

California Department of Mental Health



Service Function CODE (SFC)58
Service Function CODE (SFC)58

**THERAPEUTIC BEHAVIORAL SERVICES (TBS)
DOCUMENTATION MANUAL**

CODE 58
CODE 58

By

California State Department of Mental Health

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What is Service Function Code (SFC) 58?

All direct and indirect TBS services should be recorded as [Mode 15, Service Function Code \(SFC\) 58](#). For more information about Code 58 and which TBS activities should be recorded as Code 58, please refer to page 19 of the documentation manual.



Found throughout the documentation manual, this symbol is intended to draw attention to important information regarding TBS assessment and documentation.

Service Function CODE (SFC) 58
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CHAPTER 1

Forward

To bring the *Emily Q. v Bonta* case to a successful conclusion, the Federal Court in Los Angeles appointed a Special Master to ensure that the members of the certified *Emily Q* Class have increased access to and utilization of Therapeutic Behavioral Services (TBS).

The Special Master and the *Emily Q* Settlement Team worked collaboratively in the development of the court approved plan. This Settlement Team consists of the Department of Mental Health (DMH) and California Department of Health Care Services (DHCS) staff, defendant’s and plaintiffs’ counsels, a local mental health plan director, a mental health director’s association executive, a private sector TBS provider, and a family/youth representative. Together, this Settlement Team developed a “Nine-Point Plan” to increase access and utilization to TBS. The Court issued an order approving the Nine-Point Plan on November 14, 2008.

To support the implementation of the Nine-Point Plan, the DMH issued Information Notices 08-38, 09-10, a TBS specific webpage and the creation of the TBS Accountability Communications and Training (TACT) committee.

Point 9 of the Nine-Point Plan (Exit Strategy) explicitly states that each MHP has the responsibility to “demonstrate their ability to accurately employ procedure codes, cost reports and CSI data reporting for TBS services.” This TBS documentation manual will be instrumental in helping MHPs and TBS providers meet the Court’s expectations of success in providing and documenting TBS.

Implementation of the Nine-Point Plan began in January 2009 with the issuance of Information Notice 08-38. This comprehensive plan requires that DMH produce two technical assistance manuals: one on TBS best practices and one on chart documentation. Settlement Team members determined that the TBS documentation manual was a critical element in increasing access to and utilization of TBS for class members. DMH contracted with the California Institute for Mental Health (CiMH) to assist in the development of the training and technical assistance components of the Plan. This document is a result of the collaborative work among the parties involved in *California Department of Mental Health (DMH)*

the *Emily Q* Settlement process.

Introduction

This TBS Documentation manual is supplemental to the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Chart Documentation Manual and replaces the TBS section of that manual. This documentation manual is intended to instruct counties/provider-agencies on how to document and claim Medi-Cal appropriately when providing TBS. It will also serve as a training tool for DMH Program Compliance staff and their audit contractors to assist local agencies and their contract providers.

In all cases, the reader should defer to California Code of Regulations (CCR), Title 9; Federal requirements; Mental Health Plan (MHP) contractual requirements, and applicable MHP policies and procedures. The MHP has the authority to administer and authorize services according to program and organizational needs that may require additional standards and other requirements that are not covered in this manual. (Welfare & Institution Code §14680 - §14684).

***NOTE:** Point 1 of the Nine Point Plan significantly reduces and streamlines administrative requirements that may have been barriers to TBS access and utilization. For a complete list of these changes please refer to DMH Information Notice 08-38 at:http://www.dmh.ca.gov/DMHDocs/2008_Notices.asp.

Included with this documentation manual are Appendices 1-5 that provide information on the provision of TBS that may assist MHPs in meeting their responsibilities under the Court's approved Exit Strategy.

This Documentation Manual will be maintained by DMH and reviewed and updated as needed. The most recent version of this document can be found on the DMH webpage at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp

Acknowledgements

DMH would like to acknowledge the following groups and organizations for their dedication and efforts resulting in this documentation manual:

California Department of Mental Health (DMH)

The Emily Q Settlement Team
The TBS Accountability, Communications, and Training (TACT) Team
California Institute of Mental Health

CHAPTER 2 - THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Therapeutic Behavioral Services (TBS)

Definition

Therapeutic Behavioral Services (TBS) are *supplemental* specialty mental health services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Title 9, California Code of Regulations (CCR), Section 1810.215 states, “EPSDT supplemental specialty mental health services” means those services defined in Title 22, [CCR] Section 51184, that are “provided to correct or ameliorate the diagnoses listed in Section 1830.205, and that are not otherwise covered by this chapter.”

TBS is an intensive, individualized, one-to-one behavioral mental health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service. TBS is available for children/youth who are being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children/youth and their parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child’ and family’s needs.

A "Specialty Mental Health Service" must be one of the following as defined by California Code of Regulations:

- (a) Rehabilitative Mental Health Services, including:
 - (1) Mental health services;
 - (2) Medication support services;
 - (3) Day treatment intensive;

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- (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;
- (f) EPSDT Supplemental Specialty Mental Health Services; and
- (g) Psychiatric Nursing Facility Services.

***NOTE:** Targeted Case Management is recognized as a Specialty Mental Health Service. Targeted Case Management is defined as services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.

TBS in conjunction with a Specialty Mental Health Service can help children/youth and parents/caregivers, foster parents, group home staff, and school staff or others to 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/youth to be successful in their current environment.

TBS can be provided anywhere in the community: at home, school, other places such as after-school programs and organized recreation program, except during lock-outs (see appendix 7).

***NOTE:** TBS is not appropriate for “suicide watch” consisting solely of supervision.

ELIGIBILITY

Eligibility for TBS Services is based on Medical Necessity and Class Certification. Each of the required criteria must be supported and substantiated by documentation.

*Appendix 1 includes a “TBS Assessment/Eligibility Flowchart.” The TBS Assessment/Eligibility Flowchart will aid the clinician/organization in determining the clinical appropriateness and need for TBS services.

Establishing Medical Necessity

Medical necessity criteria must be met for reimbursement of specialty mental health services through the Medi-Cal Program. For medical necessity to be met there must first be a diagnosis identified in the California Code of Regulations (CCR), Title 9, Chapter 11, 1830.205 (see Appendix 2). A detailed description of these diagnoses may be found in the Diagnostic and Statistical Manual of Mental Disorders, (DSM), published by the American Psychiatric Association. In addition for medical necessity to be met there must be impairment as a result of the mental disorder, an intervention that addresses the impairment, and there must be an expectation that the intervention would significantly diminish the impairment or prevent deterioration, or allow for individually appropriate developmental progress (see Appendix 2).

Specific criteria for medical necessity for MHP specialty mental health services reimbursement for eligible beneficiaries under 21 years of age are identified in CCR, Title 9, Chapter 11, 1830.210 (see Appendix 2).

