

*Alameda County Behavioral Health (ACBH)*  
**Specialty Mental Health Services (SMHS)**  
**Clinical Documentation Standards Policy & Procedure**  
**Manual\***



*\*This manual and policy defines the procedures and minimum standards for documentation of SMHS (including Medicare/Medi-Cal at any site providing those services within (ACBH) and its contracted Master Care Organizations (MCO's), previously known as Community Based Organizations (CBO), who are claiming through Clinician's Gateway (CG) or InSyst.*

Revised: November 30, 2018

## ACKNOWLEDGEMENTS

Documentation has long been of utmost importance in reflecting and documenting the work we all do to serve our clients. With the changing requirements proffered by the various regulatory bodies, training of staff becomes somewhat of a challenge. This documentation manual is intended to be a living document, accessible to all staff and contract providers who deliver Specialty Mental Health Services to our clientele.

We would like to especially acknowledge and thank the ACBH Quality Improvement Committee (QIC) who developed a sub-committee of stakeholders to collaborate on the implementation of the policy, procedure and protocol changes following DHCS Info Notice 17-040. The sub-committee then incorporated the changes to ACBH protocol, policy and procedures into the revision of this Clinical Documentation Manual.

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Specialty Mental Health Services (SMHS) Clinical Documentation Standards Policy & Procedure Manual

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**CONTENTS**

CLINICAL RECORD DOCUMENTATION STANDARDS – SPECIALTY MENTAL HEALTH SERVICES (SMHS)

**POLICY STATEMENT**

All service providers within the Alameda County Behavioral Health (ACBH) system shall follow the Clinical Record Documentation Standards Policy as described herein. This requirement includes staff and providers employed by ACBH and all Master Contract Providers (MCO) who claim through Clinician's Gateway or InSyst. Individual, Group and Agency Network Providers who claim with a HCFA 1500 shall refer to the MH Provider Network Documentation Manual. Contract service providers may develop additional policies in order to adapt these standards to their specific needs. However, if variance from this policy is needed, approval must be obtained from the ACBH Quality Assurance Administrator or designee.

**PROCEDURES**

This Section of the Quality Improvement Manual contains information about basic required chart management, informing materials, and the minimum requirements for clinical documentation. Most requirements are for all types of providers. As indicated; differences and exceptions for certain types of providers are so noted.

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# Commonly Used Terms

**Specialty Mental Health Services:** This system is the broad array of Medi-Cal services available to meet the mental health needs of Medi-Cal beneficiaries. (See Appendix for [SMHS Descriptions and Examples.](#)) <sup>(CCR09)</sup>

- Mental Health Services: assessment; evaluation; plan development; therapy; rehabilitation services; and collateral services. <sup>(CCR08)</sup>
- Case Management/Brokerage: coordination and referral; placement services; and plan development.
- Medication Support Services: assessment; prescribing; administering; dispensing; monitoring drug interactions and contraindications of psychiatric medications or biologicals; evaluation; obtaining informed consent; medication education; and plan development.
- EPSDT Supplemental Specialty Mental Health Services: assessment; plan development; and treatment through mental health services, medication support services, and crisis intervention services.
  - Therapeutic Behavioral Services (TBS): an EPSDT supplemental service: assessment; plan development; and behavioral interventions.
  - Intensive Care Coordination (ICC): Services delivered using a Child and Family Team (CFT), intended for children and youth with more intensive needs and/or whose treatment requires cross-agency collaboration. ICC Services components/activities include: assessment; service planning and implementation; monitoring and adapting; and transition.
  - Intensive Home-Based Services (IHBS): Services expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the plan and the Core Practice Model, and are predominantly delivered outside an office setting, and in the home, school, or community. Services include medically necessity; skill-based interventions; development of functional skills; development of skills or replacement behaviors that allow the child or youth to participate in the CFT; improvement of self-management of symptoms; education of the child, youth and/or caregiver(s) on how to manage the mental health disorder or symptoms; support the use of social networks; and/or support to address behaviors that interfere with the achievement of a stable and permanent family life, achieve educational objectives, and behaviors to support independent living skills. Services are typically (but not only) provided by paraprofessionals under clinical supervision.
  - Therapeutic Foster Care (TFC): TFC service activities are provided through the TFC service model and include collateral, rehabilitation, and plan development as it relates to the TFC. It is delivered in the home or other community setting by a trained and qualified TFC parent.
- Day Treatment Intensive and Day Rehabilitation: assessment; evaluation; plan development; therapy; rehabilitation services; and collateral.
- Crisis Intervention: assessment; evaluation; therapy; and collateral.

- Crisis Stabilization: assessment; evaluation; medication support; crisis intervention; therapy; and collateral.
- Adult Residential Treatment Services and Crisis Residential Treatment Services
- Psychiatric Inpatient Hospital Services; Psychiatric Health Facility Services (PHF), and Psychiatric Nursing Facility Services (SNF, ICF, IMD) (CCR02)

This manual and policy addresses the documentation standards for all Specialty Mental Health Services, except Individual, Group & Agency Network Providers; Residential; and Psychiatric Inpatient Services.

**Long Term Client:** ACBH has determined that clients who require more than sixty (60) days of specialty mental health services (SMHS) will be considered a "long-term client."

**Types of Services and Claiming Eligibility:** The type of provider contract determines the documentation standards and method of claiming for reimbursement of services. Each provider's contract specifies which specialty mental health services they may claim; not all provider contracts authorize claiming for the full array of SMHS.

**Master Contract Organizational (MCO) Providers** (bill via INSYST or Clinician's Gateway):

- County-operated service providers of outpatient services (includes ACBH-identified Brief Service Programs, e.g., Crisis, Assessment Only, etc.)
- Organizational providers of outpatient services-MCO's (aka CBO's)
- Full Service Partnerships (FSP's)

**Terminology:** ACBH is inclusive in the language used to refer to persons receiving SMHS from ACBH (e.g., consumers, clients, families, children, youth, transition-age youth, participants, partners, etc.). Depending on the language used, it is possible that some beneficiaries could feel excluded or secondary in importance. While it is the goal of ACBH to honor each individual's desire to be identified as they wish, this section of the Quality Assurance Manual is bound by regulatory language that uses "beneficiary" and "client" in reference to documentation standards. In the interest of clarity, inclusion, and consistency with regulatory language, all persons who receive SMHS from ACBH will be referred to as "clients" throughout this Clinical Documentation Manual.

# General Management of Clinical Records

(CFR2) (CC1) (CC2) (HS1) (CalOHI1) (DMHcontract2) (CCR23)

For the purposes of these documentation standards, charts (paper or electronic) containing documentation of mental health services are referred to as Electronic Health Records (EHRs), Clinical Records or Records.

## General *EHR* Maintenance

Per ACBH, the following is required for both paper records and EHRs:

- Records are organized and divided into sections according to a consistent standard allowing for ease of location and referencing. (BHCSQA09)
- Records are sequential, and date ordered. (BHCSQA09)
- Paper records are fastened together to avoid loss or being misplaced. No loose papers or sticky-sheets in the chart (staples OK). (BHCSQA09)
- Progress Notes are filed in clinical records. (CalOHI1)
- All entries are legible (including signatures). (See “Clinical Documentation Standards” section, ["Signature Requirements".](#)) (CCR30) (DMHcontract3)
- Use only ink to document services across all chart entries (black or blue). (BHCSQA09)
- Every page must have some form of client identification (name or identification number, etc.). (BHCSQA09)
- Do not use names or initials of other clients in the record. In the unusual event that requires reference to another client, use initials or similar method of preserving the clients’ identities. (BHCSQA09)
- Do not copy the same words across multiple Progress Notes (e.g. “Rubber Stamping”). Each Progress Note reflects how the client responded on each day of service. (BHCSQA09)
- Correcting errors: Do not use correction tape/fluid, scribble over, etc. Instead, draw a single line through the error, indicate “error”, initial, date and then enter correct information. (BHCSQA09)
- Only original authors of the entry make alterations.
- Reviewers or supervisors do not edit an entry by the original author(s), but may supply an addendum with dated signature.
- Acronyms and Abbreviations: Use only universal and County-approved acronyms and abbreviations (see Appendix for the list of [ACBH Approved Acronyms and Abbreviations](#)). (BHCSQA09)
- All chart and EHR entries are dated based upon the time and date of documented entry.

