 9-10]

The treatment plan must be signed by the client prior to most services being provided. If the client is a minor, the treatment plan must be signed by the parent/legal guardian. A foster parent is not considered a legal guardian. For foster care children, a social worker must sign the treatment plan.

Always try to obtain an electronic signature using a signature pad.

In the event staff are unable to obtain a signature from the client or parent/legal guardian, the attempts to obtain a signature and reason why a signature could not be obtained must be documented in a Plan Development note. Enter the date of the Plan Development note in the field titled "*If no client, parent, and/or guardian signature, see progress note date*", located at the end of the treatment plan template. The treatment plan can still be finalized without a signature if a Plan Development note documenting the lack of signature is present and the date of the note is entered in this field. Although not required, it is best practice to make additional attempts to obtain the client's signature and document the attempts made in the client's medical record. [MHSUDS Info Notice No. 17-040, p. 11; 9 CCR §1810.440(c)(2)(B)]

In some cases, staff will obtain verbal agreement for the treatment plan. Staff are to document this verbal agreement and the plan to obtain a signature, included the expected date for obtaining the signature, in a Plan Development note.

Short-term Outreach or Step-down Services

Short-term services may be provided by both long-term and short-term programs. Short-term programs such as Crisis Services, RISE, Assertive Outpatient Treatment (AOT), and Homeless Services can work off an Interim Treatment Plan until a client links to the appropriate services. Once linked to a long-term program, the treatment plan is updated.

All programs providing short-term services may finalize an Interim Treatment Plan without a client signature but must document the following:

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- ✓ Efforts to obtain a signature;
- ✓ Description of the client's participation in the development of the interim treatment plan; and
- ✓ Agreement or disagreement with the interim treatment plan goal.

The Interim Treatment Plan also outlines *the process for continuity of care* for individuals that no longer meet medical necessity and need to be transitioned to a lower level of care (e.g., Holman provider, primary care physician, community services), or for individuals that have been difficult to engage and will transition from an outreach program to a longer-term program within 60 days.

NOTE: Since this service is not claimable to Medi-Cal, staff should document time spent on transition services on their timecard as "MCO 438.208" (Managed Care Organization, Section 438.208 of the Managed Care Final Rule), with MCO written project code section and 438.208 placed in the notes section.

The client's participation and agreement/disagreement to the plan must be documented in a separate Plan Development note.

Minor (17 and under) and Conserved Clients

There is no minimum age for a minor to independently sign a treatment plan (assuming the treatment plan is not used to obtain the minor's consent to treatment), though minor consent law requires that we offer all minors 12 and up the option of signing the treatment plan.

Whenever possible, staff should also obtain the signature of every parent or legally responsible person involved in the minors care.

The treatment 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. It is recommended that providers discuss treatment plan goals with minors and encourage them to sign their plan.

The legally responsible person's signature must be obtained prior to delivering ongoing services for all LPS conservatees. If the legally responsible person participates in developing the treatment plan, document agreement and participation, and then ask him/her to sign the treatment plan at the next face-to-face visit. For foster care children, the social worker is the legal guardian. Foster parents cannot sign treatment plans nor can they sign consent for treatment.

Clients Unable or Unwilling to Sign the Treatment Plan

In rare instances, a client may be unable or unwilling to sign a treatment plan. Explore the client's concern, attempt to engage/problem solve, and revise the treatment plan if needed. Make reasonable attempts to get the client's signature and document these discussions and attempts in a Plan Development note. A staff is still able to finalize a treatment plan using the staff signature.

3.9 Provision of Services Before the Completion of a Treatment Plan

The following service codes are allowed to be claimed before the treatment plan is finalized:

- ✓ Assessment
- ✓ Plan Development
- ✓ Crisis Intervention
- ✓ Crisis Stabilization
- ✓ Client Support codes
- ✓ **Interim Medication Support Services** (for assessment, evaluation, or plan development, or if there is an urgent need, which must be documented.)
- ✓ **Interim Targeted Case Management** (for referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and education services)
- ✓ **Interim Intensive Care Coordination (ICC)** (for assessment, plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and education services)

3.10 Claimable Services during “Gap” Between Treatment Plans

A “gap” between treatment plans occurs when **a treatment plan has expired** and there is an amount of time that passes before the updated treatment plan is in effect. When there is a gap between treatment plans, staff may only provide certain services that are allowable prior to a treatment plan being finalized (see Section 3.8, *Provision of Services Before the Completion of a Treatment Plan*, for more information). Only codes listed in Section 3.8 of the manual may be used during the “gap” time. The provision of any services other than those listed in Section 3.8 are not reimbursable and will be disallowed. [MHSUDS Info Notice No. 17-040, p. 13]

When using interim codes for Targeted Case Management, Intensive Care Coordination (ICC), and Medication Support Services to provide services prior to finalizing a treatment plan, staff must document in the progress note that the service rendered is an allowable and urgent service prior to finalizing a treatment plan. Staff must make all efforts to update the treatment plan as soon as possible, but no later than 30 days from the expiration date.

3.11 Services Disallowed Without a Current Treatment Plan

The Department of Health Care Services requires Specialty Mental Health Services (SMHS) to be provided based on medical necessity criteria, in accordance with an individualized treatment plan, and approved and authorized according to State of California requirements. A finalized treatment plan must be in place prior to service delivery for the following SMHS:

- ✓ Mental health services (except assessment and plan development)
- ✓ Intensive Home Based Services (IHBS)
- ✓ Certain components of Targeted Case Management and Intensive Care Coordination, specifically monitoring and follow-up activities to ensure the beneficiary’s treatment 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-emergency)

Overview

- ✓ Psychiatric Health Facility Services (22 CCR §77073)
- ✓ Psychiatric Inpatient Services [42 CFR §456.180(a); 9 CCR §1820.230(b), 1820.220(l)(i)]

[MHSUDS Info Notice No. 17-040, p. 13]

3.12 Treatment Planning for Outpatient Clients who are Incarcerated or Hospitalized Clients (clients that will return to outpatient)

If an outpatient client is hospitalized in a locked facility (i.e., PHF, IMD) or incarcerated, staff may complete a treatment plan to capture provision of services, such as case management and transition planning, for that client to prepare for discharge. This service is captured in a Client Support - Informational Note (found under the Procedure Code dropdown list within the Outpatient Progress Note template) once the client is discharged from the locked facility or jail and linked to the appropriate services, the treatment plan can be updated to reflect the appropriate level of care.

For outpatient clients who have been found Incompetent to Stand Trial (IST) are not legally able to consent to outpatient services until competency is restored.



4.1 Progress Notes

Progress notes document the actual services delivered to the client. **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 treatment plan [DHCS MHSUDS Information Notice No.: 17-040].

4.1 Required Elements of a Progress Note

- ✓ **Relevant Aspects of Client Care:** Timely documentation of relevant aspects of client care, including documentation of medical necessity.
- ✓ **Details of the Encounter:** Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions, etc.
- ✓ **Interventions and Details:** Interventions applied, client's response to the interventions, how services provided reduced impairment/restored functioning/prevented deterioration in an important area of life functioning outlined in the client treatment plan, and the location of the interventions.
- ✓ **Date of Service:** The date the services were provided.
- ✓ **Referrals:** Documentation of referrals to community resources and other agencies, when appropriate.
- ✓ **Follow-Up Care or Discharge Summary:** Documentation of follow-up care or, as appropriate, a discharge summary.
- ✓ **Service Time:** The amount of time taken to provide services (actual time, not estimated).
- ✓ **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.
- ✓ **Date of Documentation:** The date the documentation was entered in the medical record. This will auto-populate within the EHR.

Overview

Team Based Care (TBC) Progress note template: involves one provider documenting the client centered care of multi-Providers, it also includes the documentation of care coordination. The **assigned Care coordinators** should document the coordination of care monthly for all outpatient clients and more frequently for Full Service Partnership (FSP) clients. The TBC multi-provider notes should be documented when services are being provided to, or on behalf of, a client by two or more staff at one point in time, ensure that the progress notes include: (a) documentation of each person's involvement in the context of the mental health needs of the client; (b) the exact number of minutes used by each staff person who plays a role in the treatment, (c) outline reference to individualized goals and case coordination; (d) the follow up plan or outcome of case coordination, and; (e) signature(s) of person(s) providing the services. Review the assigned care coordination role and responsibilities memo [here](#).

4.2 Documentation of Medical Necessity in Progress Notes

DHCS has clarified that the components of medical necessity that must be documented in the progress note include:

- ✓ (a) the specific intervention that was provided,
- ✓ (b) how the intervention provided reduced the impairment(s), restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client treatment plan, and
- ✓ (c) the client'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 client's identified mental health diagnosis.

The interventions should be described in such a way that an external reader (e.g., 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 [DHCS MHSUDS Information Notice No.: 17-040].

4.3 Timeliness Standards for Progress Notes

As a best practice, progress notes and service documentation should be fully finalized with required co-signatures immediately following the service, but no later than the end of the day on which the service is provided. However, the exact timeliness standards are determined by the type of required documentation for type of authorized services (e.g., a progress note for every contact vs. one daily summary for an entire day of services for the CSU or services for crisis residential). A progress note will be considered “on time” if completed within the following timeframes:

- ✓ **Crisis Intervention progress notes** should be completed immediately following a crisis interaction but no later than the end of the staff’s shift. If mitigating circumstances interfere with the completion of documentation within this timeframe, staff may consult an immediate supervisor and request an extension not to exceed 24 hours. In the event that a supervisor is not available, staff will consult and seek approval from a Regional Manager or on-call administrator.
- ✓ **Individual progress notes** are ideally **finalized** within 10 calendar days from the date and time of service.
- ✓ **Group progress notes** and associated individual progress notes are ideally **finalized** within 7 calendar days from the date and time of service. Staff will ensure an individual progress note is written for each client participant in the group.
- ✓ For staff on note review and/or notes requiring co-signature, progress notes must be **submitted for review** within 5 calendar days from the date and time of service. These notes will be reviewed, sent back to staff and finalized within 10 calendar days from the date and time of service.