All components of the medical necessity criteria stated above must be met and clearly documented in the record for reimbursement through the Medi-Cal Program.

TBS Class Criteria

In addition to meeting medical necessity criteria, TBS recipients must also meet “class criteria.” The class criteria defines a certified class of children and youth who are eligible for TBS services. The following is a description of the certified class.

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

A child/youth meets the requirements of “**at risk of**” hospitalization in an acute care psychiatric facility when hospitalization is *one option* (not necessarily the only option) being considered as part of a set of possible solutions to address the child’s needs. Additionally, a child meets the requirements when his or her behavior *could result in hospitalization* in such a facility if the facility were actually available, regardless of whether an inpatient psychiatric facility is available.

A child/youth meets the requirements of “**being considered for**” placement in an RCL 12 or above when an RCL 12 or above placement is one option (not necessarily the only option) that is being considered as part of a set of possible solutions to address the child’s needs. In addition, a child meets the requirements when his or her behavior could result in placement in such a facility if the facility were actually available, regardless of whether an RCL 12 or above placement is available.

CHAPTER 3 - DOCUMENTATION STANDARDS

TBS Assessments

Documentation standards for client care are identified in the contract between DMH and the MHP. These are the minimum standards to support Medi-Cal claims for the delivery of services. All of the standards must be addressed in the client record; however, there is no requirement that the records have a specific document or section addressing these topics. For children/youth or certain other clients unable to give a history, this information may be obtained from parents/caregivers. The TBS Assessment should establish Medical Necessity for TBS by evaluating the child/youth's current behavior (presenting problem/impairment) and documenting the following:

- (1) How the behavior causes a significant impairment in an important area of life functioning,
- (2) A reasonable probability of significant deterioration in an important area of life functioning without TBS services, or
- (3) A reasonable probability that the child/youth would not progress developmentally as individually appropriate without TBS services.



The following elements are required documentation components in order to substantiate medical necessity for mental health services. TBS assessments can be separate, or part of a more comprehensive assessment.

- Presenting problem: Documentation of the client's chief behavioral impairment, history of the presenting problem(s), including current level of functioning, and current family information including relevant family history.
- Psychological Factors: Documentation of relevant conditions and psychosocial factors affecting the client's physical health and mental health, including living situation, educational/vocational situation, daily

activities, social support, cultural and linguistic factors, and history of trauma.

- Mental Health History: Documentation of mental health history and previous mental health treatment: providers, therapeutic modality, (e.g., medications, psychosocial treatments) and response. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.
- Medical History: Documentation of the complete, relevant medical history and physical health conditions reported by the child/youth or parent/caregiver. Include the name, address and current phone number of current source of medical treatment.
 - **Note**: All appropriate Releases of Information forms should be completed prior to communication with other treatment providers.
- Prenatal: Documentation of the prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
- Medication: Documentation about medications the client has received or is receiving to treat medical conditions, including duration of medical treatment. Documentation of allergies or adverse reactions to medications, etc.
- Substance exposure/Substance use: Documentation of past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over-the-counter, and illicit drugs.
- Strengths: Documentation of client strengths that may be utilized in strategies for achieving client treatment plan goals.
- Risks: Documentation of special status situations that present a risk to client or others, including past or current trauma.

- Mental status examination
- Diagnosis: A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-9 code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data.
- Any additional relevant clarifying formulation information.

TBS Assessment Documentation



In addition to the minimum components listed above, the TBS assessment must identify the following:

- Medical Necessity: Documentation must be comprehensive enough to identify that the child or youth meets the medical necessity criteria specifically for the provision of TBS services.
- Medi-Cal Eligibility: Documentation must state that the child/youth is a full-scope Medi-Cal beneficiary under 21 years of age.
- Member Eligibility: Documentation must note that the child/youth is a member of the certified class; that the child/youth is receiving other specialty mental health services; and that the child or youth has specific behaviors that require TBS.
- Targeted Behavior(s): Documentation must identify the specific behaviors that jeopardize continuation of the current residential placement or put the child at risk for psychiatric hospitalization or the specific behaviors that are expected to interfere with a plan to transition to a lower level of residential placement.

- **Clinical Judgment:** Documentation must include sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement, or to successfully transition to a lower level of residential placement; and that TBS can be expected to provide a level of intervention necessary to stabilize the child/youth in the existing placement.
- **Behavior Modification:** Documentation should identify observable and measureable changes and indicate when TBS services have been successful and could be reduced or terminated.
- **Adaptive Behaviors:** Documentation should note identified skills and positive adaptive behaviors that the child/youth uses to manage the problem behavior and/or uses in other circumstances that could replace the specified problem behaviors.

Initial and on-going TBS assessments may be included as part of an overall assessment of a child or youth's mental health needs or may be a separate document specifically establishing whether initial/ongoing TBS is needed.

TBS Plans of Care/Client Plans

TBS client plans can be either separate plans or part of a more comprehensive plan. The TBS client plan provides clinical direction for short-term intervention(s) to address specific behaviors of the child/youth that were identified in the TBS assessment. Interventions that directly address the behaviors identified during the assessment process are the key component necessary to developing an effective TBS client plan. Interventions may be modified over time based on the degree of effectiveness of the intervention strategy and the child/youth's changing behaviors and needs.

TBS client plans provide a detailed description of the treatment including behavior modification strategies for the child/youth.

TBS client plans should document the following:

- Targeted Behaviors: Clearly identified specific behaviors that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.
- Plan Goals: Specific, observable quantifiable goals tied to the targeted behaviors.
- Benchmarks: The objectives that are met as the child/youth progresses towards achieving client plan goals.
- Interventions: Proposed intervention(s) that will significantly diminish the targeted behaviors.
 - A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan, which is developed with the family/caregiver, if available, and as appropriate.
 - A specific description of the changes in the behaviors that the interventions are intended to produce, including an estimated time frame for these changes.
 - A specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving expected results.
- Transition Plan: A transition plan that describes the method the treatment team will use to decide how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks have been reached or when reasonable progress towards goals/benchmarks is not occurring and, in the clinical judgment of the treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers/school personnel with skills and strategies to provide continuity of care when TBS is discontinued.

- Transitional Age Youth (TAY): As necessary, includes a plan for transition to adult services when the beneficiary is no longer eligible for TBS and will need continued services. This plan addresses assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

If the beneficiary is between 18 and 21 years of age, include notes regarding any special considerations that should be taken into account.

- Signature: A signature (or electronic equivalent) of, at least, one of the following:
 - A clinician who developed the care plan or is providing the service(s)*
 - A clinician representing the MHP providing the service

*If the above person providing the service is not licensed or waived, a co-signature from a physician, licensed/waivered psychologist, licensed/registered social worker, or a licensed or registered marriage and family therapist is required.