## Record Storage

Clinical records contain Protected Health Information (PHI) covered by both state and federal confidentiality, privacy, and security laws. Providers are required to safeguard the

information in the record against loss, defacement, tampering, or use by unauthorized persons. (CFR1) (CFR2) (CC1)

ACBH requires that all records containing PHI be stored in at least a "double locked" manner (e.g., in a locked filing cabinet located within a locked office). If records must be transported, maintain the "double locked" and safeguarding requirement (e.g. transport in a locked box in a locked vehicle trunk. Do not leave in an unattended vehicle).

The following record storage procedures are consistent with good clinical practice: (HS2) (CC2) (CCR31) (CFR1) (CFR2)

- A controlled record check-out or retrieval system for access, accountability, and tracking.
- Safe and confidential retrieval system for records that may be stored off-site or archived.
- Secure filing system (both physical plant and electronic safeguards used, when applicable). (See above regarding "double locked" storage.)

With respect to electronic Protected Health Information (PHI) and Personal Information (PI), providers must use appropriate administrative, physical, and technical safeguards, and comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and Security Rule, Health Information Technology for Economic and Clinical Health Act (HITECH), and state Security Requirements. (BAEE) It is recommended that each contract provider consult with an IT expert knowledgeable about HIPAA/HITECH requirements and National Institute of Standards and Technology (NIST) compliance standards for protection of PHI/PI.

Currently, all workstations and laptops that store PHI/PI either directly or temporarily must be encrypted using a Federal Information Processing Standards (FIPS 140-2) certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk. All electronic files that contain PHI/PI must be encrypted when stored on any removable media or portable device; encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

## Record Retention

Per federal law and state contract requirements, ACBH is required to maintain client records as follows: (HS3) (CCR31)

- For all clients, records (paper and electronic) must be maintained for a minimum of: ten (10) years after the last service OR ten (10) years after their eighteenth (18) birthday, whichever is later. (DMH02) As well:
- If later, records must also be retained until DHCS does a final cost settlement with ACBH for the FY in which the last date of service occurred. The last cost settlement which has been finalized occurred for FY 07/01/08-6/30/09. The most recent cost settlement will always be found here.
- On the date of the ten year anniversary (after no services, or the client's 18th birthday—whichever is later), the record shall be retained until the then current DHCS contract with ACBH expires. The current contract terminates 6/30/23. The most recent contract termination date will always be found here.

- Audit situations: Records shall be retained beyond the ten (10) year period if an audit involving those records is pending, until the audit findings are resolved. The obligation to maintain the records beyond the ten (10) year period exists only if the MHP notifies the Contractor of the commencement of an audit prior to the expiration of the ten (10) year period. (BHCSQA09)

*Example:*

- Today's date is 1/8/17.
- Minor client last seen in 2006 has their 18th birthday on 1/7/2007.
- Their 10 year anniversary date (past last service date or 18th birthday—whichever is later), is 1/7/2017
- ACBH has finalized their cost settlement with DHCS for January 2007 (FY 2006-2007)
- None of these clients' records have been requested for an audit.
- As of 1/7/2017 the then current ACBH/DHCS contract expires 6/30/18.
- The client record, per ACBH Record Retention Policy, may be destroyed no sooner than 6/30/2018.

***Given the above extensions beyond the 10 year period it is highly recommended that all providers simply maintain their client's records for fifteen (15) years after the last service OR fifteen (15) years after their eighteenth (18) birthday, whichever is later.***

**Third party**: If a provider uses a third party to perform work related to their ACBH contract, the provider must require the third party to follow these same standards. ACBH also requires that all contractors that have access to PHI sign a Business Associates Agreement (BAA) annually. The BAA outlines the security and privacy standards with which the contractor must comply, including record retention and disposal/destruction requirements. (BHCSQA09)

**Provider out of business**: In the event a provider goes out of business or no longer provides mental health services, the provider is still obligated to make arrangements that will assure the accessibility, confidentiality, maintenance, and preservation of clinical records for the minimum retention time as described above. (CCR29) (HS3)

## **Record Disposal and Destruction**

Records are to be destroyed in a manner to preserve and assure client confidentiality and privacy. Documentation of the disposal and/or destruction must be maintained by ACBH and its providers. (CC1)

- Paper documents containing PHI must be shredded.
- Depending on the type of media and data, ACBH and its providers may either destroy or wipe electronic media that contains PHI when disposal is necessary. Secure methods will be used to destroy and/or wipe electronic media, data, and output.
  - Destruction methods may include pulverizing, shearing, and/or crushing.
  - Wiping methods adhere to the US Department of Defense standards for wiping data.

- ACBH and its providers are responsible for the disposal of electronic data containing PHI, as well as maintaining documentation of the disposal, including the type of method used.

# ACBH Screening Tool

The policy establishes the timeline and scope of practice for completion of the Alameda County ACBH *Behavioral Health Screening Tool* which determines if a beneficiary is eligible for Specialty Mental Health Services or should be referred to their Managed Care Plan for services.

## PROCEDURE

### 1. Directions For Using The Screening Tool Form

- a. Providers (with the proper scope of practice) must complete the screening tool to determine if a consumer meets Specialty Mental Health Services criteria with moderate-severe impairment or should be referred to their managed care plan due to mild-moderate impairment.
  - i. The ACBH *Behavioral Health Brief Screening Tool* (see Appendix) must be completed for all beneficiaries at the onset of treatment, and at the annual treatment plan/authorization update.
  - ii. The screening tool must be completed and signed by a Licensed, registered/waivered LPHA, or a second year (or greater) Trainee that has the training and experience to diagnose. The Screening Tool must contain the co-signature of a Licensed LPHA if completed by a registered/waivered LPHA, 2nd year (or greater) Student Trainee with the scope of practice to diagnose.
- b. Completing the Screening Tool. Please complete all sections of the form with the following exceptions:
  - i. A release of information should be obtained and the “Required Release of Info Completed” check box should be checked only if information will be sent to the MCP/Primary Care Provider (PCP).
  - ii. The Referring Provider Name section is only required if the screening form will be sent to MCP.
  - iii. The “For Receiving Clinician Use Only” Section does not need to be completed by the screening clinician.
- c. Use the algorithm to determine if the consumer should receive services through Specialty Mental Health Services or their managed care plan.
  - i. Screening tool criteria descriptions are listed on the back of the “Screening Tool and referral Instructions” page.

- d. If algorithm indicates mild-to-moderate condition, refer the consumer to their managed care plan or PCP for services. The name of the managed care plan should be listed on the back of Consumer's Medi-Cal card or see contact information on the screening tool instructions sheet.
  
- e. If algorithm indicates significant impairment or moderate-severe condition, which meets medical necessity for Specialty Mental Health Services:
  - i. Retain a copy of the completed Screening Tool in the client's chart. This will be requested by ACBH Quality Assurance department should the chart be audited.
  - ii. If you work for a CBO/Master Contract Provider and bill through INSYST you can provide direct services.
  - iii. Consumers age 0-21 with out-of-county Medi-Cal must receive prior authorization from ACCESS before a ACBH provider may open the case

# Medical Necessity: Providing the Rationale for Services (CCR16) (CCR20)

ACBH requires substantiation of the need for SMHS in order for those services to qualify for reimbursement. This process is known as establishing Medical Necessity (MN)

## Relevance of Medical Necessity for Documentation

- The Initial Assessment and Annual Assessment (See Appendix for [MH Assessment Templates](#)) establishes and documents that the client meets Medical Necessity. The assessment also documents that the client's diagnosis is an included diagnosis (See Appendix for [SMHS Outpatient M. /C Included \(aka Covered\) Diagnoses Lists.](#)), and was determined by a Licensed, Waivered or Registered “Licensed Practitioner of Healing Arts” (LPHA) or appropriately credentialed MH Trainee (see Scope of Practice Section).
- Client plans are based on information obtained from the MH Assessment (See Appendix for [Client Plan Templates.](#)) A signature of a licensed, waived or registered LPHA or MH Trainee, on the Assessment is attestation that MN is met.
- Client plans serve to outline the mental health objectives of treatment to address the client’s level of functioning.
- Each Progress Note (PN) contains evidence that the services claimed for reimbursement continue to meet Medical Necessity (See Appendix for [PN Template](#)). Claim submission is attestation that this requirement is met.

## Medical Necessity Determination

All clients must meet all three criteria outlined below.