In all instances, if the service documentation is not entered or fully finalized within the timeframes stated above, then the documentation is considered to be late and the late documentation may be disallowed.

Progress notes that are not finalized (e.g., left in “draft” or “pending” in the electronic health record) cannot be claimed after a certain amount of time and do not meet the compliance standards for completeness and timeliness.

For the most current information on timeliness standards, please refer to the Department’s policy [Mental Health Progress Notes](#).

The table below summarizes the frequency and timeliness standards for progress notes by type of service.

Overview

Type of Non-Hospital Service	Time Claimed In	Progress Note Standard*
Outpatient Clinic Care	Minutes/ Staff Time	Every contact is documented in progress note Individual: Finalized within 10 calendar days from the date and time of service. Group: Finalized within 7 calendar days from the date and time of service. Note review: Submitted for review within 5 calendar days and These notes will be reviewed, sent back to staff and finalized within 10 calendar days from the date and time of service.
TBS	Minutes/ Staff Time	Every contact is documented in progress note Individual: Entered within 3 working days and finalized within 5 working days Group: Entered within 3 working days and finalized within 5 working days Note review: Submitted for review within 5 calendar days and These notes will be reviewed, sent back to staff and finalized within 10 calendar days from the date and time of service.
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 Intervention	Blocks of Time	Immediately following a crisis interaction but no later than the end of the staff's shift. An immediate supervisor may grant extension of 24 hours
Crisis Stabilization	Blocks of Time	Progress note (4 hour blocks)

Overview

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

4.4 DIRT Progress Note Format

Behavioral Wellness requires providers to use a structured format to document progress notes and services. The format that is used is **DESCRIBE-INTERVENTION-RESPONSE-TREATMENT PLAN**, also known as “DIRT”. While the DIRT format ensures all required components are properly documented for each encounter, progress notes should be unique to each client and never cloned across clients.

The following grid breaks down the various components of the progress note along with brief descriptions and documentation examples. All areas are required for a progress note to be considered complete.

Note: The information in the “Area” column reflects the layout of Clinician’s Gateway. Additionally, the grid does not capture all components of a progress note and instead focuses on areas that need further clarification or are commonly documented incorrectly.

With the exception of services that are not claimed to the state (i.e. indirect service codes), all progress notes will use this format, including, but not limited to: Assessment, Crisis Intervention, Therapy, Rehabilitation, Targeted Case Management, Medication Support, Collateral, Plan Development, ICC (Intensive Care Coordination), and IHBC (Intensive Home-Based Services).



Overview

Area	Description	Examples
Description	<p>Document the presenting problem and/or reason for the current service activity. Using behaviorally-specific language, explain exactly and objectively how the client presents him/herself, or the reason for the current service activity as it relates to the impairments listed in the current client treatment plan.</p> <p>Do not provide an interpretation of the presentation or use general psychological terms or jargon (e.g. instead of "client and family report increased panic at bedtime", write "client and family reports that client paces back and forth in her room at night for up to 2 hours and fears going to sleep ...").</p> <p>Each progress note must "stand on its own" in demonstrating Medical Necessity.</p>	<p>Met with client in the office, client was able to use public transportation for weekly therapy session. Client was dressed appropriately in jeans and a T-shirt. Client had poor eye contact and seemed to have difficulty settling in. She reports that she continues to have these impairments.</p>
Intervention	<p>Explicitly state and elaborate on what interventions staff applied to reduce the client's impairments or prevent deterioration in functioning. Ensure that the interventions applied are in the current client treatment plan.</p>	<p>Staff provided education and modeling on coping skills (deep breathing) to assist client in reducing social anxiety to improve relationships.</p>
Response	<p>Document client's response to that session's interventions. In other words, what did the client do or how did the client react or respond to the current service/intervention provided?</p> <p>If the intervention involves others present during the current session (i.e. parents, spouse), describe their response/reaction as well.</p>	<p>Client engaged and participated by practicing deep breathing techniques and agreed to practice one time at school the following day. She reported that the session was helpful.</p>

Overview

Treatment Plan	Describe the next step in treatment. Provide any follow up information (i.e. referrals provided, specific focus of treatment for next session) and information not related to interventions provided in session.	Staff will meet with client next week to follow up on client utilizing deep breathing and teach “mindfulness techniques. Will refer client to primary care physician for blood pressure issues.
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4.5 Travel Time Billing

The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity (i.e., provision of specialty mental health services). This is the case whether or not the time spent on these activities is on the same day as the reimbursable service activity.

- ✓ Travel time from a provider site to an off-site location(s) where Medi-Cal specialty mental health services are delivered is claimable. The travel time must be directly linked or related to the services provided. These services 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. Note that a “provider site” is defined as a site with a provider number. This includes affiliated satellite sites and school sites.
- ✓ Travel time between provider sites, or from a staff member’s residence to a provider site, may not be claimed. [\[DHCS MHSUDS Information Notice No.: 17-040\]](#)

ALLOWED

From staff’s assigned clinic site to ...	Client’s home, or any setting in which the client is seen. Can include return time to the clinic.
Transporting a client from point A to point B	Transporting clients for linkage and brokerage services (TCM) only. This service has to be captured in the treatment plan interventions in order for staff to transport clients for this purpose, and the note needs to capture the mental health reason staff need to provide transportation.
From staff’s assigned clinic site to ...	Interagency meetings for a client (regardless if the client is present or not), such as an IEP, DSS, and Probation, during which a mental health service is provided. Return time to the clinic can be included in travel time. Outline in the progress note how the client will benefit from you attending this interagency meeting.

Overview

From staff's assigned clinic site to ...	Out-of-county youth placement (e.g., STRTP, foster care) to provide mental health service to one or more county youth. Time to return to clinic can be included in travel time.
From staff's assigned clinic site to ...	Out-of-county board and care or skilled nursing facility (SNF) to provide mental health services to one or more county clients. Time to return to clinic can be included in travel time.
From staff's assigned clinic site to ...	To see multiple clients back-to-back. For example, traveling from Client A's location to see Client B. The travel time back to the staff's assigned clinic site would be claimed as part of Client B's services.
From staff's home to...	A client's location to provide a claimable service, if the staff's home is closer than the clinic site.
NOT ALLOWED	
From location A to ...	Location B for any non-claimable service (e.g. staff arrives to the client's home but he/she is not there).
From staff's assigned clinic site to ...	A locked facility, such as an IMD, PHF, or jail, to provide mental health services to one or more county beneficiaries.
From any work site to ...	Conduct personal errands, return to staff's home or travel to off-site lunch breaks. At no time may staff have clients accompany staff on personal errands.

4.6 Accuracy, Confidentiality, Abbreviations and Recovery-Based Language in Progress Notes

Please refer to the Department's policy [Mental Health Progress Notes](#) for up-to-date standards on accuracy, confidentiality, abbreviations and recovery-based language.



Overview

This section discusses the direct service codes allowable by DHCS and Behavioral Wellness.

5.1 Client Support Codes (Non-Claimable)

Clinicians are required to document any scheduled and unscheduled interaction with clients. Some of these services might fall under the category of “client support”. These are services that do not assist clients in meeting their treatment plan goals, but are still necessary to provide for client care. In some cases, the treatment plan goals may need to be updated if these services are needed to improve the client’s mental health condition.

Client support code usage should be minimal. Whenever possible, services provided should address the client’s treatment goals, but when this is not feasible, use a client support code.

If you find yourself coding more client support codes than direct service codes, assess if other agencies or professionals should be providing these needed services. In order to document a client support note, select the Outpatient Progress Note template and claim the appropriate Client Support Code.

The following grid describes each Client Support Code and when it should be used.

Code	Description	Example
Informational	Documentation of a client interaction or activity that cannot be accounted with another service code, but needs to be included in the client record.	Mandated reporting, payee related, when client is placed in IMD or psych hospital, drug testing.
Interpretation	Providing interpretation where the interpreter is not assisting in providing a mental health service.	A professional interpreter could not be scheduled. As a last resort, a case manager is asked to interpret for a client in a psychiatrist appointment. Note: This code can only be used as a last resort. A last resort means an in-person professional interpreter could not be scheduled in time or is not available, or Language Line cannot provide an interpreter in the client’s preferred/primary language.

Overview

Scheduling	Scheduling /rescheduling, appointment reminders that did not include a mental health service, such as leaving voice messages.	Staff calls the client to schedule the next appointment.
Transportation	Solely transportation, no other mental health/rehab service provided (e.g. taking client to physical health appointment). Do not use this code if the transportation provided is a service linked to the treatment plan.	Giving client a ride to a doctor's appointment and there are no mental health needs being addressed from the Treatment plan. Need to consider the reason this is being done vs empowering the client to figure out transportation issues on their own- document plan for next time.
Vocational	Providing support to client obtaining employment that cannot be linked to a treatment plan goal. Do not use this code if the vocational service provided is linked to the treatment plan, or if the service is provided by contracted staff through the Department of Rehabilitation (unless the service cannot be claimed to Medi-Cal).	Helping client write a resume. Assisting client with soft job skills.
Parent/Family Support	Providing an intervention or engaging in discussion with client's family or support person when the intervention cannot be linked to client's treatment plan goal. This should not be an ongoing service. If supporting the family member leads to supporting the client's goals, then the service could be claimable under family collateral code.	Providing information to client's significant other about getting their own mental health treatment.
Forensic	Participation in court activities including advocacy/support that is not directly addressing mental health needs, when the client does not meet medical necessity, or the service being provided is not supported by the treatment plan.	Accompanying client to court for support.