- Evidence of the child/youth's degree of participation and agreement with the client plan as evidenced by the child/youth's or legal guardian's signature. If child/youth or legal guardian is unavailable or refuses to sign the client plan, a written explanation in the progress notes why the signature could not be obtained.
- Evidence that a copy of the Client Plan was provided to the child/youth or parent/caregiver upon request.

***NOTE:** TBS Client Plan updates should document the following: any significant changes in the child or youth’s environment since the initial TBS Client Plan; and if TBS interventions tried to-date have not been effective and the child/youth is not making progress as expected towards identified goals. In this situation, there must be documentation indicating that the provider has considered alternatives, and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective. A TBS Client Plan update is an addendum to the initial TBS Client Plan and is not a progress note.

TBS Assessments and Plans With Other Intensive Services

TBS assessments and services can be provided in conjunction with an intensive program, such as Day Treatment or Residential Treatment; however, medical necessity for TBS must be documented and should reflect that TBS is not being provided solely for the convenience of the Day Treatment or Residential Treatment program staff, that TBS does not supplant existing program staff requirements, and that the staff providing TBS are not staff counted in the other program’s staffing ratios.

***NOTE:** Although TBS can be provided in a Day Treatment setting, TBS services can only be claimed for the actual amount of time that the TBS coach spends actively implementing the TBS Plan. Additionally, the child/youth must be present in the day treatment program for at least 50 percent of the time for the provider to claim the day treatment day or half-day. If the child's behavior requires the TBS coach to intervene to the extent that the child is unable to participate in the Day Treatment Program for a minimum of 50 percent of the day, Day Treatment hours cannot be claimed.

TBS to support transition to Lower Level of Care

TBS may be appropriate for transitioning a child/youth to a lower level of care (step-down) from an inpatient or residential treatment setting when specific target behavior(s) or symptom(s) prevent, or can be expected to jeopardize, that step-down. Planned interventions must focus on the specific target behaviors identified in the assessment.

30 - Day Unplanned TBS Contact Documentation

The MHP may conditionally authorize/approve the provision of TBS for a maximum of 30 calendar days when class membership cannot be established for a child/youth. This may be done:

- Up to 30 days or until class membership is established, whichever comes first; and
- When the child/youth presents with urgent or emergency conditions that jeopardize his/her current living arrangement.

Documentation must include evidence that TBS was medically necessary and the most appropriate level of service available to address the child/youth's mental health condition.

Inpatient TBS Assessments



TBS Assessment and Planning While the Child/Youth is in a Psychiatric Inpatient Unit, an Inpatient Unit at a Psychiatric Health Facility (PHF), an Institute for Mental Disease (IMD), or Juvenile Detention Facility for Transition to a Lower Level of Care Utilizing TBS

Although a child/youth currently placed in an IMD, juvenile detention facility (unless evidence that the court has ordered placement in a group home or other non-institutional setting), or an acute inpatient facility is not eligible to receive TBS while in these settings, TBS eligibility can be established and TBS can be planned. However, such planning activities are not Medi-Cal reimbursable, except upon the day of admission. In such cases, the MHP is responsible for determining and assuring there is documentation of: 1) the child/youth's Medi-Cal eligibility upon discharge; and 2) the child/youth's eligibility for County Mental Health Plan (MHP) services upon discharge. If the MHP determines that the child/youth is eligible for Medi-Cal services upon discharge and that TBS are appropriate, the MHP must ensure that the services are available upon discharge. See appendix 7 for more details.

***NOTE:** TBS (code 58) is only reimbursable on days of admission to Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services reimbursed by Medi-Cal.

TBS Progress Note Documentation

TBS Progress notes should clearly document the occurrence of the specific behaviors that threaten the stability of the 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 provided to ameliorate those behaviors/symptoms.

Progress Note Guidelines

For the substantiation of all mental health services it is critical to maintain documentation that is **clear**, **concise** and **succinct**.



All TBS Progress notes should include the following:

- **DATE:** The date of service must be documented for all services rendered.
- **LEGIBILITY:** Charting must be legible, including the legibility of provider's signature and professional credentialing.
- **INTERVENTION:** Each progress note must document key clinical decisions and interventions that are directed to the TBS goals of the child/youth.
 - Documentation must reflect interventions that are consistent with the TBS client plan.
 - Documentation must identify clinical interventions provided that are

designed to change or eliminate maladaptive behaviors and increase adaptive behaviors (not provided solely for the convenience of the family or other caregivers, physician, teacher, or staff).

- Documentation must focus on identified target behaviors.
 - Documentation must identify child/youth's receptivity/response to interventions.
 - TBS documentation should not address conditions that are not part of the identified child/youth's mental health condition.
-
- **SIGNATURE:** A signature (or electronic equivalent) of the staff providing the service, including their clinical license, professional degree, or job title (if staff member is licensed, clinical license, such as LCSW, MD, MFT, etc., must be included).

 - **TIMELINESS/FREQUENCY:** Records should include 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 (see CCR Title 9 Section 1810.206)
 - TBS Plan of Care/Client Plan or its documented review/updates

***NOTE:** Progress notes must include a comprehensive summary covering the time TBS services were provided, but need not document every minute of service time.

TBS Service Function Codes (SFC 58)



All direct and indirect TBS services should be recorded as [Mode 15, Service Function Code \(SFC\) 58](#). The following descriptors further clarify what TBS activities should be recorded and documented under SFC 58. (Note: In some counties Code H 2019 is the crosswalk code that links to SFC 58.)

The following are billable TBS (SFC 58) services:

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

A TBS intervention can be provided either through face-to-face interaction or by telephone; however, a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time. (See Appendix 8 – Reasons for Recoupment)

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

***NOTE:** Not all contacts with a significant support person will qualify as a TBS Collateral contact; it is important to distinguish TBS Collateral contacts from Case Management service contacts.

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

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

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

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

CHAPTER 4 - SERVICES NOT ALLOWABLE

TBS is not allowable when:

1. 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 the child/youth’s physical safety or the safety of others, e.g., suicide watch;
 - To address behaviors that are not a result of the child/youth’s mental health condition; or
 - For supervision or to assure compliance with terms and conditions of probation.
2. The children/youth can sustain non-impulsive self directed behavior, handle themselves appropriately in social situations with peers, and appropriately handle transitions during the day.
3. The child/youth will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.
4. The children/youth is currently admitted on an inpatient psychiatric hospital, psychiatric health facility, nursing facility, IMD, or crisis residential program.
5. On-Call Time for the staff person providing TBS (note, this is different from “non-treatment” time with staff who are physically “present and available” to provide intervention – only the time spent actually providing the intervention is a billable expense).