- The client has a primary diagnosis from the [SMHS Outpatient Medi-Cal Included \(aka Covered\) Diagnoses List](#) (see Appendix) that is substantiated by chart documentation. (CCR17)
  - A client’s excluded diagnosis should be noted, but there must be an "included" diagnosis that is a primary focus of treatment. (An "excluded" diagnosis may not be noted as primary. Note-“primary” means the diagnosis which is the “primary focus of treatment”.)
  - Identify the DSM diagnostic criteria for each diagnosis that is a focus of treatment. The signs and symptoms that support this must be documented in the MH Assessment and must be specific to the client
  - List both the ICD-10 code and DSM-5 descriptor (name) with specifiers. If no DSM-5 diagnosis exists—list the ICD-10 descriptor (name).
- The client must have at least one of the following impairments as a result of a mental disorder. (CCR18)
  - A significant impairment in an important area of life functioning; OR
  - A probability of significant deterioration in an important area of life functioning; OR
  - A probability the child will not progress developmentally, as individually appropriate. OR
  - Children covered under EPSDT qualify if they have a mental disorder that can

be corrected or ameliorated with mental health services.

- Proposed service intervention must meet all three listed below: (CCR19)
  - The focus of proposed intervention is to address the condition identified in impairment criteria above, and
  - It is expected the beneficiary will benefit from the proposed intervention by: significantly diminishing the impairment; or by preventing significant deterioration in an important area of life functioning; and/or for children it is probable that child will progress developmentally as individually appropriate, or for EPSDT Medi-Cal beneficiaries under age 21, to correct or ameliorate the condition. (CCR20)
  - The condition would not be responsive to physical health care based treatment.

## Medical Necessity Documentation

Medical necessity must be documented in the following forms, as applicable: (CCR19)

- Interim and/or Initial Assessment
- Annual Reassessment
- Crisis Assessment
- Psychiatric/Medication Assessment
- Client Treatment Plan
- Progress Notes

Recommended Medical Necessity Impairment & Intervention Criteria Checklist for the MH Assessment:

Impairment Criteria, must have one of the following:		AND:	Intervention Criteria, proposed INTERVENTION will:
<input type="checkbox"/>	A. Significant impairment in an important area of life function.	AND	A. Significantly diminish impairment
<input type="checkbox"/>	B. Probability of significant deterioration in an important area of functioning.	AND	B. Prevent significant deterioration in an important area of life functioning.
<input type="checkbox"/>	C. (Under 21) Without treatment will not progress developmentally as individually appropriate.	AND	C. (Under 21) Probably allow the child to progress developmentally as individually appropriate.
<input type="checkbox"/>	D. None of the above. (no medical necessity)	AND	D. None of the above. (no medical necessity)

# Clinical Documentation Standards for Specialty Mental Health Services

## Signature Requirements (DMHcontract2)

This section describes signature requirements for all providers, as noted. It also describes the required contents of clinical documents, per type of provider or service, as noted below:

All providers - for the following documentation:

- Initial Assessment
- Annual Re-Assessment(s)
- Client Treatment Plans
- Progress Notes
- Discharge/Termination/Transition Documentation
- Child and Adolescent Needs and Strengths Assessment (CANS 0-5 yrs.' & CANS 6 – 17 yrs.); Adult Needs and Strengths Assessment (ANSA 18 -24 yrs.' and ANSA 25 yrs.' and older)
- Therapeutic Behavioral Services (TBS) providers – Additionally, See TBS Section.

A. Complete Signature: Every clinical document must be finalized by a “complete signature,” which includes the writer's signature, their appropriate Medi-Cal credential (see credentials below) and the date signed. It is best practice to include the Professional Board’s license or intern number with the Medi-Cal credential when applicable. (BHCSQA09)

B. Legibility: Signatures should be legible.

- If signatures are illegible, the claims associated with the document may be subject to disallowance. Therefore, ACBH recommends that the name and appropriate credential (See Appendix: [ACBH Scope of Practice Table](#)), be typed under signature lines. Providers may also have an administrative “signature page” (See Appendix: [ACBH Scope of Practice](#), pg., 2) containing staff signatures with their typed name and credential if it is placed in the client’s record (rather than typing staff name on each document signature line) (CCR30) (DMHcontract3)
- Electronic signatures, utilizing electronic signature pads, are also allowed and must indicate the providers appropriate Medi-Cal credential unless provide legibly with signature

C. Credentials (See Appendix: [ACBH Scope of Practice Table](#)): Every provider signature must also include the provider’s credential that allows them to bill Medi-Cal: Psychiatrist (MD or DO), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Physician Assistant (PA), Clinical Registered Pharmacist (RPh), Registered Nurse (RN), Licensed Vocational Nurse (LVN), Psychiatric Technician (Psych Tech),

NP/CNS/PA Student or Intern, Licensed Psychologist (PhD-L or PsyD-L), Waivered Psychologist (PhD-W or PsyD-W), Marriage and Family Therapist (MFT), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), LPCC-F (includes family counseling credentialing), Associate MFT (AMFT or RAMFT), Associate Social Worker (ASW), Associate Professional Clinical Counselor (APCC or RAPCC), RPh-Intern, Mental Health Rehabilitation Specialist (MHRS), MFT or MSW or PCC Waivered, Trainee (Student in Mental Health Program: MA/MS/MSW/PhD/PsyD program), and Adjunct staff (e.g. peer or family provider)

- D. Dates: Signatures on all documents and progress notes require the date (month, day, and year) that the document was signed. If the document or progress note was completed late, do not back date the signature.
- E. Completion Line: Nothing may be added to an existing entry within a document after it is signed. To indicate the end of an entry in a paper chart, draw a line from the bottom of the page up to the signature (N/A for electronic signatures). (BHCSQA09)
- If additional information must be added, write an addendum, and reference the date of service, as well as document the date of the addendum.
- F. Addendums: An addendum is new documentation used to add information to an original entry. Addendums should be timely and document the current date, reason for the additional information being added to the record, and include a complete signature (see definition above). (BHCSQA09)

## ELECTRONIC SIGNATURES

California approved the use of electronic signatures in electronically signed records as equivalent to a manual signature affixed by hand for financial, program, and medical records audit purposes.

ACBH requires that electronic signatures meet the following standards:

- The electronic signature mechanism is a) unique to the signer, b) under the signer's sole control, c) capable of being verified, and d) linked to the data, so that if the data is changed, the signature is invalidated.
- Computer systems that utilize electronic signatures comply with the Certification Commission for Healthcare Information Technology (CCHIT) certification criteria or equivalent.

## DIAGNOSTIC EVALUATIONS (Initial and Annual Mental Health Assessments) (DMHcontract2)

Definition: Assessments are a collection of information and clinical analysis of the history and the current status of a client's mental, emotional, and/or behavioral health. Documentation of the client's history and current functioning in the Assessment must support the Medical Necessity criteria defined above so that a diagnosis may be established, and mental health services may be provided. (CCR04)

Assessment information must be in a specific document (Interim Assessment, Initial Assessment, Annual Re-Assessment or Assessment Addendum) and section of the clinical record, per ACBH requirements. (BHCSQA09)

All County Operated programs: must use ACBH Assessment templates in the Electronic Health Record (EHR), Clinician's Gateway (CG).

Contract Providers: Per ACBH requirements, contract providers may develop their own Assessment templates, if the ACBH minimum required content areas are addressed in the document. <sup>(BHCSQA09)</sup>

## 1. Initial Assessment (BHCSQA09)

All Providers (See exceptions below): Per the MHP requirements, a completed and filed full Initial Assessment is required within 60 days of the Episode Opening Date (EOD), unless required earlier per contract or type of program (see below for earlier deadlines).

- If it is not possible to address all required elements of the assessment due to issues of client participation or inability to obtain a full history, but medical necessity has been established, the Assessment should be completed within the required deadlines, with notations of when addendums with missing information are expected.
- In cases when there are extenuating circumstances, e.g. if a high risk, difficult to engage client has a clinical presentation that requires additional assessment time, extensions of 30 day (or one calendar month – whichever is longer) increments may be authorized to complete the assessment if **the clinical need is documented** in the clinical record. (Each 30 days, the clinical justification for extension is reviewed in CQRT until authorized or closed.) In these cases, the provider should still obtain as much information as possible to complete sections of the assessment, e.g., if a client is chronically psychotic, off medications, using drugs and alcohol, rarely shows for appointments and therefore cannot be fully assessed within the 60 day timeline. The provider should review InSyst history for past mental health treatment and hospitalization episodes and past diagnoses, and/or interview family members, etc., and document this information in the MH Assessment form. The provider should also document attempts to complete the Assessment.
- An extension for the MH Assessment deadline does not allow for the claiming of “planned services”--see Client Plan section below. **Note:** If the Client Plan has been completed--the completed full MH Assessment may not be extended beyond the due date. In that case, if medical necessity has been established, the Assessment should be completed within the required deadlines, with notations of when addendums with the missing information are expected.
- If the case is closed before 60 days, best practice is to complete those sections of the Initial Assessment for which data has been collected.
- Progress Notes for every billed Assessment service must be in the clinical record.
- Within one agency--multiple RU's (who share a medical record) are allowed to share one MH Assessment (and diagnosis) for concurrent services. The MH Assessment must be an ACBH M/C equivalent one to be utilized.
  - This may only be done when two episodes are concurrently open.
  - This is accomplished by back dating the second RU opening date to the first RU opening date.
  - When indicated, any documentation that is in need of updating must be addressed. This will almost always include a new Client Plan. As well, this may require additional consents (to a new modality of treatment), additional Release of Information Consents, Medication Consents, etc.
  - Note: In these circumstances multiple RU's within one agency may also decide to share a Client Plan OR create a Client Plan for each RU.
  - If multiple RUs (in one agency) do not share a chart, all shared

documentation must be copied into each chart. This includes documents from the initial EOD, such as:

- Screening Form (with associated PN's),
- Informing Materials (with associated PN's),
- Mental Health Assessments (with associated PN's),
- CANS/ANSA (with associated PN's),
- Client Treatment Plan (with associated PN's),
- ROIs (with associated PN's), etc.
- ACBH County owned and operated programs, "one agency" is considered one program which has a unique folder in the Laserfiche database. (e.g. Eden Child Services or Oakland Community Support Center)
- Contact your [ACBH-QA TA contact](#) for any questions regarding this process (See Appendix).
- For Initial assessment only: Across multiple outpatient agencies the completed MH Assessment from one agency be allowed to be shared (for Initial Assessment only) if the first MH Assessment was conducted within the past 6 months. The cross agency MH Assessment must be an ACBH M/C equivalent one to be utilized.
  - The MH Assessment utilized from an outside provider must be a completed full MH Assessment done by that Provider (that is, it may not be a MH Assessment that the outside Provider utilized from a different Provider and then updated with their MH Assessment Addendum).
  - The Assessment from the outside Provider must be incorporated into the Medical Record with a MH Assessment Addendum which includes:
    - the interim history,
    - any changes in all of the areas of the MH Assessment previously collected,
    - A current included (aka "Covered") diagnosis,
    - Signs and symptoms of the Diagnosis that meet DSM criteria,
    - Mental Status Exam,
    - Functional impairments as a result of that Diagnosis,
    - Level of impairment,
    - Client's ability to benefit from treatment, and
    - Date of attached Complete MH Assessment.
  - Contact your [ACBH-QA TA contact](#) for any questions regarding this process (See Appendix).
  - ACBH County owned and operated programs, utilizing MH Assessments across multiple outpatient agencies includes not only from non-ACBH programs, but across all ACBH programs as well.
- An agency who has a client returning to treatment may be able to utilize a pre-

existing assessment with an Assessment Addendum if the following criteria are met:

- The MH Assessment must be an ACBH M/C equivalent one to be utilized.
- It was completed within the past 12 months, within the same agency.
- The Assessment utilized must be a completed full MH Assessment done by the same Provider (it may not be a MH Assessment utilized from a prior episode, or from an outside Provider, which was updated with a MH Assessment Addendum).
- The Assessment from the same Provider must be incorporated into the Medical Record with a MH Assessment Addendum which includes:
  - the interim history,
  - any changes in all of the areas of the MH Assessment previously collected,
  - a Mental Status Exam (MSE),
  - A current included (aka "Covered") diagnosis & signs and symptoms of the Diagnosis that meet DSM criteria,
    - Note, the Diagnosis must be current (conducted by the provider) and specify the *current* specific signs and symptoms that meet the DSM criteria for that M/C Included (aka "Covered") diagnosis.
  - Functional impairments as a result of that Diagnosis,
  - Level of impairment,
  - Client's ability to benefit from treatment, and
  - Date of attached Complete MH Assessment.
- ACBH/ACBH County owned and operated programs, "one agency" is considered one program which has a unique folder in the Laserfiche database. (e.g. Eden Child Services, Oakland Community Support Center, etc.)
- Contact your [ACBH-QA TA contact](#) for any questions regarding this process.
- Interim MH Assessment: A completed full MH Assessment is not required in advance of providing planned services if an initial Client Plan is in place and consistent with the documented Medical and Service Necessity which is documented in an Interim Assessment. Program exceptions are outlined below. Per DHCS, Medical and Service Necessity is required prior to the development of the Initial Client Plan in order to provide and claim for planned services. This is documented in the Interim MH Assessment and includes:
  - A current included (aka "Covered") diagnosis,
  - Signs and symptoms of the Diagnosis that meet DSM criteria,

- Functional impairments as a result of that Diagnosis,
- Level of impairment, and
- Client’s ability to benefit from treatment.
- In addition, all Client Plan requirements must be met (see Client Plan section).

The provider should note that Initial Client Plans meeting the criteria above and completed before completion of the full MH Assessment must be reviewed once the MH Assessment is completed, and updated as clinically appropriate. Such an Initial Client Plan that is written very early in treatment is usually considered an “Interim” Plan and as such is usually rewritten within 30 – 90 days of the Episode Opening Date (EOD).

Program Exceptions: A completed Full MH Assessment (and Client Plan) with sooner due dates below by program, type:

- Day Treatment Intensive: by day seven.
- Day Rehabilitation: by day seven.
- Adult Residential Treatment Services: by day seven.
- Crisis Residential Treatment Services: by day seven.
- Psychiatric Health Facility Services: 72 hours (actual count).
- Psychiatric Inpatient Services: 72 hours (excluding Saturday and Sunday).
- TBS Behavioral Interventions may not be claimed until the TBS Assessment and TBS Plan are completed. If the provider is claiming for additional SMHS services, the MH Assessment and Client Plan must also be completed prior to the delivery of TBS Behavioral Interventions.

Time-Limited Programs: The due dates for a completed and filed Initial Assessment varies based upon program length. Consult with your agency’s MHP contracts and [QA TA contacts](#) for these timeframes.

Out-of-County Providers: The due date for a completed and filed Initial Assessment is based upon the MHP requirements in the county in which the provider is located.

## 1. Annual Re-Assessments

All Providers: Per MHP requirements, a completed and filed Annual Re-Assessment is required. The Annual Assessment is completed in the calendar month prior to the Episode Opening Month (EOM) and is due by the first day of the Episode Opening month. Historical items can be carried forward from a previous assessment, but all other items must be updated and a new Assessment form is required.

- Within one agency--multiple RU's (who share a medical record) are allowed to share one Annual MH Assessment (and diagnosis) for concurrent services. The MH Assessment must be an ACBH M/C equivalent one to be utilized.
  - This may only be done when two episodes are concurrently open.
  - When indicated, any documentation that is in need of updating must be addressed. As well, this may require additional consents (to a new modality of treatment), additional Release of Information Consents,

- Medication Consents, etc.
- Note: In these circumstances multiple RU's within one agency may also decide to share a Client Plan OR create a Client Plan for each RU.
- If multiple RUs (in one agency) do not share a chart, all shared documentation must be copied into each chart. This includes documents from the initial EOD, such as:
  - Screening Form (with associated PN's),
  - Informing Materials (with associated PN's),
  - Mental Health Assessments (with associated PN's),
  - CANS/ANSA (with associated PN's),
  - Client Treatment Plan (with associated PN's),
  - ROIs (with associated PN's), etc.
- For ACBH county-owned and operated programs, "one agency" is considered one program which has a unique folder in the Laserfiche database. (e.g. Eden Child Services or Oakland Community Support Center,)
- Contact your [ACBH-QA TA contact](#) for any questions regarding this process.

**Returning Clients:** If a beneficiary's episode is closed but they return to the provider (same agency) for additional services within 12 months of an Assessment's completion, that Assessment may be updated with new clinical information in an addendum and re-used for the new episode opening. This addendum must be clearly linked to the previous Assessment and signed no later than the required timeframes indicated above. See prior Initial Assessment section for additional information and requirements.

If the beneficiary returns for services after 12 months of an Assessment's completion, the Assessment must be re-done as a new Initial Assessment.