Overview

Outcome Reporting	For the completion of Child and Adolescent Needs and Strengths (CANS) tool only.	
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5.2 List of Services Claimable to Medi-Cal

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 (there are highlighted in blue below).*

- ✓ Rehabilitative Mental Health Services:
 - Mental Health Services
 - Assessment
 - Plan Development
 - Collateral
 - Rehabilitation (Individual or group)
 - Therapy (Individual, family, or group)
 - Medication Support Services
 - Interim Medication Support Services
 - Day Treatment Intensive- defined under 9CCR §1810.213 as well as CA SPA 12-025
 - Day Treatment Rehabilitation- defined under 9 CCR §1810.212
 - Crisis Intervention
 - Crisis Stabilization
 - Adult Residential Treatment Services
 - Crisis Residential Treatment Services
- ✓ Targeted Case Management
- ✓ Interim Targeted Case Management
- ✓ Psychiatrist Services
- ✓ Psychological Services

Overview

- ✓ EPSDT Supplemental SMHS
 - Therapeutic Behavioral Services (TBS)
 - Intensive Care Coordination (ICC)
 - Interim Intensive Care Coordination (ICC)
 - Intensive Home-based Services (IHBS)
 - Therapeutic Foster Care
- ✓ Psychiatric Nursing Facility Services

“Rehabilitative Mental Health Services” are services recommended by a physician or other LMHP 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.

NOTE: When services might not be claimable due to the client’s treatment plan being out of compliance (past due), staff should always attempt to update the treatment plan as soon as possible. However, if it is very difficult to connect with a client to update the treatment plan, then use the same code that would be used if the treatment plan were in compliance. The billing component will be handled by MIS and fiscal; in other words, the claim will be blocked by the business rule unless it is an interim code. If the service is an interim code, make sure all requirements to claim the interim code are in place.

5.3 Assessment

Assessment means a service activity designed to evaluate the current status of a client'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 client's clinical history; analysis of relevant cultural issues and history; and the use of testing procedures.

Assessment services must be provided within a clinician's scope of practice. See the [Service and Staff Claiming Privilege Matrix](#) to identify the types of credentialed staff who may provide assessment services. The Matrix outlines all of the claimable services and corresponding credentialed staff.

For more information on assessments, please refer to Chapter 2 of this manual.

5.4 Plan Development

“Plan Development means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a client's progress.” (Title 9, 1810.232)

Plan Development services constitute the development of a new treatment plan, making changes to an existing treatment plan, or discussion of treatment planning, treatment progress or lack of progress for a client. This progress note may not capture *the participation of the client and/or significant support person(s), and any agreement to partake in interventions unless the services are to complete a new or updated treatment plan*. Often, changes need to be made to reflect new information and changes in the client's condition. Plan Development also includes team-based care meetings that address treatment needs and case conferences for the purpose of planning and discussing treatment progress or lack of progress. In order to document a Plan Development note, select the **Outpatient Progress Note** template and claim **Plan Development**.

Examples of the most common types of Plan Development services include:

- ✓ Writing the initial and updated treatment plans
- ✓ Reviewing previous documents in order to develop the treatment plan
- ✓ Treatment meetings such as team-based care to monitor client's progress, even when there is not a need to update the plan.
- ✓ Meeting with another professional that is part of the client's treatment team that results in changes to the treatment plan or for the purposes of monitoring client's progress.

Overview

- ✓ Meeting with a client to discuss the treatment plan and obtain client/caregiver signature as evidence of agreement and participation.

Practical Learning: Plan Development Services

Sample Progress Note	
<u>Description</u> ✓ Why client is present for service (if client is present). OR ✓ The purpose of the team discussion regarding the client's progress or lack of progress in treatment. AND ✓ Behavioral/appearance observations if the client was present. ✓ Where the Plan Development service took place.	<i>The Family Facilitator (FF) on the SPIRIT Team met with the client's parents and the client in their home to evaluate client's progress with treatment and discuss treatment options. The parents indicated that they have seen some improvements in their child's behavior since services began. However, their child continues to act out in the school setting. Client was quiet and unengaged while his parents spoke.</i>
<u>Intervention</u> ✓ Describe strategies used to gather information ✓ Describe how the plan was explained to client/parents.	<i>FF assessed the client's current symptoms and behaviors. Highlighted client's progress with treatment within the home, and discussed obstacles/barriers that are preventing client from meeting his mental health goals within the school setting. Collaborated with parents and client in developing a treatment plan that reflects client's current symptoms and behaviors that family would like to work on. FF reviewed new goals, interventions, and frequency with parents.</i>
<u>Response</u> <u>Client's Response</u> ✓ If client was present, how did the client react? What did they say? ✓ Document client/parent agreement with plan, that signatures were obtained or any reason why signatures were not obtained and plans to get signatures	<i>Parents report that client has some strengths where the client is resilient and appears to be trying hard after he makes a mistake and gets detention at school. Obstacles continue to be client being triggered by one student in his class. Parents state that they would like client to continue to work on reducing aggressive behaviors in the classroom. They report that he does appear to be making friends, as he has been doing well with the new friends he has made. Parents and the child agreed to the goals and signed the plan.</i>
<u>Treatment Plan</u> ✓ The next steps in treatment, followup and referrals.	<i>FF will communicate change and updates in goals to the SPIRIT team. Will have the Case Worker on the SPIRIT Team follow-up with the client's teacher on what options or solutions can be implemented that could help reduce aggression in the school.</i>

5.5 Collateral

“Collateral services are activities provided to significant support person(s) in a client’s life for purpose of meeting the needs of the client in achieving the goals of the client’s care plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better use of Specialty Mental Health Services by the client, 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 client may or may not be present for this service activity.” (Title 9, 1810.206)

The **Collateral** services claiming code is used when the person plays a significant role in the client’s life, whether it be parents, spouses, caregivers, friends, siblings, a spiritual advisor, or any other non-paid, non-professional significant support person(s) of a client that is directly receiving support for mental health needs. If seeing family members in family therapy without the client present, the code used is Collateral, but the client’s goals need to be addressed as priority. In order to document a Collateral note, select the Outpatient Progress Note template and claim Collateral.

Collateral services help the significant support person(s) to understand and accept the client’s condition, involve them in treatment service planning and in the implementation of the treatment plan, and assist in helping the client achieve their treatment goals.

Services are usually centered on providing **education, training, and consultation** for the express purpose of benefiting the client.

Contact with significant support person(s) to link to or brokerage resources **are not** Collateral services. These could be considered Targeted Case Management services. Discussion of treatment progress or lack of progress would be considered a Plan Development service.

Who is considered a “significant support person”?

“Significant support person” is defined as “persons, in the opinion of the beneficiary 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 beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary’s spouse, and relatives of the beneficiary.” (9 CCR §1810.246.1) “Family”, as defined by Medicare, may apply to traditional family members (including husband, wife, siblings, children, grandchildren, grandparents, mother, father), live-in companions, or significant others involved in the care of the client. This includes a primary caregiver who provides care on a voluntary, uncompensated, regular, sustained basis, such as a guardian or health care proxy. Services to other significant support persons in a client’s life are considered “Collateral” services in Medi-Cal and are identified by the client themselves, or the person providing services.

Overview

Teachers, probation officers, and other agency personnel (usually a paid professional) may not fall under the “significant support person” definition. The client will define who they feel is a significant support person.

Practical Learning: Collateral Services

Sample Progress Note	
<u>Description</u> <ul style="list-style-type: none"> ✓ Why significant support person in the client’s life is present ✓ What impairments/ symptoms continue to exist for medical necessity? ✓ Behavioral/appearance observations 	<i>Mother and father dressed appropriately and made good eye contact throughout session. Mother reported ongoing symptoms and impairments that continue to affect the client.</i>
<u>Intervention</u> <u>Education/Training</u> <ul style="list-style-type: none"> ✓ What education/training was provided? ✓ How does the intervention link to the Treatment Plan goal? 	<i>Therapist provided psychoeducation to teach parents the importance of utilizing effective and supportive communication styles within the home, which will aide in increasing client's self-concept and decreasing incidents of physical aggression which lead to relationship impairments. Therapist modeled effective and supportive communication styles, and taught parents: "I" statements, validation, and "Pause" between stimulus and response.</i>
<u>Response</u> <u>Support Person’s Response and Plan/Follow-up Care</u> <ul style="list-style-type: none"> ✓ How did the support person(s) react to this session? What did they say was helpful about the interventions? 	<i>Parents reported understanding psychoeducation pertaining to the importance of using effective and supportive communication within the home. Parents responded favorably to therapist's modeling, and stated understanding when and how to use newly taught skills, i.e. "I" statements, validation, and "Pause" between stimulus and response.</i>
<u>Treatment Plan</u> <ul style="list-style-type: none"> ✓ The next steps in treatment ✓ Homework or practice tips for the family to use at home. ✓ Follow up for next time ✓ Referrals 	<i>Therapist will meet with client individually to continue to work on developing healthy social and communication skills.</i> <i>Will follow up with the parents in two weeks.</i>

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5.7 Rehabilitation Services (Individual)

“Rehabilitation is 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 medication education.” (Title 9, 1810.243)

Rehabilitation services concentrate on face-to-face **active skill-building** and **teaching** as it relates to the clients mental health, and may be provided by unlicensed, un-waivered or unregistered mental health workers, such as a Recovery Assistant, a Case Worker, and/or Rehabilitation Specialist. Rehabilitation **does not** include psychosocial or psychotherapeutic interventions. A Licensed Mental Health Professional (LMHP) is also able to provide Rehabilitation services when the LMHP is teaching skill-building or self-management skills. A LMHP should not claim for Therapy services when providing Rehabilitation services. In order to document a Rehabilitation note, select the **Outpatient Progress Note** template and claim **Rehabilitation**.

CAUTION: Scope of Practice Issues

Therapy services are only provided by LMHPs whose training and licensure qualify them to practice psychotherapy. For staff qualified to provide Rehabilitation services only, notes lacking a skill-building or educational component can create the impression that the staff is providing service outside his or her scope of practice.