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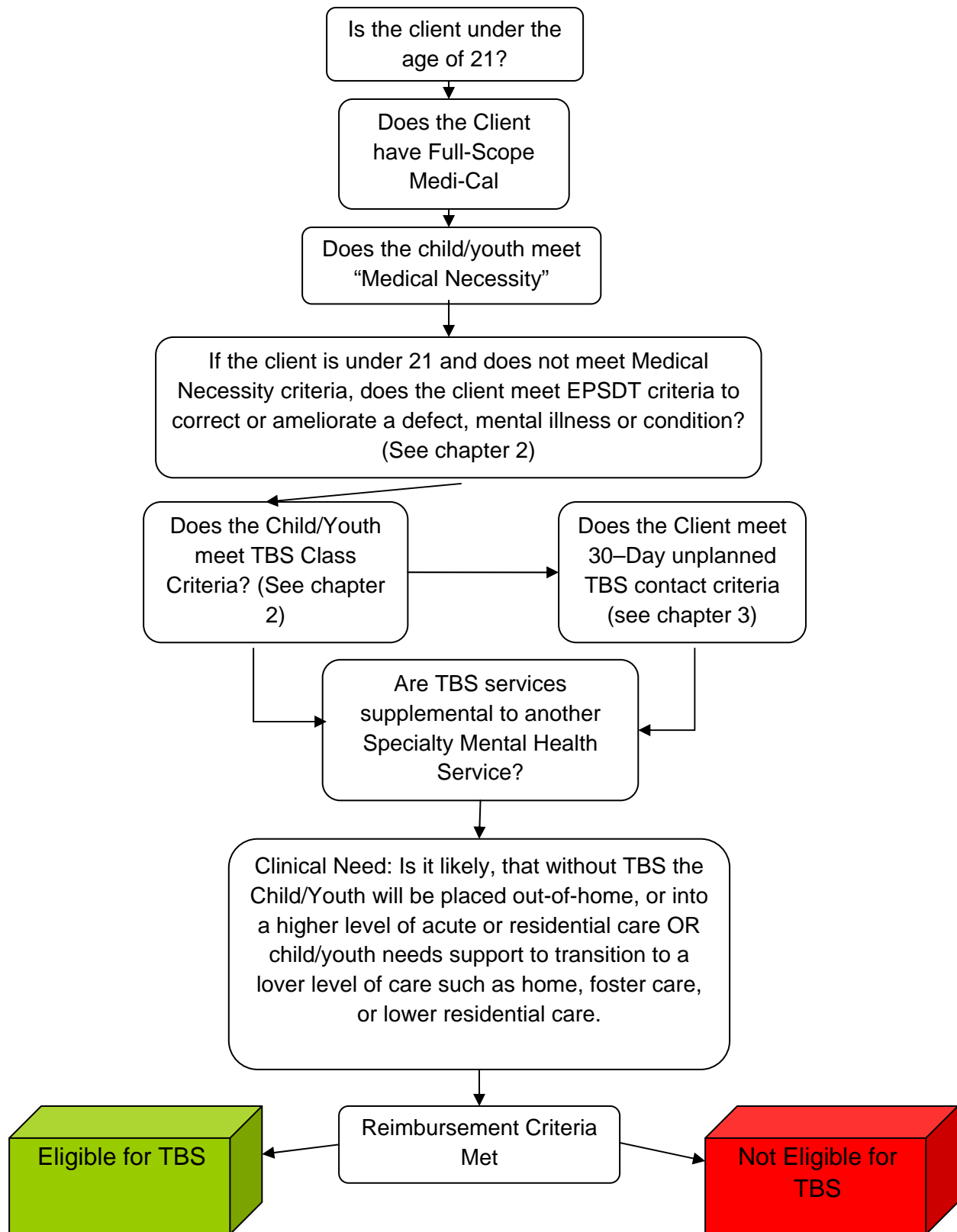
6. The TBS staff provides services to a different child/youth during the time period authorized for TBS.
7. Transporting a child or youth. (Accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented, circumstances).
8. TBS supplants the child or youth's other mental health services provided by other mental health staff.

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APPENDIX 1 – TBS FLOWCHART

TBS Assessment/Eligibility Flowchart

To provide a “quick” start for TBS service eligibility, the following TBS Required Criteria Flowchart will aid the clinician/organization in determining the clinical appropriateness and need for TBS services. A “yes” response allows you to move down the flowchart.



APPENDIX 2 – MEDICAL NECESSITY

MEDICAL NECESSITY CRITERIA

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

- (a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under the Subchapter, except as specifically provided.

- (b) The beneficiary must meet criteria outlined in Subsections(1),(2),(3) below to be eligible for services:
 - (1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:
 - (A) Pervasive Developmental Disorders, except Autistic Disorders
 - (B) Disruptive Behavior and Attention Deficit Disorders
 - (C) Feeding and Eating Disorders of Infancy and Early Childhood
 - (D) Elimination Disorders
 - (E) Other Disorders of Infancy, Childhood, or Adolescence
 - (F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
 - (G) Mood Disorders, except Mood Disorders due to a General Medical Condition

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- (H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- (I) Somatoform Disorders
- (J) Factitious Disorders
- (K) Dissociative Disorders
- (L) Paraphilias
- (M) Gender Identity Disorder
- (N) Eating Disorder
- (O) Impulse Control Disorders Not Elsewhere Classified
- (P) Adjustment Disorders
- (Q) Personality Disorders, Excluding Antisocial Personality Disorder
- (R) Medication-Induced Movement Disorders related to other included diagnoses

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

- (A) A significant impairment in an important area of life functions.
- (B) A reasonable probability of significant deterioration in an important area of life functioning.

- (C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

- (A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.
- (B) The expectation is that proposed intervention will:
 - 1. Significantly diminish the impairment, or
 - 2. Prevent significant deterioration in an important area of life functioning, or
 - 3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
 - 4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).
- (C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

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

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

- (1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
- (2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
- (3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in *T.L. v. Belshé*.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d(r), United States Code.

APPENDIX 3 – TBS CHECKLIST

| Item | Criteria | Additional Criteria | YES | NO |
|------|--|--|-----|----|
| 1 | Under the Age of 21? | | | |
| 2 | Full Scope Medi-Cal? | | | |
| 3 | Principal Diagnosis is an included DSM IV-TR/ICD-9 diagnosis (see List) | This included Principal Diagnosis is the focus of treatment | | |
| 4 | As a result of the included diagnosis, the child/youth must have, at least, one of the following criteria: | Significant impairment in an important area of life functioning. | | |
| | | A probability of significant deterioration in an important area of life functioning | | |
| | | A probability that the child will not progress developmentally as individually appropriate | | |
| 5 | Additionally, the child/youth must meet the following intervention criteria: | Focus of proposed intervention is to address the condition identified | | |
| 6 | The proposed mental health intervention will do, at least, one of the following: | Significantly diminish the impairment | | |
| | | Prevent significant deterioration in an important area of life functioning. | | |
| | | Allow the child to progress developmentally as individually appropriate. | | |