## 2. Minimum Required Elements for Initial and Annual Assessment Content

The following areas must be included in the Initial and Annual Re-Assessment, as appropriate, as part of a comprehensive clinical record. (See [MH Assessment Template](#) in Appendix.) <sup>(DMHcontract1)</sup>

- *Identifying information:* the Assessment must include: (BHCSQA09)
  - The date of initial contact and admission date;
  - The client's name and contact information (including address/phone and emergency contact information);
  - The client's: age, sex-assigned at birth, self-identified gender, sexual orientation, personal (aka preferred) pronoun, preferred name, ethnicity, and relationship status;
  - Information about significant others in the client's life including guardian, conservator or other legal representatives;
  - The client's school and/or employment information; and
  - Other identifying information, as applicable.
- Communication needs are assessed for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter

services, etc.). If required, indicate whether it was/will be provided, and document any linkage of the client to culture-specific and/or linguistic services in the community. Providers are required to offer linguistic services and document the offer was made. If the client prefers a family member as an interpreter the clinician should first provide psychoeducation about the contraindications to such an arrangement. Their preference and discussion should be documented. Service-related correspondence with the client must be in their preferred language/format. All Progress Notes must indicate what language the service was provided in unless the Assessment indicates the client's primary and preferred language is English and all services will be provided in English (e.g., one cannot indicate Spanish as the preferred language in the MH Assessment and then not indicate in each PN that each service was provided in Spanish. The PN must indicate each service that was delivered in Spanish.). (BHCSQA09)

- Medical History - Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports. (DMHcontract1) Indicate the client's primary care provider with contact information. If none, make referral and follow-up to ensure client is linked with physical health care.
- Presenting problem/referral reason & relevant conditions affecting the client's physical health, mental health status and psychosocial conditions (e.g. living situation, daily activities, social support, etc.). Includes: problem definitions by the client; significant others and referral sources, as relevant; the client's chief complaint; history of the presenting problem(s); and includes current relevant family history and family information. (DMHcontract1)
- Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma.
- Special status situations that present a risk to the client or to others must be prominently documented and updated, as appropriate. (DMHcontract1)
  - DHCS has identified twelve (12) specific categories of risk as follows:
    - History of Danger to Self (DTS) or Danger to Others (DTS);
    - Previous inpatient hospitalizations for DTS or DTO;
    - Prior suicide attempts;
    - Lack of family or other support systems;
    - Arrest history, if any;
    - Probation status;
    - History of alcohol/drug abuse;
    - History of trauma or victimization;
    - History of self-harm behaviors (e.g., cutting, drinking & driving, high

risk sexual behavior, etc.);

- History of assaultive behavior;
- Physical impairments (e.g., limited vision, hearing impaired, mobility limitations) which make the beneficiary vulnerable to others; and
- Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

**Note: If a serious risk (such as above) has been identified within the last 90 days, (e.g. suicidal or homicidal ideation OR any other high risk ideation/behaviors) the record MUST include a comprehensive written risk assessment (See Appendix: [Comprehensive Risk Assessment](#)) AND a separate formal written safety plan (See Appendix: [Safety Plan](#)) as well as being addressed in the client plan.**

- Client's/Family strengths in achieving Client Plan Objectives and goals related to the client's mental health needs and functional impairments as a result of the MH diagnosis (e.g., client's skills and interests, family involvement and resources, community and social supports, etc.). (DMHcontract1)
- Medications:
  - List medications prescribed by a Medical Provider (MD, DO, PA, NP) employed by the provider, including: dose/frequency of each, date of initial prescriptions & refills. Documentation of informed consent for medications is required and may be located in a different section of the record. (DMHcontract1)
  - Medications prescribed by an outside Medical Provider must be listed as above, per client or Medical Provider's report; provide the Medical Provider's name and contact information (address and telephone) and as known: dose/frequency of each, date of initial prescriptions & refills. (BHCSQA09)
  - Document the history of prescribed medications (for physical and mental health) as above (each element as known), per client or Medical Provider's report; provide Medical Provider's name and contact information (address and telephone).
- *Allergies & adverse reactions/sensitivities*, per client or by report, to any substances or items, or the lack thereof, must be noted (DMHcontract1) and prominently noted on the front of the chart, or in agency identified data field in their Electronic Health Record (EHR). (BHCSQA09)
- *Substance Exposure/Use*: Document client's past and present exposure and/or use of Tobacco, Alcohol, Caffeine, Complementary & Alternative Medications (CAM), Prescribed, Over-the-Counter, and Illicit drugs. (DMHcontract1)
- *Mental health history*, including (when known) previous treatment dates and providers; therapeutic modality and interventions (e.g. medications, psychosocial treatments) and responses; and inpatient admissions. If possible, include sources of clinical data (such as previous mental health records, lab tests, psychological testing and consultation reports); and relevant family MH information. (DMHcontract1)
- *Other history*: histories of employment/work, living situation, etc. (BHCSQA09)

- *For clients under age 18:* Include (or document efforts to obtain) pre-natal/perinatal events, and complete developmental history (physical, intellectual, psychological, social & academic). (DMHcontract1)
- *Relevant Mental Status Examination:* Includes signs and symptoms relevant to determine diagnosis and plan of treatment. All “positive” or “abnormal” findings must be described in the narrative. (DMHcontract1)
- *Complete Diagnosis* (both included and excluded diagnoses) with primary diagnosis from the ACBH Medi-Cal included (aka "Covered") diagnosis Lists, consistent with presenting problem, history, mental status examination, and/or other assessment data. [See ACBH SMHS Outpatient Medi-Cal Included Lists in Appendix.](#) (DMHcontract1)
- At least one diagnosis (primary) must be the focus of treatment and must be on the “included” Medical Necessity criteria list. (CCR16)
  - Only a licensed clinician (MD/DO/NP/CNS/MFT/LCSW/LPC) may independently assign a psychiatric diagnosis.
  - Advanced Practice Pharmacists may conduct the MH Assessment, but may not conduct the MSE or diagnose.
  - A waived or registered intern may assign a diagnosis only if it is co-signed by a Licensed LPHA. A full-time equivalent second year Graduate Trainee/Student (with appropriate training and experience) can conduct the Mental Status Exam (MSE) and establish a diagnosis with a written attestation (placed in his/her personnel file) by the current Licensed Clinical Supervisor of the Trainee/Student. The attestation shall indicate that the student has sufficient education, training, and experience to diagnose independently with only the Licensed Supervisor’s on-going full record review, supervision, and co-signature.
  - An RN, with appropriate training and experience, may conduct a MH Assessment, MSE and Diagnose with a Licensed LPHA co-signature. Note, an RN with Master’s degree and two years MH experience (not credentialed as a CNS or NP) may do so without a co-signature. See ACBH [Scope of Practice Table](#) in Addendum for additional information.
  - When a Graduate Trainee/Student, whose scope of practice does NOT include diagnosis, completes the MH Assessment—they must indicate which LPHA made the current diagnosis and on what date (an LPHA from that agency). A MH Assessment and/or PN must document this in the medical record.
- A historical diagnosis (including a recent inpatient diagnosis) may not be simply referenced as the current diagnosis in an outpatient setting without re-diagnosis. The assessment is designed to evaluate the current status of a client’s mental, emotional, or behavioral health which may change as the client transitions—such as from inpatient to outpatient services. The outpatient provider should review the inpatient assessment documentation to inform the outpatient assessment, but a current diagnosis (with current supporting criteria) is required.
- Each contracted agency must have its own process for resolving discrepant

diagnoses between staff members' diagnoses. This must be done (aligning diagnoses) as best practice. As well, it is best practice for providers to collaborate across agencies regarding conflicting diagnoses. (Each agency will have one primary included diagnosis.)

- Note: History can be carried forward from a previous assessment, but all other items must be updated and a new Assessment form is required (See exceptions above for when a complete new MH Assessment is not required). Clinical Analysis: "Best practice" is to also provide a clinical analysis (aka clinical impression or formulation) of how the client's mental health issues impact life functioning, based on the Assessment information. This may be part of the Assessment document or the Client Plan.
- Complete signature of the Licensed LPHA completing the Assessment OR the signature of the RN, or MH Trainee or Waivered/Registered Intern WITH a licensed LPHA co-signature. (CCR21) (CCR11) (BP1) (CCR01)

## MEDICATION CONSENTS

Medication Consents: ACBH requires providers to obtain and retain a written medication consent form signed by the client (or appropriate client representative) agreeing to the administration of each psychiatric medication prescribed. These requirements apply to all clients receiving medications. The process of obtaining Informed Consent is invaluable to assist the medical practitioner in educating and empowering their clients about the course of their treatment.

### A. Minimum Content Requirements

The Consent for Treatment with Medications contains at least the following, for each medication prescribed:

- The nature of the client's mental condition.
- The reason that the medical provider has for prescribing the medication, including the likelihood of the condition improving or not improving without the medicine, and that the client can refuse to take the medications at any time by communicating with any member of the treating staff.
- Reasonable alternative treatments available for the client's condition must be addressed and discussed.
- The type of medication that the client will be receiving, the frequency and range of dosages, the method by which the client will take the medication, and duration of such treatment.
- The side effects of these drugs known to commonly occur, any particular side effects (aka short term) likely to occur in their particular case, and any possible side effects which may occur to the client taking such medications beyond three (3) months (aka long term).
- A new consent must be completed each time a new medication is prescribed or after an end date is noted on a previous Informed consent.
- Dosage changes may be updated (dated and initialed by provider and client) on an existing consent or a new consent may be completed.