Practical Learning: Individual Rehabilitation services

Sample Progress Note	
<u>Description</u> <ul style="list-style-type: none">✓ Why client is present for services✓ Transportation needs for services✓ Behavioral/Appearance observations✓ Who was present for the session✓ Client’s objective reporting of functional impairments and symptoms that illustrate ongoing medical necessity	<i>Staff arrived to the client’s home for the scheduled rehabilitation meeting due to client having primary difficulties in the home. Client has roommates that he has difficulty engaging with, but they were not present. Client presented as tired and unengaged as evidenced by slouching in the couch and moving slowly. Client reported ongoing symptoms and impairments of anxiety, which that hinder his ability to socialize and maintain relationships.</i>
<u>Intervention</u> <i>Clinical Decisions and Treatments</i> <ul style="list-style-type: none">✓ Document a mental health intervention✓ Explain how the intervention will help the client meet their treatment plan goal	<i>Implemented the following interventions to assist client in improving relationships: provided education on body language to help client understand how others might perceive client’s way of talking while looking at the ground, modeled appropriate eye contact and reciprocal communication, and attempted to engage in role</i>

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✓ Document any relevant legal, ethical, or safety issues	<i>play to assist client in practicing ways to appropriately problem solve. Provided client with Psychoeducation that could help in helping client see how he can make improvements on his goals.</i>
<u>Response</u> <i>Client's Response</i> ✓ How did the client react to this session? Were the interventions helpful?	<i>Client was engaged in the beginning of session and was open to education. Client stated "I can see what you mean" in response to the psychoeducation that was provided. Client later began to slouch and close his eyes and declined to role play, client indicated that he would instead practice skills when he felt better.</i>
<u>Treatment Plan</u> ✓ The next steps in treatment ✓ Follow up, and referrals, home assignments	<i>Case worker will follow up with client next week to discuss client's progress with relationship goal and work on role play. Encouraged client to practice skills at home at least two times a week.</i>

5.8 Therapy Services (Individual and Family)

"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." (Title 9, 1810.250).

Therapy services include interactive psychosocial or psychotherapeutic processes that are face-to-face between a person or group and a LMHP qualified and/or licensed to provide psychotherapy treatment. The focus of therapy is the **exploration of thoughts, feelings and behavior** for the purpose of problem solving to improve mental health functioning through insight-oriented therapy or use of an evidenced-based practice.

As indicated, staff will document use of evidence-based practices (EBPs) within the progress note in the specially marked EBP Elements section. Family therapy can be claimed as therapy as long as the client is present and the client's treatment goals are the ones being addressed. In order to document a Therapy note, select the **Outpatient Progress Note** template and claim **Therapy**.

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Therapy Services CPT (Current Procedural Terminology) Codes

Utilize the correct CPT code based on the service type and the total face-to-face service time range.

<i>Service Type</i>	<i>CPT Code</i>	<i>Typical Minutes Face to Face</i>	<i>Total Face to Face Time Range</i>
Individual Psychotherapy	90832	30	16-37
	90834	45	38-52
	90837	60	53-90
Family Psychotherapy (with patient)	90847	60	31-90
Group Psychotherapy	90853	60	31-90

Recording Face-to-Face and Travel Time for Therapy

For all Therapy services, staff must ensure face-to-face time is recorded within the progress note. Staff must also document any travel time, but separately from face-to-face time. Staff can then total these times and document it in the note.

Therapy Lasting 15 Minutes or Less/90 Minutes or More

There are currently no CPT codes for individual therapy that lasts 15 minutes or less, or for individual or family lasting 91 minutes or more. In these cases, from the “Procedures” dropdown within the Outpatient Progress Note template, select the “Individual Therapy” and “Family Therapy” codes. Face-to-face and travel time does not have to be inputted into the note.

Additional Family Therapy Requirements

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 the 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 treatment plan.

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5.9 Group Progress Note (Rehabilitation and Therapy Services)

Group progress notes capture interventions provided to several clients during a single session or activity. A group consists of two or more members per one staff. Count all members of the group, regardless if they are Medi-Cal or non-Medi-Cal, for the total group count. This note is similar to a standard progress note with a few key exceptions. In order to document a group note, select “Group” under Service Type and “Outpatient Progress Note” under Note Template.

Service Type	CPT Code	Typical Minutes Face to Face	Total Face to Face Time Range
Group Collateral	N/A	N/A	N/A
Group Rehabilitation	N/A	N/A	N/A
Group Psychotherapy	90853	60	31-90

Group Collateral is used for parent groups, typically facilitated by parent partners as well as other team members.

Group Rehabilitation is used with non-licensed staff.

Group Psychotherapy is used with staff that are Licensed Mental Health Professionals (LMHPs).

- ✓ **Group Members:** Select all standing members of the group within the outpatient progress note. After creating the initial progress note, this section will automatically populate with the group member’s information. Check the “Present” box to indicate if the member was present at that group session. In the “Additional participants in group” box, enter the number of clients that are not standing members but participated during that group session.
- ✓ **Describe Service:** Describe the purpose of the group and the details of the group set up for this particular service.
- ✓ **Interventions:**
 - Document the skill-building interventions provided to the entire group (i.e. what did staff do/teach?). For example, “Taught the group independent living

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skills to assist clients such as how develop a budget by listing expenses...practiced balancing a checkbook...”

- Then, go to each individual note and document how the group intervention will assist client in meeting their individual treatment plan goal. Also document any individual interventions that were implemented with each client. Each group participant should have a group intervention added to their treatment plan that addresses how the group will help reduce MH impairments.
- ✓ **Response/Reactions:** Document each client’s behavior and participation in their individual note for that session.
- ✓ **Treatment Plan:** Document what follow up services will be provided or if there is a follow up treatment group, or any referrals that will be offered to the client.

5.10 Medication Support

“Medication Support are 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; instructions in the use, risk, and benefits of and alternatives for medication.” (Title 9, §1810.225)

Medication Support services are individually tailored to address the client’s medication treatment needs. Medication support progress notes must follow DIRT format and contain a mental health intervention that addresses client plan goals. In order to document a medication support note, select the **Outpatient Progress Note** template and claim **Medication Support**.

Where is Medication Support provided?

Medication Support services may be provided face-to-face, by telephone or by telemedicine with the client or significant support person(s), such as a parent or caregiver, and may be provided anywhere in the community.

How much time can be allotted (i.e. claimed) for Medication Support?

The maximum number of hours claimable for Medication Support services in a 24-hour period is 4 hours per client.

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Who is authorized to provide Medication Support?

Physicians (MD or DO), registered nurses (RN), certified nurse specialist (CNS), licensed vocational nurses (LVN), licensed psychiatric technicians (LPTs), physician assistants (PA), nurse practitioners (NP), and pharmacists may provide these services.

What are the most common types of Medication Support services?

Services may include providing detailed explanations and information on:

- ✓ 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
- ✓ Medication interactions or possible complications related to using medications with alcohol or other medications or substances
- ✓ The impact of choosing to not take medications

Can staff claim for clerical type activities, such as photocopying, faxing, etc.?

No, these services are not considered part of Specialty Mental Health Services.

A conversation with another qualified provider (e.g. MD) about side effects or other medication-related issues can also be billed as Medication Support as long as the intervention is related to a client treatment plan goal.

Overview

Practical Learning: Medication Support services

Sample Progress Note	
<u>Description</u> <ul style="list-style-type: none"> ✓ Why client is present for services ✓ Behavioral/Appearance observations ✓ Objective report from client on medical necessity or impairments 	<i>Client is here for monthly medication review. He arrives on time, dressed in unkempt clothes and appears lethargic. Has poor eye contact. Client reports these Sx / impairments....</i>
<u>Intervention</u> <i>Clinical Decisions and Treatments</i> <ul style="list-style-type: none"> ✓ Document any medications administered and pertinent health information ✓ Document a mental health intervention related to client plan goal. ✓ Complete and document vitals 	<i>Staff asked client if they were taking medications as prescribed and if they felt medications were continuing to reduce auditory hallucinations (hearing voices) when communicating with other people to assess for efficacy of medications in assisting client in improving relationships.</i> <i>Staff coached client to bring up his concerns of sleeplessness with the psychiatrist following the medication support session to encourage client to continue to take medications to help with managing voices.</i>
<u>Response</u> <i>Client's Response</i> <ul style="list-style-type: none"> ✓ How did the client react? What did they say about this session? 	<i>Client engaged in discussion and answered questions. Client stated he will discuss concerns with psychiatrist. Reported that the psychoeducation provided regarding the potential risks of the medications were helpful.</i>
<u>Treatment Plan</u> <ul style="list-style-type: none"> ✓ The next steps in treatment ✓ Are there any referrals, labs that need to be done? 	<i>Staff will consult with psychiatrist regarding client's sleeping concerns. Staff will see client for monthly medication review in a month. Client will be referred for labs that are due.</i>

*** Reminder:** 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 Treatment Plan, unless there are urgent or crisis situations that arise.

5.11 Interim Medication Support Services

DHCS provided guidance on claiming for “urgent medication support services” [DHCS MHSUDS Information Notice No.: 17040]. The following guidelines should be met:

- ✓ Urgent clinical need: The client must have a current and urgent clinical need to obtain medication that is clearly documented.
- ✓ 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.
- ✓ Service sufficiency: The client’s urgent mental health need is met through the contact with the prescriber.

For a client with urgent medication needs, the case is staffed within team-based care with a prescriber. The prescriber’s name should be used as the “Admitting Practitioner” field of Clinician’s Gateway if a client is newly opened to outpatient.

When using the interim code for Medication Support Services to provide services prior to finalizing a treatment plan, staff must document in the progress note that the service rendered is an allowable and urgent service prior to finalizing a treatment plan.

5.12 Crisis Intervention

Crisis Intervention is an **immediate, unplanned, emergency mental health response service** enabling an individual to cope with the crisis while maintaining her/his status as a functioning community member to the greatest extent possible. Crisis Intervention services are limited to stabilization of the presenting emergency. In order to document a crisis intervention note, select the Crisis template and claim crisis intervention.

“Crisis Intervention means services lasting less than 24 hours to the beneficiary for a condition which requires more timely response than a regular scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy”. (Title 9, 1810.209)

Due to the nature of a crisis, prior authorization or treatment planning is not required to provide Crisis Intervention services.