| | | | | | | |
|---|--|--|---|--|---|--|
| <p>7</p> | <p>If the client is under 21 years of age and does not meet the above Medical Necessity criteria, the client is eligible under EPSDT when specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition.</p> | | | | | |
| <p>8 a. OR</p> | <p>Meets Class Inclusion Criteria currently or must have previously received TBS while a member of the certified class....OR</p> | <table border="1"> <tr> <td data-bbox="753 520 1273 779"> <p>Either currently placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs (not necessarily the only option)</p> </td> </tr> <tr> <td data-bbox="753 779 1273 1073"> <p>Are being considered for placement in these facilities; (child/youth behavior could result in placement in such a facility if the facility were actually available, regardless of whether an RCL 12 or above placement is available) or</p> </td> </tr> <tr> <td data-bbox="753 1073 1273 1501"> <p>Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months; (child/youth behavior could result in psychiatric hospitalization in such a facility if the facility were actually available, regardless of whether hospitalization is available)</p> </td> </tr> </table> | <p>Either currently placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs (not necessarily the only option)</p> | <p>Are being considered for placement in these facilities; (child/youth behavior could result in placement in such a facility if the facility were actually available, regardless of whether an RCL 12 or above placement is available) or</p> | <p>Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months; (child/youth behavior could result in psychiatric hospitalization in such a facility if the facility were actually available, regardless of whether hospitalization is available)</p> | |
| <p>Either currently placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs (not necessarily the only option)</p> | | | | | | |
| <p>Are being considered for placement in these facilities; (child/youth behavior could result in placement in such a facility if the facility were actually available, regardless of whether an RCL 12 or above placement is available) or</p> | | | | | | |
| <p>Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months; (child/youth behavior could result in psychiatric hospitalization in such a facility if the facility were actually available, regardless of whether hospitalization is available)</p> | | | | | | |

| Item | Criteria | Additional Criteria | YES | NO |
|---|---|---|-----|----|
| 8 b. | <p>Class Inclusion Criteria cannot be established for a child/youth</p> | <p>Maximum 30 Day Unplanned Contact</p> | | |
| | | <p>Child/youth presents with urgent or emergency conditions to address his/her behaviors, and</p> | | |
| | | <p>Those behaviors jeopardize his/her current living arrangement, and</p> | | |
| | | <p>The MHP determines that TBS would be an appropriate intervention, and</p> | | |
| <p>Documentation includes evidence that TBS was medically necessary and the most appropriate level of service available to address the child/youth’s mental health condition.</p> | | | | |
| 9 | <p>TBS is supplemental to other specialty mental health services</p> | <p>Child/youth is receiving other specialty mental health services</p> | | |
| 10 | <p>Clinical Need Criteria: If the clinical judgment of the mental health provider indicates that it is highly likely that without the additional short-term support of TBS that:</p> | <p>The child/youth will need to be placed out-of-home, or into a higher level of residential care, including acute care, because of the child/youth’s behaviors or symptoms which jeopardize continued placement in the current facility; “acute care” includes acute psychiatric hospital inpatient services, psychiatric health facility services, and crisis residential treatment services or;</p> | | |
| | | <p>The child/youth needs this additional support to transition to a home or foster home or lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS are needed to stabilize the child/youth in the new environment. The MHP or its provider must document the basis for the expectation that the behavior or symptoms will change.</p> | | |

| | | | | |
|----|---|---|--|--|
| 11 | <p>Reimbursement Criteria: TBS Is <u>NOT</u> provided for any of the following:</p> | -for the convenience of the family or other caregivers, physician, or teacher. | | |
| | | -for supervision or to assure compliance with terms and conditions of probation. | | |
| | | -to ensure the child/youth's physical safety or the safety of others (e.g. suicide watch). | | |
| | | -to address conditions that are not a part of the child's mental health condition. | | |
| | | -for children/youth who can sustain non-impulsive, self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day. | | |
| | | -for children/youth who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision; or when the beneficiary is an inpatient of a hospital, psychiatric health facility, nursing facility, Institutions for Mental Diseases (IMD), or crisis residential program. | | |

APPENDIX 4 – REIMBURSEMENT REQUIREMENTS

Reimbursement Requirements for TBS

Contact and Site Requirements

The person providing TBS is typically available on-site to provide individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written treatment plan.

TBS must be provided by: Licensed Practitioner of the Healing Arts (LPHA), a registered/waiver LPHA or trained staff members who are under the direction of a LPHA. The type and breadth of training will be determined by the MHP.

The person providing TBS services should be trained in functional behavioral analysis with an emphasis on positive behavioral interventions.

Claiming Unit

The Claiming unit is the time of the person delivering the service in minutes of time. TBS designated time periods may vary in length and may be up to 24 hours a day, depending upon the needs of the child/youth.

Reporting and Recording (TBS)

MHPs should use mode 15 and service function code 58 for all TBS related service time to allow DMH to track utilization.

APPENDIX 5 – NON REIMBURSABLE ACTIVITIES

Non-Reimbursable Services/Activities: Trends recorded by DMH

The following table illustrates the most frequently reported TBS services that were determined to be non-reimbursable services/activities:

| Type of Non-reimbursable service/activity | Fiscal Year 04/05 | Fiscal Year 05/06 | Fiscal Year 06/07 | Fiscal Year 07/08 | Fiscal Year 08/09 |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|
| <p>Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in Section 1830.205(b)(1)(A-R), the child/youth has, at least, one of the following impairments:</p> <ul style="list-style-type: none"> ➤ A significant impairment in an important area of life functioning ➤ A probability of significant deterioration in an important area of life functioning ➤ A probability the child will not progress developmentally as individually appropriate <p>For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate</p> | X | X | X | X | X |
| <p>Initial plan was not completed within time period specified in MHP’s documentation guidelines, or, lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.</p> | | | X | X | X |
| <p>No documentation of client or legal guardian participation in the plan or written explanation of the client’s refusal or unavailability to sign as required in the MHP Contract with DMH.</p> | X | X | | | X |
| <p>No progress note was found for service claimed.</p> | X | X | X | X | X |
| <p>The time claimed was greater than the time documented.</p> | | | X | X | |
| <p>The progress note indicates the service provided was solely clerical.</p> | X | X | | X | |

APPENDIX 6 – FACTORS TO CONSIDER

Factors to consider: Common Causes for Disallowance and Possible Solutions

The six most common reasons for disallowance can be addressed by the MHP and providers.

The number one reason for recoupment is the absence of progress notes. Although it is predicted this issue may be resolved with technical innovations, such as the migration to an electronic health record, in the meantime providers should consider the development of in-house checks and utilization management reviews to assure that all claims are supported by a documented record filed in the correct chart.