- Must be signed and dated by the client (unless the client is willing to take the medication but unwilling to sign. In this case, that should be documented in the space available on the Consent Form, along with the clinical reason the client refuses to sign (either on the Consent Form and/or in the associated Progress Note.)
- Must be signed and dated by the prescribing medical practitioner.
- Must be legible.
- Information regarding the medical provider's license and certification by the the associated Medical (MD, DO & PA) or Nursing (NP, CNS) Boards of California.

It is best practice that each of the above items is documented in full on each Medication Consent form. However, it is allowable for the Medication Consent to include attestations, signed by the provider and the beneficiary, that the provider discussed each required component (state each) with the beneficiary:

- a. For example, a Medical provider may include a statement that they discussed the type, range of frequency, amount, method (e.g. oral or injection), and duration of the medication(s), rather than specifying, "Prozac, for depression 10-20mg, po BID for 6 months." However such content must then be documented in the Progress Note (PN).
  - However, there would then be the need for a new Medication Consent (or update to original with signatures) every time the dosage is changed by the prescriber – where the original Medication Consent could have indicated a dosage range and not need to be updated when changed to a dose within the stated range.
- b. The provider and beneficiary must sign and acknowledge the statement of attestation on the Medication Consent form.

The use of check boxes on the Medication Consent indicating the provider discussed the need for medication and potential side effects is acceptable as long as:

- The information is included in accompanying written materials provided to the beneficiary (and a copy is in the Medical Record with the Medication Consent form).

The reasons a provider prescribed a medication for a beneficiary must be documented in the beneficiary's medical record, but is not required specifically on the medication consent form.

**It is HIGHLY RECOMMENDED that all providers use the fully compliant [Medication Consent Forms](#) posted on the ACBH website. (See Appendix)**

#### B. Psychotropic Medication Consents for Wards of the Juvenile Court

Forms JV-220 through JV-223:

Although the JV court forms are required for Wards of the Juvenile Court--they do not include all of the required components for informed consent to medication(s) and therefore may not substitute for the required Medication Consents.

## **CLIENT PLANS** (DMHcontract2) (CCR12)

Definition: Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.) are plans that outline the client goals and mental health objectives of treatment, based upon the diagnoses, areas of functioning, and Medical Necessity. Selected services address identified mental health needs consistent with the diagnosis/diagnoses that are the focus of mental health treatment. MH objectives on the Client Plan must be measurable and/or observable, with the identified duration of services. The client plan must include documentation of the client's participation in the development of an agreement with the client plan (as well as document the client was offered a copy of the Client Plan). (CCR05) (BHCSQA09)

### **County owned and operated programs are required to use the Client Plan template in the EHR-Clinician's Gateway.**

Per ACBH requirements, Master Contract Organizational providers (MCO's, aka CBO's) may develop their own Client Plan templates as long as the ACBH minimum required content areas are addressed in the document.

#### **1. Services which require an Approved Client Plan**

State standards require SMHS to be provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to State requirements.

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

- Planned Mental health services: Individual, Group, and Family Psychotherapy; Individual and Group Rehabilitation; Collateral; and Medication Services. (Unplanned Services that are not required on the Client Plan include: Assessment, Client Plan Development, Case Management-Linkage and Referral only, and Urgent Medication Services.);
- Intensive Home-Based Services (IHBS);
- Intensive Care Coordination (ICC) (except those services for linkage and referral purposes only);
- Targeted Case Management (TCM): Monitoring and follow up activities to ensure the client's Plan is being implemented and that it adequately addresses the client's individual needs. [Linkage TCM and ICC Case Brokerage services may continue to be provided (before the Plan is in place) until the client has successfully engaged with the desired community resource.];
- Therapeutic Foster Care;
- Therapeutic Behavioral Services (TBS);
- Day Treatment Intensive;
- Day Rehabilitation;
- Adult Residential treatment services;
- Crisis Residential treatment services;
- Psychiatric Health Facilities; and

- Psychiatric Inpatient Services.

## 2. Provision of Services prior to Client Plan Approval

Prior to the client plan being approved, the following Unplanned SMHS and service activities are reimbursable:

- Assessment;
- Plan Development;
- Crisis Intervention;
- Crisis Stabilization;
- Medication Support Services (for assessment, evaluation, or plan development; or if there is an URGENT need, which must be documented); and
- Targeted Case Management and 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 educational services).

Exceptions to the provision of such Unplanned Services when a Client Plan is not in place include: Day Treatment Intensive, Day Rehabilitation, and Adult Residential & Crisis Residential.

## 3. Timeliness and Frequency of Client Plans

### Initial Client Plan

- Client Treatment Plans must be completed and signed within 60 days (or earlier) of the initial assessment appointment (see MH Contract for time-limited programs).
- If the case is closed before 60 business days, a completed Plan is not required (and planned services may not have been provided)
- The Initial Client Plan may be completed before the deadline. (BHCSQA09)
- Modalities which require an earlier Client Plan Due Date (with documentation of Medical Necessity as described below through Interim or full MH Assessment as indicated below) are listed below— as the service claimed is by the day. The following services require a completed Client Plan by the date indicated below:
  - Day Treatment Intensive: first billed day, signed (or co-signed) by LPHA and client (or reason client refused), Interim or Full MH Assessment & Client Plan;
  - Day Rehabilitation: first billed day, signed (or co-signed) by LPHA and client (or reason client refused), Interim or Full MH Assessment & Client Plan;
  - Adult Residential Treatment Services: 72 hours (actual count), signed (or co-signed) by LPHA and client (or reason client refused), Interim or Full MH Assessment & Client Plan;
  - Crisis Residential Treatment Services: 72 hours (actual count), signed (or co-signed) by LPHA and client (or reason client refused), Interim or Full MH

- Assessment & Client Plan;
    - Psychiatric Health Facility Services: 72 hours (actual count), signed (or co-signed) by LPHA and client (or reason client refused), Full MH Assessment and Client Plan; and
    - Psychiatric Inpatient Services: 72 hours (excluding Saturday and Sunday), signed by MD and client (or reason client refused). Full MH Assessment and Client Plan.
- Development of a Client Plan requires (and must be documented in the full Initial Assessment or Interim Assessment) that the client meets medical necessity (also see Medical Necessity Section) including:
  - A current Included Diagnosis,
  - Current specific signs and symptoms of the diagnosis that meet DSM criteria,
  - M.S.E.,
  - Functional impairments as a result of that diagnosis,
  - Level of impairment, and
  - Client's ability to benefit from treatment.
- **If unable to fully address each component of a Client Plan** within the specified timeframe, the Plan may be finalized by the deadline date and indicate when the missing information will be added. See above Initial Assessment section for clinical justification of extending the Initial Plan due date (when applicable.)
- In addition, it is required that charts undergo a CQRT review and authorization when the complete full MH Assessment and Client Plan are initially due, and annually thereafter. This practice will ensure that the Assessment and the Treatment Plan have been thoroughly completed with all signatures, on time. (See Appendix for all of the various CQRT Forms). As well, when Client Plans require a change in services (modalities) a new Authorization Form is required. See [CQRT and Authorization Manual, Policy & Procedure](#) in [Appendix](#).

### Annual Update to the Client Plan

- Treatment Plans are required on an annual basis. The cycle must be kept in sync with the Episode Opening Date (EOD). The Annual Client Plan is written during the calendar month prior to the Episode Opening Month (EOM) and due by the first of the EOM. If the case is closed before that month, a completed Plan is not required. (DMHcontract1) (BHCSQA14)
- If the case is closed before the 12-months have ended, an updated Client Plan is not required, unless clinically indicated.
- If unable to fully address each component of a Client Plan within the specified timeframe, the Plan may be finalized by the deadline date and indicate when the missing information will be added. (BHCSQA09) In addition, it is required that all charts undergo a CQRT review and authorization initially, annually, and upon change in SMHS services (modalities) using the required documents. See [CQRT](#) and

Authorization Manual, Policy & Procedure in Appendix. This practice will ensure that the Assessment and the Treatment Plan have been thoroughly completed with all signatures, on time—thereby reducing the provider’s recoupment in an audit.