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Examples of Crisis Intervention services include:

- ✓ Intervening in a client crisis and providing interventions to assist with de-escalation of a mental health crisis situation when the session was thought to be for a different service.
- ✓ Conducting a 5150/crisis assessment to determine the client's need for urgent psychiatric services
- ✓ Contacting collateral sources (i.e. family, friends) regarding the crisis situation while the client is still in crisis.
- ✓ Intervening in a family crisis that has escalated to the point that the police have been contacted and it is the actual client that is in crisis, and not the family members.
- ✓ School requesting crisis intervention for a child and it is determined that the child is having a mental health crisis.

Crisis Intervention Documentation

At a minimum, all Crisis Intervention progress notes will capture the following:

- ✓ **Current Presenting Problem(s)** - document how crisis service was initiated (who requested crisis evaluation and why, or what transpired that led to the crisis). Clearly illustrate what the client is doing or saying (in his or her own words, when possible) that could jeopardize his or her ability to be maintained in their home or safe community setting. Demonstrate how without intervention services the individual is likely to go into a more severe crisis.
- ✓ **Precipitating Events** - when known, describe any events or stressors that influenced or lead to the unplanned service. Or outline what you observed and what you believe led to the crisis if the client's episode was initiated while you were present.
- ✓ **Risk Assessment** - document the presence or absence of suicidal or homicidal ideation, or grave disability. Other risk factors are documented as thoroughly as possible, including:
 - The presence of mental illness, or clinical impressions that suggest mental illness
 - Access to means/lethality of means
 - Current plan/intent/preparatory behavior

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- Drug and alcohol use
 - Past attempts
 - Hopelessness/lack of future orientation
 - Lack of social support
 - Demographic factors, including age and gender, which may increase or mitigate risk
 - Evidence of the client's grave disability (i.e., as a result of a mental health disorder the client is unable to provide for his or her basic personal needs for food, clothing, or shelter)
- ✓ **Objectivity** - clinical, behavioral observations are clearly stated in an objective, nonjudgmental manner.
 - ✓ **Protective Factors** - list protective factors, such as strong support system and no access to means, which mitigate risk factors.
 - ✓ **Clinical Interventions** - describe interventions attempted and/or accomplished by staff at the time the service was being provided and what measures were taken to decrease, eliminate or alleviate danger, reduce trauma and/ or ameliorate the crisis. Whenever possible, explain the risks and benefits of treatment (including the risks of refusing treatment) and obtain written consent for treatment.
 - ✓ **Client's Response** - record what the client did in response to these interventions, including any agreements to a safety plan and accepting referrals.
 - ✓ **Follow-up** - explain the plans for follow-up and aftercare (e.g. safety planning), or if applicable, the decision to complete a 5150 evaluation that could lead to placing the client on an involuntary hold. For example, "Client will call primary care physician (461-xxxx) this afternoon" or "Client was 5150'd to PHF for evaluation".

IMPORTANT CLAIMING TIPS

- ✓ The maximum amount claimable for Crisis Intervention services within a 24-hour period is 8 hours per client. If Crisis Intervention services may exceed the maximum amount claimable, staff must consult with their immediate supervisor and ensure that crisis services are not claimed beyond the 8 hours.
- ✓ Except for the day of admission to those services, Crisis Intervention services cannot be billed once the client is placed in a Crisis Residential Treatment Facility, a

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Psychiatric Health Facility, Psychiatric Skilled Nursing Facility, jail, or a psychiatric inpatient hospital.

- ✓ If the client is on a hold, interventions directed at placing client such as looking for beds, corresponding with psychiatric facilities and transporting clients can be claimed as Crisis Intervention.
- ✓ If the client is not on a hold, interventions applied to alleviate the potential crisis such as safety planning and transportation to the CSU are still claimable.

5.13 Crisis Stabilization

Crisis Stabilization is defined under [9 CCR §1810.210](#) and [CA SPA 12-025](#) as “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.

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.

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. Within Behavioral Wellness, the Crisis Stabilization Unit (CSU) located in Santa Barbara is the only program currently certified to provide crisis stabilization.

Assessment for Crisis Stabilization

An Initial Assessment is required at the time of admission. Since Crisis Stabilization is an unplanned service and the expected length of stay for is less than 24 hours, the initial and annual Treatment Plan requirements are not applicable to clients admitted to the CSU.

Timeliness of Service Documentation

At a minimum, providers must document every four-hour block of service time within a single Progress Note. An “hour” is defined by the client’s admission time (e.g., if the admission is 5:15

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a.m. , then the first hour of service is 5:15 a.m. - 6:14 a.m.). The first hour of service is defined as the client's admission time rounded up to the next hour.

Example: 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 claiming purposes, staff should round up to 60 minutes.

Claiming Issues and Guidelines:

Service & Claiming Privileges: See the [Staff Claiming and Service Privileges Matrix](#) to determine the type of staff who are permitted to claim Crisis Stabilization services and when co-signatures are required.

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

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

5.14 Targeted Case Management (TCM)

"Assisting a client 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 client access to service and the service delivery system; monitoring of client's progress; placement services; and plan development." (Title 9, 1810.249)

Targeted Case Management (TCM) services can be provided face-to-face, in the office, or community but can also occur by telephone. TCM includes linkage or brokerage type of services. The client does not need to be present to broker services or to link them to a resource, but staff documentation for this service must include a mental health reason for providing linkage or brokerage services. In order to document a Targeted Case Management note, select the Outpatient Progress Note template and claim Targeted Case Management. TCM is NOT a skill building type of intervention. It is primarily the coordination of care for clients to ensure continuity of care. Interventions must always link to a treatment plan goal and interventions.

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Examples of the most common types of TCM services include:

- ✓ Establishing and making referrals
- ✓ Monitoring the client's access to services
- ✓ Monitoring the client's progress once access to services has been established
- ✓ Assisting clients in locating and securing an appropriate living arrangement, including linkage to resources (e.g. Board and Care, Section 8 Housing, or transitional living) as it relates to their mental health condition.
- ✓ Assisting clients in arranging and conducting pre-placement visits, including support for clients to be able to negotiate housing or placement contracts as it relates to their mental health condition.

TCM always involves an intervention on behalf of the client based on their mental health need and the client's inability to secure these services on their own due to their mental health condition. Merely transporting a client to an activity because they don't have a car, or securing housing for the client and not including the client in the planning are not TCM activities because no therapeutic intervention was provided on behalf of the client. In order to claim, the TCM service will need to include the client in securing their own housing, and include the client to resolve transportation issues at the same time that staff are addressing the mental health barriers that keep the client from performing these tasks on their own.

Clinical Supervision is not claimable as a TCM service. Clinical Supervision is a project code within the timecard system.



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Practical Learning: Targeted Case Management

Sample Progress Note	
<u>Description</u> <ul style="list-style-type: none"> ✓ Why does the client need the TCM service? What is the purpose? What is the mental health reason? ✓ If the client is present for services- the client does not need to be present for TCM services. ✓ Behavioral/Appearance observations if the client is present. 	<p><i>This caseworker placed a telephone call with the section 8 housing as had been discussed, planned and approved by the client in the prior session due to his extreme anxiety and lack of understanding for the process.</i></p>
<u>Intervention</u> <i>Accessing Services and Monitoring Delivery</i> <ul style="list-style-type: none"> ✓ How did the clinician facilitate access to services? ✓ Any referrals made? ✓ Any housing/placement arrangements coordinated? <p>How does intervention link to treatment plan goal?</p>	<p><i>Contacted section 8 to follow up on the client's application to see if client was able to follow through in the application process and to see how this caseworker can support client further. This caseworker inquired into what needs to take place in order to assist client to secure housing.</i></p> <p><i>The housing agency provided additional resources that this caseworker can work on to support client.</i></p>
<u>Response</u> <i>Client's and/or Support Person's Response and Plan/Follow-up Care</i> <ul style="list-style-type: none"> ✓ How did the client/support person react? What did they say? 	<p>This caseworker will provide the information and education to client regarding the status of his application and the process. Will also provide client with additional resources that could help him manage his anxiety as he goes through this housing process. This will enable client to participate in weekly rehab sessions to help manage his symptoms.</p>
<u>Treatment Plan</u> <ul style="list-style-type: none"> ✓ The next steps in treatment, referrals. 	<p>Caseworker will follow up with client next week to provide the updates, and to provide client with a standardized appointment time so he can begin to consistently work on managing his anxiety.</p>

5.15 Interim Targeted Case Management

Interim Targeted Case Management (TCM) may be provided before the treatment plan or assessment is in place, including following the expiration of an annual treatment plan. Interim TCM is allowed during this “gap” time for up to 60 days. Documentation must demonstrate that the services are urgent and necessary either for linking a client to outpatient services or referring out to needed community resources such as medical, alcohol and drug treatment, social and education services.

5.16 Day Treatment Intensive and Day Rehabilitation

As some Short-Term Residential Therapeutic Programs (STRTPs) may include a Day Treatment program, the requirements for staffing, documentation, and service requirements are outlined below so that Behavioral Wellness can monitor the services.

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.

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 (DHCS MHSUDS Information Notice No.: 17040):

- ✓ Therapeutic Milieu;
- ✓ Community Meetings;
- ✓ Process Groups;
- ✓ Skill-Building Groups; and
- ✓ Adjunctive Therapies.

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In addition, Day Treatment Intensive programs must provide:

- ✓ Psychotherapy (which may include individual or group therapy);
- ✓ An established mental health crisis protocol;
- ✓ 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.: 17040).

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:

The client was present for at least 50% of the program time on a given day, and

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,

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- ✓ 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

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, the daily progress note for Day Treatment Intensive services must include daily progress notes may be signed by a LMHP, Registered/Waivered staff and Mental Health Rehabilitation Specialists. All other staff daily notes must be cosigned by a LMHP. The weekly Clinical Summary for Day Treatment Intensive must include:

- ✓ Dates of service within the time period covered by the progress note;
- ✓ A summary describing what was attempted and/or accomplished toward the client's goals(s) by the client and service staff;
- ✓ Status of the client (symptoms, behaviors, impairments justifying continued Day Treatment Intensive services);
- ✓ Plan (should interventions be modified, do other behaviors need to be addressed); and
- ✓ Staff signatures, discipline, and professional license/registration number or title.