The second most frequently encountered reason for recoupment is the lack of documented medical necessity. Staff training should emphasize the requirement of a thorough assessment that documents how the child/youth's targeted behaviors are tied to an included diagnosis and functional impairment. This clinical formulation would inform the TBS Plan of Care/Client Plan with specific interventions addressing the targeted behaviors and reflected in the service delivery progress notes that substantiate need and intervention activities.

Issues surrounding "time claimed was greater than the time documented" fall into two different areas of concern. The first is a technical error: the time entered in the chart was on the wrong date or the time recorded on the physical progress note was entered incorrectly into the claiming system. This type of error will also be reduced or corrected with the introduction of an electronic health record and diligent utilization management review and cross-checking claims against the physical record. The second area of concern, is that the time claimed is not justified by the documentation provided can be addressed by staff training that should include training on documentation standards that support and substantiate the TBS service provided and claimed. Additional staff supervision and internal reviews can also decrease this reason for recoupment.

The lack of documentation for the absence of caregiver or client's participation in the Plan of Care/Client plan and not completing a plan of care within the time allotted can

either be technically or clinically driven. Staff should be reminded to document how the client participated in the development and implementation and due diligence should be taken in obtaining evidence of the client’s agreement or participation in their own client plans of care. Solutions may include a “tickler” or “flagged” file at the front of the chart for those documents requiring additional attention (such as signatures, attestations or acknowledgements); staff can be trained to refer to the tickler file each time they open the chart for items requiring follow-up or immediate attention.

The remaining reason for recoupment, i.e., the claiming of a service that was solely clerical/administrative activities can also be addressed with staff training and reminders that clerical activities are not reimbursable. Examples of non-reimbursable activities include, but are not limited to: copying or faxing charts, collating or filing, mailing out appointment reminders, leaving voicemail messages, writing discharge summaries, etc.

The checklist in appendix 3 may be useful in assuring the criteria for reimbursement are met.

APPENDIX 7 – LOCK OUTS

Lock-outs (TBS)

TBS Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission to the facility.

TBS Service (and any other service) are not reimbursable on days when the child/youth resided in a setting where the client was ineligible for FFP, e.g., Institute for Mental Disease (IMD), juvenile hall (unless there is evidence that the court has ordered placement in a group home or other non-institutional setting), jail or other similar settings).

Because Crisis Stabilization is an all inclusive service, TBS Services are not reimbursable when provided during the same time period that Crisis Stabilization – Emergency Room or Crisis Stabilization – Urgent Care services that are reimbursed by Medi-Cal.

Service Function CODE 58

APPENDIX 8 – REASONS FOR RECOUPMENT

The Department of Mental Health produces an annual document titled “*Reasons for Recoupment*” illustrating the specific parameters for possible recoupment penalties, as well as the associated references to California Code of Regulations. You can find the 2008-2009 list of ‘reasons for recoupment’ at the following location.

http://www.dmh.ca.gov/DMHDocs/docs/notices08/08-22_Enclosure2.pdf

APPENDIX 9 – ADDITIONAL INFORMATION

Websites:

The following public websites are available for easy access to additional relevant information and resources.

California Department of Mental Health (DMH) – EPSDT and TBS

http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp

DMH County Administrators and Providers

http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/docs/Contacts/1-StatewideTBSProviderRoster.pdf

<http://www.dmh.ca.gov/docs/CMHDA.pdf>

APPENDIX 10 – CODE REFERENCES

Code References

The following Regulations, Laws and Citations are arranged alphabetically according to the Regulation Area/Topic.

California Code of Regulations

| Title 9 (Quick Reference Index) Regulation or Law | Title | Code Section (§) | Regulation Area/Topic |
|--|--------------|-------------------------|---|
| California Code of Regulations | 9 | §1810.204 | Assessment |
| California Code of Regulations | 9 | §1810.205 | Beneficiary |
| California Code of Regulations | 9 | §1810.206 | Collateral |
| California Code of Regulations | 9 | §1810.209 | Crisis Intervention |
| California Code of Regulations | 9 | §1810.210 | Crisis Stabilization |
| California Code of Regulations | 9 | §1810.211 | Cultural Competence |
| California Code of Regulations | 9 | §1810.212 | Day Rehabilitation |
| California Code of Regulations | 9 | §1810.213 | Day Treatment Intensive |
| California Code of Regulations | 9 | §1810.215 | EPSDT Supplemental Specialty Mental Health Services (i.e., Therapeutic Behavioral Services-TBS) |
| California Code of Regulations | 9 | §625 | (Licensed Clinical) Social Worker [LCSW] |

| Title 9 (Quick Reference Index) Regulation or Law | Title | Code Section (§) | Regulation Area/Topic |
|--|--------------|-------------------------|---|
| Code of Federal Regulations | 42 | §440.130 | (Licensed Practitioner of the Healing Arts) [LPHA] Diagnostic, screening, preventative, and rehabilitative services |
| California Code of Regulations | 9 | § 626 | Marriage and Family Therapist (formally Marriage, Family and Child Counselor) [MFT] |
| California Code of Regulations | 9 | §1830.205 | Medical Necessity Criteria for MHP Reimbursement Of Specialty Mental Health Services |
| California Code of Regulations | 9 | §1830.210 | Medical Necessity Criteria for MHP Reimbursement for Specialty MHS for Eligible Beneficiaries Under 21 Years of Age |
| California Health & Safety Code | N/A | §123105(b) | Medical Record |
| California Code of Regulations | 9 | §1810.225 | Medication Support Services |
| California Code of Regulations | 9 | §1810.226 | Mental Health Plan |
| California Code of Regulations | 9 | §1810.227 | Mental Health Services |
| California Code of Regulations | 9 | §630 | Mental Health Rehabilitation Specialist |

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| Regulation/Law | Title | Code Section (§) | Regulation Area/Topic |
|--------------------------------|--------------|-------------------------|---|
| California Code of Regulations | 9 | §1840.312 | Non-Reimbursable Services |
| California Code of Regulations | 9 | §1810.231 | Organizational Provider |
| California Code of Regulations | 9 | §1810.232 | Plan Development |
| California Code of Regulations | 9 | §623 | Psychiatrist |
| California Code of Regulations | 9 | §624 | Psychologist |
| California Code of Regulations | 9 | §1810.243 | Rehabilitation |
| California Code of Regulations | 9 | §782.44 | Registered Nurse |
| California Code of Regulations | 9 | §1810.247 | Specialty Mental Health Services |
| California Code of Regulations | 9 | §1810.246.1 | Significant Support Person |
| California Code of Regulations | 9 | §1810.380 & §1810.385 | State Oversight & Civil Penalties |
| California Code of Regulations | 9 | §1810.249 | Targeted Case Management |
| California Code of Regulations | 9 | §1810.250 | Therapy |
| California Code of Regulations | 9 | §1810.254 | Waivered/Registered Professional (LPHA) |