#### 4. Updating Client Plans in Other Circumstances

Providers MUST be attentive to the need to update the Client Plan throughout the year when there is a “significant change” in a client’s status. DHCS (and QA) will disallow claims if the Client Plan has not been updated to reflect new client goals and mental health objectives when clinically indicated (or a PN explaining what changes were considered and why they were not needed).

In addition to the required the annual update, the Client Plan must be revised/updated in the following circumstances (and requires CQRT authorization):

- Addition of new Service Modalities; or change in frequency, or duration, of existing Modalities;
- Change in plan Client Goals and/or Mental Health Objectives. For example, when a client has met all of the goal(s) and/or objective(s), an updated Client Plan is required, with new goals and objectives; and
- Whenever there is a change in the client's circumstance, including, but not limited to:
  - New thoughts or behaviors of self-harm or dangerousness to others (new ideation alone requires a Plan Update, written Comprehensive Risk Assessment, and development of a formalized written Safety Plan created in collaboration with the client);
  - A beneficiary who has never been suicidal makes a suicide attempt;
  - A beneficiary who regularly (whatever frequency or intensity is normal for them) participates in client plan services suddenly stops coming to appointments. This is a clinical “red flag” that the client is potentially at high risk, including for harm to self or others;
  - A psychiatric inpatient hospitalization; and
  - Major life events that might lead to a change in the beneficiary's condition including, but not limited to:
    - job loss,
    - birth of a child,
    - death of a family member or significant other,
    - change in relationship status (such as divorce), and
    - change in residence/living situation.

Providers are encouraged to routinely utilize the [SMHS Chart Audit Tool](#) (See [Appendix](#)) to ensure that all documentation components are completed in a timely and thorough manner. (Also, See [ACBH/DHCS Reasons for Recoupment](#) in Appendix.)

In addition, it is required that charts undergo a CQRT review and authorization at 60 days (or ideally sooner upon completion of the Plan) after the EOD, and annually, and

whenever there is a change in services (with Client Plan revision) using the various CQRT Forms (See Appendix). This practice will ensure that the Assessment and the Treatment Plan have been thoroughly completed with all signatures, on time.

## 5. Gap in Client Plans

A "gap" between client plans results when a client plan has expired and there is an amount of time that passes before the updated client plan is in effect. When there is a gap between client plans, those unplanned services that are allowed without a Client Plan, can be provided and are reimbursable. However, services provided in the "gap" that are planned services that cannot be provided prior to a client plan being in effect are not reimbursable and will be disallowed (unplanned services may be provided)

For TCM and ICC (Case Management Linkage Only), and Medication Support Services (Urgent only) provided prior to a client plan being in place, the progress notes must clearly reflect that the service activity provided was a service that is reimbursable prior to an approved client plan being in place. (Exceptions to these Unplanned Services being claimable when a Client Plan is past due are for: Day Treatment Intensive, Day Rehabilitation, Crisis Residential & Adult Residential services.)

## 6. Minimum Required Elements for Client Plans

The following elements must be fully addressed in the Initial and Annual Client Plans, as appropriate, as part of the clinical record. Annual Client Plans must provide updated information, as applicable, for each element. A copy of the Client Plan must be offered to the client. See [Client Plan Templates](#) in [Appendix](#).

Client Plans contain at least the following elements:

- Client name and ID number (usually InSyst);
- Client Goals (client goals should be meaningful and stated in their own words, when possible. Goals can also include a long-term mental health goal that links a client's non-mental health goal to medically necessary mental health services.); (DMHcontract1) (BHCSQA09)
- Mental health objectives optimally are specific, measurable (or observable), attainable, reasonable, and time bound (SMART), and are linked to the Assessment's clinical analysis and diagnosis (e.g. must be related to mental health barriers to reaching client's goals). Projected time frames for attainment of each mental health objective must be indicated.; (DMHcontract1) (BHCSQA09)
- Service Modalities (required for all providers) & Detailed Interventions (recommended but not required): Their focus must be consistent with the mental health objectives and must meet the medical necessity requirement that the proposed intervention(s) will have a positive impact on the identified impairments. (DMHcontract1) (BHCSQA09) CA DHCS requires that the following be listed in the Client Plan along with the proposed frequency and duration:
  - Collateral (includes Collateral, Collateral-Caregiver, Collateral-Family Counseling, & Collateral-Health Care Provider),
  - Brokerage/Case Management (Follow-up and monitoring services are Planned Services),
  - Individual Rehabilitation,

- Group Rehabilitation,
- Individual Psychotherapy,
- Group Psychotherapy,
- Family Psychotherapy WITH client present (this code may only be claimed when client is present. Code 413 which was previously Family Psychotherapy without client present is now changed to Collateral—Family Counseling),
- Multi-Family Group Psychotherapy WITH client present (without client present may only be claimed as Collateral Family Group),
- Collateral Family Group (with or without client present),
- TBS (Therapeutic Behavioral Services),
- ICC (Intensive Care Coordination),
- IHBS (Intensive Home Based Services),
- DR (Day Rehabilitation),
- DTI (Day Treatment Intensive),
- Crisis Residential,
- Adult Residential,
- Crisis Stabilization, and
- Medication Management (non-urgent);
- Requirements for Service Modalities:
  - The frequency and duration of the intervention/modality is required., and
  - Use of terms such as "as needed" and "ad hoc" or "PRN" alone do not meet the requirement that a client plan contain a proposed frequency for interventions.
  - The proposed frequency for delivery of an intervention must be stated specifically (e.g., daily, weekly, etc.), or as a frequency range (e.g., 1-4 x's monthly). OR one may indicate a specific time frame “AND as needed” (e.g. monthly AND as needed):
    - Duration must also be documented in the client plan and refers to the total expected timespan of the service (e.g., the beneficiary will be provided with two individual therapy sessions per week for 6 months.)
    - Planned mental health services must all be indicate;, and
  - Detailed Clinician Interventions for each Service Modality (are recommended but not required), which are the provider’s proposed actions during services to support the client’s progress toward mental health objectives (e.g., “Offer stress reduction techniques to reduce anxiety” or “Support client to express unresolved grief to reduce depression”). (DMHcontract1) (BHCSQA09) At a minimum, it is best to describe the approach to the intervention modality for a detailed intervention. (e.g. For Individual Psychotherapy: “Cognitive Behavioral Therapy”, or for Individual Rehabilitation: “Social Skills Training”).
- Tentative discharge plan (termination/transition plan). It is the policy of ACBH that

discharge planning begin upon admission to any of our programs. Tentative service discharge date, termination, or plan (indicating readiness signs), as applicable must be noted in the record;

- “Complete Signature” (see also “Clinical Documentation Standards” section, “Signature Requirements”) or the electronic equivalent by at least one of the following: <sup>(CCR13)</sup>
  - Person providing the service (completing the Plan with the Client),
  - It is Best Practice that any current medical provider (for the client) within the same agency reviews and signs the Client Plan indicating their agreement, and
  - If the above person providing the service(s) is not licensed, registered, or waived, a complete co-signature is required by a Licensed LPHA.
- A Client Plan effective date is the date it is signed by the staff person creating it OR the date of that staff person’s required Licensed LPHA co-signature, whichever is later.
  - Note, this does not change the timeframe for the required client/representative Plan signature (or reason why not is documented) AND always the following:
    - Client/representative’s participation in the creation of the Plan,
    - Client/representative’s agreement to the Plan, and
    - Client/representative was offered a copy of the Plan;
- Client signature (If the client is unable to sign the Client Plan, an entry in the Progress Note will describe why the client’s signature could not be obtained)
  - **Evidence of the client’s degree of participation and agreement** with the Client Plan must be addressed in the following ways: <sup>(CCR14) (BHCSQA09)</sup>
    - The client’s (or representative’s) signature on the Client Plan is required when:
      - The client is expected to be in treatment longer than 60 days, or
      - The client is receiving MORE than one SMHS service modality other than Plan Development, MH Assessment, urgent Medication Services, Crisis Services, or TCM/ICC linkage and referral to community supports.
      - This is only likely to occur when a provider is only claiming for Medication Services OR TBS Services.
      - Note, even if one of these exceptions is met--it always highly recommended that the client sign the Client Plan. Note, additional requirements for documentation (in the Client Plan and or PN) if client does not sign the Plan:
        - The client’s participation in the creation of the Client Plan, the client’s agreement (or disagreement with certain sections) to the Client Plan, and that the client was offered a copy of the Client Plan (indicate dates for all).