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The weekly clinical summary may be signed by a LMHP or Registered/Waivered staff. For all other staff, a LMHP 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, the daily progress notes for Day Rehabilitation services must include:

- ✓ Time period covered by the progress note;
- ✓ Dates of service within the time period covered by the note;
- ✓ The total number of minutes/hours the client actually attended the program;
- ✓ 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;
- ✓ A summary describing what was attempted and/or accomplished toward the client’s goals(s) by the client and service staff;
- ✓ 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 LMHP, Waivered or Registered staff and Mental Health Rehabilitation Specialist (MHRS). Graduates students must have their progress notes co-signed by a LMHP and all other staff must have their progress notes co-signed by a LMHP or an MHRS.

Day Treatment Intensive and Day Rehabilitation Authorization Requirements by Behavioral Wellness:

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.

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Day Rehabilitation must be reauthorized at least every six months.

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:

- ✓ 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 waived/registered staff
 3. Licensed Clinical Social Workers or related waived/registered staff
 4. Marriage and Family Therapists or related waived/registered staff
 5. Registered Nurses
 6. Licensed Vocational Nurses
 7. Psychiatric Technicians
 8. Occupational Therapists
 9. Mental Health Rehabilitation Specialists

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

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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).
- ✓ **Day Treatment Intensive** - "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.
- ✓ **Day Treatment Rehabilitation** - "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

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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.

5.17 Intensive Care Coordination (ICC)

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 do not need to 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

Like any other service type, ICC services must be reflected in the treatment plan's goals and interventions. In order to document an ICC note, select the Outpatient Progress Note template and claim ICC.

Although there may be more than one mental health providers participating on a Child and Family Team (CFT, 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.

- ✓ Help the youth access and coordinate medically necessary services in a manner consistent with the Integrated Core Practice Model (ICPM) values.
- ✓ Facilitate collaborative relationships between the youth, his or her family, and the involved child serving systems.
- ✓ Support the parent/caregiver in meeting the youth's needs.
- ✓ Help establish the Child and Family Team (CFT) and provide ongoing support.
- ✓ Organize care across providers and systems to allow the child/youth to receive services in his/her home community.

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 youth appropriately and effectively met.

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

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- ✓ 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.
- ✓ 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).
- ✓ Progress notes must include evidence of incorporation of Core Practice Model (CPM) elements described in the CPM Guide. [Please see the Integrated Core Practice Manual.](#)

ICC Service Settings

ICC may be provided to children/youth living and receiving services in the community as well as those currently in a hospital, group home, or other congregate or institutional placement.

When ICC is provided in a hospital, psychiatric health facility, community treatment facility, group home or psychiatric nursing facility, it may be used solely for the purpose of coordinating placement of the child/ youth on discharge from those facilities.

ICC Core Service Components

ICC services are principally focused on (1) Assessing, (2) Service Planning and Implementation; (3) Monitoring and Adapting; and (4) Transition.



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Area	Description	Examples
Assessing	<p>Assess the client's and family's needs and strengths.</p> <p>Assess the adequacy and availability of resources.</p> <p>Review information from family and other sources.</p> <p>Evaluate the effectiveness of previous interventions and activities.</p>	<p>CFT members discussed the circumstances and situations where John's physically aggressive behavior takes place at school, identifying potential triggers; including adults leaning too close physically 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 and the adult is at least four feet away during the conversation.</p>
Service Planning And Implementation	<p>Develop a plan with specific goals, activities and objectives.</p> <p>Ensure the active participation of client and individuals involved.</p> <p>Clarify the roles of the individuals involved.</p> <p>Identify the interventions/course of action targeted at the client's and family's assessed needs.</p>	<p>CFT members discussed potential strengths that John can use to manage his anxiety when he is feeling stressed and frustrated by his school work that could form the basis of positive intervention strategies.</p> <p>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.</p>
Monitoring and Adapting	<p>Monitor to ensure that identified services and activities are progressing appropriately.</p> <p>Change and redirect actions targeted at the client's and family's assessed needs, not less than every 90 days.</p>	<p>Discussed John's level of participation and progress at the Boys and Girls Club for the past month. John reports liking art, but that two boys are bullying him so he does not want to go back. The ICC Coordinator suggested strategies to increase behavior specialist support to observe and coach John to respond to the boys or talk to an adult. John agrees to the changes made to the treatment plan, which will be reviewed in two weeks.</p>
Transition	<p>Develop a transition plan for the client and family to foster long-term stability, including the effective use of natural supports and community resources.</p>	<p>CFT participants reviewed John's gains and progress, along with personal strengths and external resources in order to better assist John's transition away from formal supports. CFT members identified the presence and effectiveness of their natural supports, which include John's church youth group, soccer team, and Boys' and Girls' Club leadership group.</p>

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Practical Learning: ICC Services

Sample Progress Note	
<u>Description</u> <ul style="list-style-type: none"> ✓ Why client is present for services ✓ Behavioral/Appearance observations ✓ Ongoing impairments/Sx that meet medical necessity 	<p><i>Client present for weekly scheduled CFT meeting. Team to problem solve client's school attendance issues.</i></p>
<u>Intervention</u> <p><i>Document details about discussion related to any of the below:</i></p> <ul style="list-style-type: none"> ✓ Always Start with client strengths ✓ Assessment ✓ Services planning ✓ Implementation ✓ Monitoring ✓ Adapting ✓ Transition 	<p><i>Therapist facilitated discussion regarding the client's strengths, areas of achievement, reviewed current school attendance and school report that absences have increased. Therapist facilitated problem solving activity to come up with a plan for how team can support client in increasing school attendance. Parent Partner suggested educating mother on nighttime and morning routines. Rehab Specialist suggested creating reward system. Social worker stated that the school already has a reward system in place and would like to see if it can be improved.</i></p> <p><i>Those in attendance also participated in the interventions</i></p>
<u>Response</u> <p><i>Support Person's Response and Plan/Follow-up Care</i></p> <ul style="list-style-type: none"> ✓ How did the support person(s) react to this session? What did they say about the interventions and input from all attending? 	<p><i>Client's mother agreed to work on creating a nighttime and morning routine to support client in school attendance. Client did not engage in discussion, instead looked down at the table but indicated that he wanted to know more about the reward programs.</i></p>
<u>Treatment Plan</u> <ul style="list-style-type: none"> ✓ What plan did the team decide on? ✓ How will team members help client meet treatment plan goals? ✓ The next steps in treatment ✓ Assignments to each person who attended CFT/ICC and copies of the plan provided to members- what is the follow up for each ✓ What referrals need to be made on behalf of this client, and who will follow up? 	<p><i>Team will work with mother and client on education and implementation of bed-time and morning routines to improve client's school attendance.</i></p> <p><i>School will work with the mother to review the incentive program.</i></p> <p><i>Follow up CFT in 3 months or sooner if necessary.</i></p>

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Child and Family Team (CFT) Meetings

When the clinician is facilitating a CFT, the appropriate way to document would be to select the CFT template and claim ICC. When claiming ICC within the CFT template, it is imperative that the staff document all the members that were present, clearly outline who the facilitator was, and ensure that the plan is outlined and a copy is provided to the family and CWS. Each staff attending a CFT meeting must write a separate progress note that includes the length of the CFT meeting plus documentation and travel time. However, the CFT template is to be completed by only one staff on the treatment team in order to not duplicate the number of CFTs completed; the template has a “tickler” that notifies staff when the next CFT is due.

The CFTs completed within the EHR follow the client so clients should not be closed out when moving from one provider to another when still receiving services. CFT must be completed at a minimum of every 90 days for sub-class and 6 months for class members.

5.18 Interim Intensive Care Coordination

Interim Intensive Care Coordination (ICC) may be used prior to an assessment or treatment plan being in place, including following the expiration of an annual treatment plan. Interim ICC is allowed during this “gap” time for up to 60 days. Interim ICC allows for referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and education services. All documentation must demonstrate that the services are urgent and necessary.

5.19 Intensive Home Based Services (IHBS)

Intensive Home Based Services (IHBS) must be pre-authorized. 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.

IHBS Services must be provided/offered to all sub-class children and children with more intensive needs that are not Katie-A.

Service activities may include, but are not limited to:

- ✓ Behavior management interventions (e.g., Positive behavioral plans, modeling interventions for the youth’s family and/or significant others, parent training, etc.)

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- ✓ Skill training to improve self-care, self-regulation, or other functional daily living tasks
- ✓ Development of replacement behaviors or positive coping skills
- ✓ Improvement of self-management of symptoms, including self-administration of medications as appropriate
- ✓ Education about the youth's mental health disorder and illness management
- ✓ Support to develop, maintain, and use natural and community resources
- ✓ Support to address behaviors that interfere with (1) family stability and permanence; (2) seeking and maintaining a job; (3) a youth's school success; and (4) transitional independent living objectives, such as seeking and maintaining housing and living independently.

IHBS may be provided in any setting where the child/youth is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, child care centers, and other community settings. IHBS are available wherever and whenever needed including weekends and evenings. IHBS services should not be provided in an office.

IHBS are typically (but not only) provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS. Case workers and practitioners can also provide IHBS services, and if they are providing the services, they will need to code IHBS.

A Child and Family Team (CFT) meeting is required for all Katie A. open cases, and for services provided to non-Katie-A consumers that are receiving IHBS services due to more intensive needs.

CFTs for Katie A. children are required within the first 30 days of referral/opening, every three months for sub-class children, and every 6 months for class children. A closing CFT must be completed to discharge a child from Katie-A or IHBS services.

5.20 Therapeutic Foster Care (TFC)

The Therapeutic Foster Care (TFC) services must be pre-authorized. TFC 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.

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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 and 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 (CFT) to develop and guide the planning and service delivery process. Appropriateness for TFC services is determined at a CFT meeting. Authorization for services is submitted to the Behavioral Wellness Quality Care Management (QCM) division.