CODE 58

APPENDIX 11 – SAMPLE PROGRESS NOTES

***NOTE:** Sample Progress notes are not intended to be a template for TBS Progress note documentation and should not be used as a ‘one size fits all’ method of TBS documentation. These notes simply outline the necessary features required in a TBS progress note. The *Suggested Enhancements* are simply other recommended ways to make the progress notes more comprehensive and descriptive for optimum documentation standards.

| | | | | | | |
|--|---------------------------------|-----------------------|------------|----|----|--------|
| Individual Service : xxxxxxxx | | <i>Medical Record</i> | xxxxxxx | | | |
| EXAMPLE 1: Represents an adequate note with suggested enhancements. | | Service Date | xx/xx/xxxx | | | |
| Provider: | | Location | Field | | | |
| Procedure: | Therapeutic Behavioral Services | Number of client(s) | 1 | | | |
| Client | | | | | | |
| Name of Clinician | | Staff Time | 2 | HR | 55 | Min(s) |

GOAL/REASON FOR SERVICE:

TBS initial treatment meeting to present and explain TBS services to family, establish target behavioral goals, establish client’s crisis plan, gather background information relevant to the development and implementation of client’s behavioral plan, and discuss frequency of visits and fade-out plan. Face-to-face time, travel time, and documentation time included. Present at meeting: TBS Clinical Supervisor, TBS Specialist Care Coordinator, and client’s foster mother. Target Behavior Goal #1: Increase anger management skills to decrease aggression, so that verbal aggression (screaming, tantrums, crying, threatening) occur no more than 5x’s per day, and physical aggression (kicking, hitting, throwing objects,

slamming doors) occurs no more than 5x's per week over the next 30 days.
Target Behavior Goal #2: To increase communication skills to decrease non-compliance so that non-compliance occurs no more than 10x's per day over the next 30 days.

INTERVENTION/CLINICAL DECISION

Specialist focused on gathering information regarding client's interests in order to formulate interventions that will engage client in services. Specialist then explained possible future TBS interventions designed to assist client in goal attainment including: coping skills, development of system of rewards and consequences, coaching, and parent meetings. Specialist also reviewed mandated reporting laws and identified client's crisis plan before ending visit. Specialist thanked mother for her participation in TBS services, and scheduled first observation and assessment visit at school on 5-27-09. The team agreed that the TBS specialist will meet with client at school and at home as target behaviors were present in both environments.

Suggested Enhancements: To make this a stronger note, the TBS specialist should describe the information gathered regarding the client's interests. The TBS specialist should also indicate how the information gathered will be utilized in the formulation of the treatment interventions. The information gathered may be included in the Client Plan. It would be helpful if additional detail were available within the note to determine whether the information was utilized appropriately—or whether the time billed is commensurate with the amount of information obtained.

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| | | | | | | |
|---|---------------------------------|---------------------|------------|----|----|--------|
| Individual Service : xxxxxxxx | | Medical Record | xxxxxxx | | | |
| PROGRESS NOTE: EXAMPLE 2 : Represents an adequate note with suggested enhancements | | Service Date | xx/xx/xxxx | | | |
| Provider: | | Location | Home | | | |
| Procedure: | Therapeutic Behavioral Services | Number of client(s) | 1 | | | |
| Child | | | | | | |
| Name of Clinician | | Staff Time | 1 | HR | 45 | Min(s) |

GOAL/REASON FOR SERVICE

TBS scheduled in-home client visit with Specialist. Face-to face time, travel time, and documentation time included. Target Behavior Goal #1: To increase self-soothing skills to decrease unsafe behaviors (cutting, scratching people’s name in arm, running away) so that client will have 0 incidents of unsafe/self-injurious behaviors over next 30 days.

INTERVENTIONS/CLINICAL DECISIONS

TBS arrived for scheduled visit and was greeted by client. Client completed tracking chart and reported 1 incident of unsafe/self-injurious behaviors over the past 3 days. Specialist utilized open-ended questions to gather more information regarding client’s report. Client shared she started to scratch her boyfriend’s name in her arm but stopped after thinking about consequences to her actions, including moving down level system in group home. Client further shared she was able to speak with group staff to ask for help. Specialist highlighted client’s increased ability to link her actions with outcomes she does not want, and verbally praised client for making positive choice to utilized coping skill of asking for help and sharing her feelings. Specialist then facilitated discussion to explore possible triggers to client’s target behaviors. Client shared she was sad that she would not see her boyfriend for one week. Specialist provided client with supportive environment by actively listening and validating her feelings.

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Specialist and client then identified positive coping skills she can use when faced with similar situation where she feels sad including reading, writing poetry, and drawing. Specialist verbally praised client for visit Specialist checked-in with group home staff regarding client's report. Staff identified knowing about incident and highlighted client's increased ability to ask for help when having urge to engage in unsafe/self-injurious behavior.

Suggested Enhancements: It would be helpful if the TBS specialist would document whether the client had a significant history of self- injurious behavior.

NOTE: TBS is not appropriate for "suicide watch" consisting solely of supervision. TBS can be utilized to assist a child /youth, who is not actively suicidal or at imminent risk of self –harm, with behavioral interventions identifying, increasing and supporting his/her coping skills.

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| | | | | | | |
|--|--------------------------------|---------------------|-----------|-------|--|--------|
| EXAMPLE 3: Represents an adequate note with suggested enhancements. | | Medical Record | xxxxxxx | | | |
| Child: | | Service Date | x/xx/xxxx | | | |
| Provider: | | Location | Home | | | |
| Procedure: | Therapeutic Behavioral service | Number of client(s) | 1 | | | |
| Name of Clinician: | | Staff Time | 2 | hr(s) | | Min(s) |

GOAL/REASON FOR SERVICE

TBS scheduled home visit with TBS Specialist. Creation of feeling log, face to face time, documentation time, travel time included. Goals: Target Behavior #1: Increase compliance with house rules and parental expectations so that client has at least one day per week, where client can follow house rules (such as yelling, name-calling, and not being able to “keep hands and feet to self”. Target Behavior #2: Increase self-soothing coping skill to decrease self-injurious tantrums so that tantrums occur no more than 1 time per week over next 30 days.

INTERVENTIONS/CLINICAL DECISIONS

Upon specialist arrival client was available for home visit. Client’s mood was sad as evidence by client’s expression and body posture. Client stated she didn’t want to do any TBS activities and only wanted to play. Specialist then implemented open ended questions to assess client’s mood and possible triggers to client’s mood.