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 which TFC may be an appropriate services model to address a client's mental health needs. These circumstances should be considered as indicators of need for TFC and are intended to identify clients who should be assessed to determine if TFC is medically necessary:

- ✓ 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:
 - 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

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child or youth is immediately at risk of residential, inpatient, or institutional care; or

- 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 Behavioral Wellness as a Medi-Cal provider to provide TFC services. The TFC Agency may provide a wide array of other SMHS, if these SMHS are included in its contract with Behavioral Wellness.

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 Mental Health Practitioner (LMHP) 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 LMHP 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;

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- ✓ 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 Resource Family as a SMHS Provider

The TFC resource family 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 resource family provides one or more of the following TFC service model SMHS service activities:

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

Example: The TFC resource family informs the LMHP 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 resource family 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.
- ✓ **Collateral:** The TFC resource family 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 resource family 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.

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TFC Resource Family Provider Qualifications

Resource families who provide TFC services must meet the Behavioral Wellness 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, Behavioral Wellness policies and procedures, and the contract between DHCS Behavioral Wellness. Providers must meet all applicable documentation requirements of this manual, as well as the following minimum documentation requirements:

- ✓ The TFC resource family 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 resource family will not have access to the client medical record and will not document into it directly. Providers are required to ensure that TFC resource family progress notes are entered into the client medical record by qualified staff.
- ✓ A LMHP 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 LMHP 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 Behavioral Wellness and the contract between DHCS and Santa Barbara Behavioral Wellness (MHP).
- ✓ TFC services must be included in the client plan.

TFC Service Limitations

TFC does not include:

- ✓ Reimbursement for the cost of room and board; or
- ✓ 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.

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TFC Service Lockouts

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

- ✓ 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;
- ✓ While a client is detained in juvenile hall or is otherwise considered an inmate; or
- ✓ 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.

Services activities for TFC

Service activities may include, but are not limited to:

- ✓ 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;
- ✓ Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace nonfunctional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- ✓ 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;
- ✓ Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- ✓ Education of the client and/or their family or caregiver(s) about, and how to manage the client's mental health disorder or symptoms;
- ✓ Support of the development, maintenance and use of social networks including the use of natural and community resources;
- ✓ Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- ✓ Support to address behaviors that interfere with seeking and maintaining a job;

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- ✓ Support to address behaviors that interfere with a client's success in achieving educational objectives in an academic program in the community;
- ✓ Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

5.21 Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Services (TBS) is a one-to-one behavioral mental health service that must be pre-authorized. TBS is 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. Each client must have a lead practitioner/case worker that is actively involved in providing treatment.

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 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

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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.

TBS Client Plan Reviews

All TBS client plans must be reviewed every 30-90 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:

- ✓ Date service was provided;
- ✓ Start time of the service;
- ✓ Key clinical decisions and interventions that are directed to the TBS goals of the client:
 - That are consistent with interventions reflected in the TBS client plan;
 - 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);
 - Focus on identified target behaviors;

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- Client response and receptivity to interventions; and
- 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;
- ✓ 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 claimable when:

- ✓ Services are solely:
 - For the convenience of the family or other caregivers, physician, or teacher;
 - To provide supervision or to assure compliance with terms and conditions of probation;
 - To ensure a child or youth's physical safety or the safety of others (e.g., suicide watch); or
 - To address behaviors that are not a result of a child or youth's mental health condition;
- ✓ 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;
- ✓ 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;
- ✓ 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 claimable expense);
- ✓ The TBS staff provides services to a different child or youth during the time period authorized for TBS;

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- ✓ Transporting a child or youth (accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented, circumstances);
- ✓ TBS supplants a child or youth's other mental health services provided by other mental health staff.

5.22 Pre-Service Chart Review

It is permissible to include time spent reviewing previous documentation in preparation for the following services: *assessment, plan development, collateral, rehabilitation, therapy, targeted case management, medication support services, and crisis intervention*. Time can be billed as long as the time is clearly documented and reasonable. The time spent reviewing the chart is included along with the time spent providing the direct service if the client shows for the appointment. As an example, a clinician who spent 10 minutes reviewing previous documentation and provided service for 50 minutes will document 60 minutes total.

If the client is a no-show for the appointment, the time spent on chart preparation is still claimable. Staff will document the time spent reviewing the chart and purpose of the chart preparation in a note, claiming the code of the original planned service. Staff will check the "Chart Preparation" box to indicate this was the only service provided. Remember, staff should also document the no show and attempts to follow up with the client and reschedule the missed appointment. Staff should also complete a separate no-show note.

5.23 Progress Note for Hospitalized and Incarcerated Clients

Staff should attempt to complete the treatment plan to ensure we can provide continuity of care, such as case management and transition planning, for individuals that are in jail or hospitalized to ensure the services can be provided upon discharge. The services will be client support notes. Within the outpatient progress note template, staff are to select the service location that reflects the individual's current placement (e.g., "correctional facility" of incarcerated individuals). Selecting the correct service location will ensure an accurate health record and staff need to ensure that the services are not claimed.

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6.1 Integrated Core Practice Model (Pathways to Wellbeing, Formerly known as Katie-A)

The Integrated Core Practice Model guides treatment which is intensive, needs-driven, and strength-based intended for at risk children and their families (previously available only for the Katie-A subclass and now are for all Katie-A referred class children). Once a client is identified as class/sub-class members, these children and youth qualify to receive a more intensive array of medically necessary mental health services in their own home, a family setting, or the most home-like setting to meet their needs for safety, permanence, and well-being.

To access the most current Integrated Core Practice Model, go to:

<https://www.countyofsb.org/behavioral-wellness/Asset.c/5261>



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7.1 CPT Codes

All Specialty Mental Health Services are tied to a corresponding service code that accurately captures (1) the type of services or activity provided and (2) the billing reimbursement rate.

The nationally recognized service code set is the *Healthcare Common Procedural Coding System (HCPCS)*. This system is divided into two code levels:

- ✓ Level I codes are also known as *Current Procedural Terminology (CPT)*.
- ✓ Level II codes are a mixture of Alcohol and Drug Treatment Codes, Rehabilitation, and other material and services codes. Level II codes will be referred to as HCPCS codes. These are not currently used.

Level I - CPT

CPT codes may only be used by certain licensed, waived, or registered staff: physicians/psychiatrists (MD or DO); psychiatric nurse practitioner (NP); licensed/waivered psychologists (PhD, PsyD); licensed marriage and family therapists (LMFT); registered MFT interns; licensed clinical social workers (LCSW); registered associate social worker interns (ASW); and certified psychiatric/mental health nurses (CNS).

For more information on which codes are allowed for use by job classification/discipline, please refer to the Service Code Matrix.



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8.1 Lockouts

A lockout is a situation or circumstance under which Federal Financial Participation (FFP) (definition of FFP) is not available for a specific Specialty Mental Health Service. In other words, certain services are “locked out” of the Medi-Cal billing system and do not qualify for reimbursement.

Common Lockout Scenarios

Scenario	Explanation/Solution	Documentation Instructions
Outpatient client admitted to the PHF or other Psychiatric Inpatient Hospital	When an adult client is admitted to an inpatient psychiatric hospital, outpatient services cannot be billed except for the day of admission, and TCM to arrange appropriate placement during the last 60 days of an inpatient stay.	Write a progress note using the appropriate Client Support Code.
Client is at IMD or state hospital	When a client is admitted to an IMD or state hospital, no services can be billed (outpatient services are “locked out”).	Write a progress note using the appropriate Client Support Code.
Client is incarcerated or in Juvenile Hall (not adjudicated)	When a client is incarcerated or in Juvenile Hall (not adjudicated), no services can be billed (outpatient services are “locked out”). Except ICC	Write a progress note using the appropriate Client Support Code. Or outpatient progress note for the ICC note.
A valid treatment plan is not in place	If there is no treatment plan, use your current or upcoming appointment with the client to develop a plan. (claim this intervention as Plan Development)	<ul style="list-style-type: none"> - Assessment (if the service is within the first 60 days of admission to our Dept), and - Crisis Intervention service can be claimed for prior to developing the client’s treatment plan. - Other services, if provided, must be coded as the appropriate Client Support Code. Every effort needs to be made to complete the treatment plan with the client.
Second opinions	Second opinions require that the staff contact QCM and they always involve a new assessment. A review of the existing assessment by a LMFT or LCSW is discouraged until the second opinion assessment is completed. It is permissible to claim assessment code for the second opinion, the beneficiary is never charged for the service.	Complete the second opinion assessment and claim the assessment code for the second opinion.

9.1 Discharge Documentation

When a client is transferred or referred to new service provider, or ongoing services are ending, an outpatient discharge summary must be completed. The completion of the summary is claimable as TCM or Plan Development if the client is present, and documentation captures all of the following:

- ✓ Brief treatment summary that will inform the client of next steps in treatment
- ✓ Discussion with the client and his or her psychiatrist, program supervisor, etc. regarding the discharge
- ✓ Status update on the client's progress toward their treatment plan objectives
- ✓ Referrals provided to ensure continuity of care
- ✓ Reason for termination of services is explained to the client
- ✓ Follow-up plans (if applicable) with the client
- ✓ Other pertinent information such as whether medications were provided upon termination and explanation of next steps for refills with the client present

If a clinician does not establish Medical Necessity during the initial assessment process, continuity of care is required.

9.2 Non-claimable Discharge Scenarios

Any discharge services that are clerical in nature are not claimable. For example, copying or filing of discharge documentation needs to be coded as client support code or may be considered administrative and not necessary to enter into the Electronic Health Record unless it is important to document continuity of care.

Refer to Policy and Procedure [Policy and Procedure 8.303 Discontinuation of Client Mental Health Services](#) for more information on closing client cases and discharge procedures.

10.1 Archiving Progress Notes from Clinician's Gateway

Request any needed archiving of progress notes to BWellHIM@co.santa-barbara.ca.us.

10.2 Definitions of Key Terms

- ✓ **CBO** - community-based organizations such as Family Service Agency, Telecare, Community Action Commission (CAC), etc.
- ✓ **Consent for Treatment** - prior to beginning outpatient services, each client and/or legally responsible person must make an informed decision about the risks and benefits of treatment (including no treatment). The decision to participate in treatment is documented by obtaining the signature of each client on the Consent for Treatment form. A legally responsible person must sign on behalf of all minor clients, with the exception of an “emancipated minor” or a self-sufficient minor. Consent for treatment is valid from the date of signature for 12 months, or until revoked by the client legally responsible person. An LMHP is responsible for reviewing and acquiring all required signatures, and for ensuring the consent for Treatment is updated annually.
- ✓ **Department of Health Care Services (DHCS)** - the state agency charged with preserving and improving the health status of all Californians. DHCS works closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income and persons with disabilities.
- ✓ **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** - a benefit program that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medi-Cal.
- ✓ **Federal Financial Participation (FFP)** - the portion paid by the federal government on claims for reimbursement for services delivered to Medi-Cal eligible clients.
- ✓ **Legally responsible person** - a parent, guardian, or legal custodian other than a parent who has been granted specific authority by law to consent for medical care, including psychiatric treatment.
- ✓ **Licensed Mental Health Professional (LMHP)** - as defined by the California Code of Regulations, Title 9, Chapter 11, possesses a valid California clinical licensure in one of the following professional categories:

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- Physician
- Licensed Clinical Psychologist/Waivered Psychologist
- Licensed Clinical Social Worker/ Registered ASW
- Licensed Marriage and Family Therapist/Associate AMFT
- Registered Master's Level Nurse
- ✓ **Long-term client** - any client who has received outpatient mental health services through the Mental Health Plan (MHP) for 60 days or longer, with the exception of clients who have received Crisis Intervention
- ✓ **Mental Health Plan (MHP)** - a Department of Health Care Services (DHCS) contract that mandates the direct provision or external contracting of Specialty Mental Health Services to Medi-Cal beneficiaries by Santa Barbara County Department of Behavioral Wellness.
- ✓ **Mental Health Services** - 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.
- ✓ **Outpatient Client** - an individual is considered to be an outpatient client when the individual gives informed consent for treatment (evidenced by signature) and has an expectation of privacy. Legally responsible persons may consent on behalf of outpatient clients who are minors or Lanterman-Petris-Short (LPS) conservatees. All outpatient clients are assigned a medical record number. **NOTE: Throughout the manual, an outpatient client will simply be referred to as "client"**. Services are received from an outpatient clinic that is not a locked facility.
- ✓ **Primary Diagnosis** - the diagnosis from DSM, ICD-10 which is the primary focus of clinical services and treatments.
- ✓ **Secondary Diagnoses** - those conditions that coexist, or develop subsequently, to the primary diagnosis, and that affect the client care for the current episode of care. Secondary diagnoses may reflect other conditions requiring ancillary supports and

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treatments (i.e. medication management, substance use disorder treatment).
Secondary Diagnoses are not the primary focus of treatment.

- ✓ **Serious Emotional Disturbance (SED)** - a state reporting element that applies to any youth under age 18 who has an included diagnosis and a significant functional impairment. Some youth qualify for services due to “a reasonable probability that they will not progress developmentally as individually appropriate” without current functional impairments.
- ✓ **Serious Mental Illness (SMI)** - a state reporting element that applies to any adult (18 and over) who has an included diagnosis and a significant functional impairment. Adults who meet Medical Necessity criteria might not meet SMI criteria.
- ✓ **Significant Support Person** - a person who could have a significant role in the successful outcome of the treatment of the beneficiary (e.g. parents, legal guardian of a minor, legal representative of an adult, spouse, a person living in the same household).
- ✓ **Specialty Mental Health Services** - per Title 9, Chapter 11, Section 1810.247, means:
 - (a) Rehabilitative Mental Health Services, including:
 - (1) Mental health services;
 - (2) Medication support services;
 - (3) Day treatment intensive;
 - (4) Day rehabilitation;
 - (5) Crisis intervention;
 - (6) Crisis stabilization;
 - (7) Adult residential treatment services;
 - (8) Crisis residential treatment services;
 - (9) Psychiatric health facility services;
 - (b) Psychiatric Inpatient Hospital Services;
 - (c) Targeted Case Management;
 - (d) Psychiatrist Services;
 - (e) Psychologist Services;

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- (f) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Specialty Mental Health Services; and
- (g) Psychiatric Nursing Facility Services.

10.3 Frequency Asked Questions

How do I document Case Conferences (Team Based Care Meetings)?

Depending on the content of the discussing, team Based Care meetings can be coded in many possible ways.

Use this grid as a reference in deciding the appropriate bill code and documenting procedure:

Bill Code	Treatment Plan	Examples	What to write
Client Support	No service provided that links to treatment plan	Updates, consultation, supervision	- What was discussed: prioritizing any legal/ethical/safety issues
Plan Development	Staff is monitoring client's progress toward treatment goals	A team member reports observations that client has an increase of a symptom or behavior and team decides to adjust their approach with client	- The information you gathered, as it relates to a plan goal. - What will change in your approach to treatment based on the information you gathered. - The team plan (who will do what and when)
Targeted Case Management	Staff provided a service that will assist client in linking or brokering a service as it relates to their mental health condition- and this intervention is listed on the treatment plan goal	Staff informs psychiatrist that client is only taking medications on the weekends because they make her drowsy and this is interfering with client meeting goal of reducing symptoms- Make sure your participate in linkage and brokerage has a justified professional reason and outline why a neighbor or best friend couldn't do the linkage or brokerage.	- Document how the intervention provided will assist client in meeting goal. i.e. "Staff informed psychiatrist client is not taking meds as prescribed so that psychiatrist can consider adjusting meds to help client decrease loss of energy so that she is able to get up and go to work daily." Must list reason you participated in session such as a concern the client's MH condition makes it difficult for client to present

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			accurate information to the Psychiatrist... etc.
Assessment	Discussion relevant to assessment not treatment plan	Team holds a team-based care meeting assessment discussion regarding client's needs to determine which clinic team to place client on to determine levels of care needed.	- Document the purpose of discussion and what factors were considered (symptoms, impairments, cultural considerations) and determination. And clearly outline the plan.

Can I bill for reviewing a client's chart prior to a client visit?

Yes. It is permissible to include time spent reviewing previous documentation in preparation for the following services: assessment, plan development, collateral, rehabilitation, therapy, targeted case management, medication support, and crisis intervention. Time can be billed as long as the time is clearly documented and reasonable.

If the client is a no-show for the appointment, the time spent on chart preparation is still billable. Staff will document the time spent reviewing the chart and purpose of the chart preparation in a note, billing the code of the original planned service. Staff will check the "Chart Preparation" box to indicate this was the only service provided. Remember, staff should also document the no show and attempts to follow up with the client and reschedule the missed appointment.

What is the process for QCM Chart Review? (QCM Chart Review is the process of reviewing for documentation compliance and is not the same as Chart Preparation as described above).

The Chart Review Process is as follows:

The chart review committee members - managers, supervisors and QCM Coordinator.

- ✓ Charts are chosen randomly via an MIS program.
- ✓ QCM notifies the clinician on the case and offers the self-audit form be completed. The staff are not required to complete the self review, they can wait for the outcome of the final review.
- ✓ Clinician chooses to make changes to bring chart into compliance prior to committee reviewing the chart OR Clinician waits to see chart committee feedback before making any changes.
- ✓ Clinician emails completed self-audit form to their Regional Manager if they choose to complete.

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- ✓ Chart review committee meets and reviews charts.
- ✓ QCM sends the chart review forms to the manager along with any corrective action request.
- ✓ Manager provides feedback to clinician.
- ✓ Clinician completes any requested changes by the due date, consulting with supervisor when needed.
- ✓ Clinician requests that supervisor sign off on completed changes.
- ✓ Clinician notifies manager when changes are completed and approved by supervisor.
- ✓ Manager informs the QCM Coordinator that the corrective action was completed.
- ✓ QCM will notify the Division chief if the same charts reappear for review and the corrections were not made as indicated by the Manager.

Medical Component:

- ✓ QCM psychiatrist and/or the assigned Psychiatrist to the chart review committee will review medical notes of the selected charts and provide feedback to the assigned practitioner.
- ✓ Assigned practitioner will provide feedback to medical staff on the team, as appropriate.

What is the process for completing QCM Corrective Action Requests?

Instructions for Completing Corrective Action Requests are as follows:

The assigned practitioner is responsible for ensuring all corrections are made.

If the assigned practitioner is not available, the supervisor will be responsible for ensuring that all corrections are made.

To correct an assessment: If the lead practitioner is the original assessor, they will add an addendum to the clinical comprehensive assessment. If the practitioner is not the original assessor, the practitioner will do an assessment note. It is not necessary for staff to meet with the client to make corrections to the assessment. Typically when corrections are required, it is because DSM symptom language or onset is missing or functional impairments are not identified or well

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described. The clinician will use the information they already know about the client to provide the missing information. Staff should not be claiming assessment time for chart corrections.

To correct a treatment plan: The assigned practitioner will revise the treatment plan by reforming the objectives (when requested) so that each objective is observable/measurable, has a baseline and a target, and addresses symptoms or a functional impairment from the assessment. The case manager will reform the interventions (when requested) so that each intervention is individualized and states what staff will do to help client meet treatment plan goals.

Progress notes: progress notes will need to be corrected (re-written) unless specifically stated that it is not necessary. The Practitioner/case worker will review with team members the reasons why notes need corrections, the process to delete notes and rewrite notes to correct the claims need to be followed.

Documents: The assigned practitioner will ensure that all missing forms are completed on Clinician's Gateway and signed by the client.

Psychiatric Review: The assigned practitioner will provide feedback to the medical staff on the team, as appropriate.

Supervisor Approval: The assigned practitioner will have their supervisor review the changes and sign the corrective action form. The assigned practitioner or the supervisor inform the Manager when the corrections have been completed.

Late Plans of Corrections: When plans of correction notifications to the QCM Coordinator are not received within one week of the due date, QCM will email a reminder to send the completed form as soon as possible.

Plans of corrections that are late beyond 2 weeks will be reported at the Clinical Documentation Sub-Committee and further action may be taken by Compliance or the Division Chief of Clinical Operations.