Client stated she didn’t want to talk about it. Specialist provided client with the option of doing outside activities. Client was open to engage in outdoor activities. Specialist validated client’s feelings of being upset and client’s choice of not wanting to talk about it. Specialist then presented client with a feeling log and prompted client to utilize to the log to identify the different feelings client felt throughout the day. Specialist encouraged client to use the feeling log on her own to assist in feeling identification and informed client she would receive

reinforcement for utilizing the log. Client was receptive to the intervention. Specialist then coached client to utilize self soothing coping skill of playing a game. Client was receptive to specialist’s suggestion and agreed to play a game. At the end of game specialist implemented open-ended questions to assist client with self awareness of feelings before and after playing game. Client was able to respond that she was upset before playing the game and she felt better after the game was over and was not upset. Specialist reinforced client’s response and encouraged client to utilize such coping skills when experiencing similar feelings. Specialist then ended visit by coaching client to utilize feeling log. Client was able to identify her feelings for the day on the log including feeling sad, smart, and happy. Specialist reinforced client’s participation in the day’s session.

Suggested Enhancement: It would be helpful if the TBS specialist identified what kinds of outside activities were used in order to facilitate a discussion with the client. This note demonstrates how the TBS specialist used flexibility (allowing client to engage in outdoor activities) as a means of introducing an intervention (use of game as self-soothing behavior, recommendation regarding use of “feeling log”).

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| | | | | | | |
|--|---------------------------------|---------------------|------------|----|----|--------|
| Individual Service : xxxxxxx | | Medical Record | xxxxxx | | | |
| EXAMPLE 4: Represents an adequate note with suggested enhancements. | | Service Date | xx/xx/xxxx | | | |
| Provider: | | Location | Home | | | |
| Procedure: | Therapeutic Behavioral Services | Number of client(s) | 1 | | | |
| Client | | | | | | |
| Name of clinician | | Staff Time | 1 | HR | 40 | Min(s) |

GOAL/REASON for SERVICE

TBS scheduled home visit with TBS Specialist. Face to face time, documentation time, travel time included. Goals: Target Behavior #1: Increase compliance with house rules and parental expectations so that client has at least one hour each day (when with family) where client can follow house rules (such as yelling, name-calling, and not being able to “keep hands and feet to self). Target Behavior #2: Increase self-soothing coping skills to decrease self-injurious tantrums so that tantrums occur no more than 2 times per week over 1st 30 days.

INTERVENTIONS/CLINICAL DECISIONS

Plan Development

Before scheduled home visit specialist met with Asst. Clinical Supervisor, to engage in plan development. Caregiver and child participated in plan development. Antecedents to behavior, information gathered during observations and assessment visits, parenting skills of parents, and the formulation of various TBS interventions were discussed. Interventions to include trigger and coping skill development and rehearsal, emotion regulation exercises, feeling identification, trigger identification (thoughts and body), assertiveness and communication training, impulse control skills (stop-think-choose), token economy reinforcement system, parent education and support, coaching and training, self soothing techniques, relaxation training (deep breathing, cognitive restructuring), mood tracking, coping strategies training (including replacement

phrases for negative self-talk), strength based interventions, self-esteem coaching and activities, parent training: (e.g. positive activity scheduling) and problem solving. Discussion with the clinical supervisor resulted in the modification of the client plan.

Home Visit:

Upon arrival client was open to meet as evidenced by verbal feedback. Specialist noticed client's tracking chart had a number of stickers indicating that client has been doing well with Target behavior goals: Specialist praised client's ability to earn stickers by meeting TBS goals. Specialist then engaged client in an art activity to assist client with feeling identification. Specialist prompted client to draw lines that she associated with feelings such as happy, sad, excited, etc. Client was able to appropriately draw line for each feeling. Specialist then engaged client in another art activity to assist client with decreasing self injurious tantrums. Specialist prompted client to list a number of positive self statements. Client was able to appropriately identify positive statement such as "I'm happy, I'm friendly and I'm Cool." Specialist reinforced client's participation in the day's session with an art activity.

Suggested Enhancements: It would be helpful if the TBS specialist identified and documented the specifics of the information gathered during the observation and assessment visit and how the information was used to modify the client plan.

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| | | | | | | |
|--|---------------------------------|---------------------|-----------|----|----|--------|
| Individual Service : xxxxxxx | | Medical Record | xxxxxx | | | |
| EXAMPLE 5: Represents a note with suggested enhancements. | | Service Date | xx/x/xxxx | | | |
| Provider: | | Location | Field | | | |
| Procedure: | Therapeutic Behavioral Services | Number of client(s) | 1 | | | |
| Client | | | | | | |
| Name of clinician | | Staff Time | 1 | HR | 30 | Min(s) |

GOAL/REASON for SERVICE

TBS scheduled home visit with TBS Specialist. Face to face time, documentation time, travel time included. Goals: Target Behavior #1: Increase problem-solving skills to decrease opposition to classroom expectations (not following directives, arguing back, not staying in seat, making inappropriate noise, etc) so that client has no more than 4 referrals and 0 suspensions due to his opposition over the next 30 days. Target Behavior #2: Increase anger management skills to decrease aggression (hitting, punching, cussing, spitting, calling names, harassment) so that the client has at least 5 days a week w/out aggression over the next 30 days.

INTERVENTIONS/CLINICAL DECISIONS

Middle School Principal spoke to TBS specialist before client’s scheduled home visit to update on client’s behaviors. As evidenced by principal’s verbal report, client did not meet target behavior goal #1. Out of 2 days tracked, client received 1 referral and 1 suspension from school for engaging in oppositional behaviors. The opposition included, making inappropriate noises, not staying in seat, arguing back and not following directives.

TBS SPECIALIST MET WITH CLIENT FOR HOME VISIT. Upon TBS arrival client’s mood was calm as evidenced by a relaxed facial expression. Client greeted TBS specialist and sat down to join the session. Specialist facilitated

discussion receiving an update on client's progress. As evidenced by client's classroom expectations tracking chart and father's verbal report, client did not meet target behavior goal #1 as follows. Out of 2 days tracked, client received 1 referral and 1 suspension from school. As evidenced by client's aggression tracking chart and father's verbal report client did not meet target behavior goal #2 as follows. Out of 4 days tracked client had 3 incidents of aggression (e.g. hitting and name-calling). To aid client with target behavior #2 specialist then implemented open-ended questions to facilitate client identifying his compliance or lack of compliance with client's system of rewards and consequences. As evidenced by client's verbal report, client was not complying with the consequences established for his aggression. Specialist reviewed the behavioral expectations tied to his system of rewards and consequences (e.g. client will lose privileges for 1 week if he does not comply with the consequences established for his aggression; if client does not give his phone to his father, TBS will no longer reinforce client with phone cards). As evidenced by client's verbal report, client understood the behavioral expectations but was not willing to give up his phone. Specialist acknowledged client's choice and informed him that TBS would no longer reinforce him with phone cards. As evidenced by client's verbal report, client accepted the consequence implemented by specialist. At the end of the visit, specialist reinforced father's participation with services.

Suggested Enhancements: In this case the TBS specialist and client should be encouraged to review the goals and objectives of the client plan together and discuss why the identified goals and objectives were not met.

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