- Alternatively, the provider could attest on the Client Plan that all three requirements were met.
- Note: Collateral is considered a second service modality and would require the client's signature on the Client Plan.
- If the client (or legal representative) is unavailable or refuses to sign the Client Plan, the Client Plan shall include a written explanation of the refusal or unavailability AND the following must be documented in the dated Progress Note for the service:
  - The client's participation in the creation of the Client Plan, the client's agreement (or disagreement with certain sections) to the Client Plan, and that the client was offered a copy of the Client Plan (with dates).
  - Alternatively, the provider could attest on the Client Plan that all three requirements were met.
  - In either case, it is required to include evidence in Progress Notes of follow-up efforts (as clinically appropriate) to obtain the signature. Failure to do so may result in audit disallowances.
- If the provider believes that including the client in treatment planning would be clinically contraindicated, the provider's dated/initialed explanation should be included in the Client Plan or in a specific Progress Note that explains why, and the reason must be supported by the clinical record documentation. This is highly usual and discouraged as the Client Plan language should be such that it is strength based and one the client can endorse.
  - The client's signature is not required to be dated on the Client Plan. However, it is best practice to do so. The Provider may add the date the client signed, initial it, and indicate the reason they added the date for the client in the Progress Note.
- ***It must be explicitly indicated that the client collaborated in the creation of the Plan, agreed to the Plan and that A copy of the Client Plan*** was be offered to the client (or legal representative) **AND** a statement whereby the client acknowledges these, must be on the Plan above the client's signature or within the associated Progress Note (with dates for each activity indicated).
- Date signed by staff and client;
- Coordination of care: If applicable, it is "best practice" to include a Collateral Service modality with detailed intervention in the Client Plan regarding coordination of a client's care with other identified providers. May describe in the "Detailed Interventions" section for the Collateral Modality. For minors also receiving Therapeutic Behavioral Services, the Client Plan must indicate coordination of services with the TBS provider.
- When case management is claimed, documentation must include the impairments of the client's included Medi-Cal diagnosis that are preventing them from accessing and utilizing services on their own. Alternatively for children, it must be indicated that without the provision of case management services the client's symptoms will

worsen. As well, it must be documented that successful case management services will result in a decrease in the client's symptomatology.

## PROGRESS NOTES

Definition: Progress Notes are the evidence of a provider's services to or on behalf of a client and relate to the client's progress in treatment. Progress Notes describe how services provided addressed the: reduction of the impairment(s), restoration of functioning, and/or prevention of significant deterioration in an important area of life functioning as outlined in the client plan. Progress Notes must clearly link the intervention to the identified functional impairment(s), which are a result of the client's identified mental health diagnosis. (BHCSQA09)

In order to submit a service for reimbursement:

- There must be a complete, signed, and filed Progress Note for that service.
- Progress Notes must address the client's progress toward the mental health objectives as outlined in the Client Plan (versus, for example, a Progress Note that focuses on the mental health needs of a depressed mother in a family session, without addressing how her depression impacts the client/child's mental health needs). (CCR23)
- Progress Notes relate to the client's progress in treatment and include only the information required by the MHP (described later in this Progress Note section). Progress Notes become part of the clinical record, which may be requested by the client at any time.

*Progress Notes vs. Psychotherapy/Process Notes* (CFR3)

Alameda County ACBH expects that all providers will understand the content difference between HIPAA defined Progress Notes and Psychotherapy Notes (also known as Process Notes) and the differences in privacy protection. If a provider chooses to write Psychotherapy Notes, they should maintain them in a separate HIPPA compliant file to protect the privacy of those notes.

### 1. Timeliness of Progress Notes

It is best practice to write the Progress Notes on the same/next day of the date of service. Progress Notes must be entered in to the clinical record within five (5) business days of the date of service (DOS) with all required signatures or they will be considered a "late note". Approval by the supervisor and clinician finalization of the Progress Note must be completed within five (5) business days.

If an entry is late, the beginning of the Progress Note must clearly identify the note as a late entry for the DOS with "Late Entry for Month/day/year" at the beginning of the Progress Note.

**All Signatures must include the date the note was written whether the note was written on same date of service or on a later date.** The note must be filed chronologically in the clinical record per the date it was written, not per the date of service.

Exceptions:

- The ACBH After-Hours Program's progress notes must be completed, finalized

and emailed to the supervisor and to the consumer's primary case manager the next business day.

## 2. ACBH Frequency of Progress Note Documentation

The frequency of documentation depends on the type of service, as indicated below:

- Every contact/service:
  - Mental Health Services
  - Medication Support Services
  - Crisis Intervention Services
  - Case Management/Brokerage
  - Intensive Care Coordination (ICC)
  - Intensive Home-Based Services (IHBS)
  - Therapeutic Behavioral Services (TBS)
- Daily:
  - Crisis Residential
  - Crisis Stabilization (one per 23/hour period)
  - Day Treatment Intensive
  - Therapeutic Foster Care
- Weekly (summaries):
  - Day Treatment Intensive (clinical summaries required in addition to daily notes).
  - Day Rehabilitation
  - Adult Residential

## 3. Minimum Required Elements for Progress Note Contents

Progress notes are documentation of services provided to or on behalf of clients. ACBH standards and Medi-Cal regulations require that a Progress Note be written for each billed service. Progress Notes include all direct services to the client and/or services delivered to other persons to support the client in meeting goals and objectives.

NOTE: Not all providers are contracted to provide all of the services described in this section. Contract providers are only reimbursed for services outlined in their annual service contracts.

Progress Notes must clearly relate to the mental health objectives as established in the Client Plan (versus, for example, a Progress Note that focuses on managing psychotic symptoms when the Client Plan only addresses depression is at risk of recoupment)

Progress Notes document at least the following:

- Date of service delivery <sup>(DMHcontract1)</sup>
- Service modality-Procedure Code (InSyst and/or CPT Code, or Exact Procedure Description as listed on the [ACBH Procedure Code List](#)—see Appendix)

(DMHcontract1)

- Location of service (BHCSQA09)
- Contact type (Office, Phone, Field, etc.)
- A progress note must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of functioning outlined in the client plan.
- Relevant aspects of client care, including interventions applied, client's progress toward MH objectives, and relevant clinical decisions
- Interventions should be described in such a way that a reviewer reading the note would be able to determine whether the interventions were clinically appropriate to the impairments and whether there was a reasonable likelihood that the interventions would reduce those impairments, restore functioning, prevent deterioration, or allow developmental progress as appropriate.
- Client's responses on that date of service to the interventions and the location of the interventions.
- Documentation of ongoing medical necessity.
- Documentation of referrals to community resources and other agencies, when appropriate.
- Follow-up services or discharge summary.
- Signature of staff delivering services, and co-signatures as required; and including the person's Scope of Practice designation as indicated on pg. 2 of the ACBH [Scope of Practice](#) document (see Appendix). (If the scope of practice is written in below the staff signature that is sufficient.)
- Duration of service
  - Note: Time spent providing a billable service varies per provider type, as below. (CCR26)
    - Enter claims only by the minute. Add the length of service time to documentation time and indicate total time.
    - Include time spent travelling to/from a location ONLY IF IT is a component of a reimbursable service activity. The purpose of travel time is for the staff to provide specialty mental health services in the field when indicated. This time is only claimable is allowed by provider contract.
    - If travelling from home, the time from the staff's home to/from the field location is allowed to be claimed as travel time once their commute time is subtracted. (e.g. Staff's normal commute time is 15" from home to work site. Instead of going first to the work site and then to the field to see the client, they go directly to see the client in the field. The time from home to the field is 30"; the 15" commute time is subtracted, and only 15" minutes is claimed as travel time. This must be explicitly documented in the Progress Note).

- A “field location” for a Provider Entity does NOT include any sites that are Medi-Cal certified that are the umbrella of the same Agency/Corporation Tax ID#.
  - That is, travel time to another office or clinic is not reimbursable. Office or Clinic is defined as a Medi-Cal Certified Site for the same Tax ID Identity for which the staff person is employed or contracted.
    - For example, staff works at Clinic #1 but is scheduled to work at Clinic #2 which is further away. Time from home to Clinic #2 or time from Clinic #1 to Clinic #2 or time to pick up a county car to get to Clinic #2 is not reimbursable and is recouped.<sup>(DHCS2)</sup>
- All ACBH Owned and Operated programs are under the same Tax ID #, and as such travel time cannot be claimed between sites.
- Exception: Providers of full-day, half-day or hourly services only claim for those portions of time (e.g., day treatment and crisis stabilization). These contracts do not provide for reimbursement of documentation or travel time.
- Always indicate face-to-face time and total time on the Progress Note. It is strongly recommended to also separate out travel (claim only if allowed) and documentation time.

The documentation of the progress note must support the type of service claimed.

If the documentation only justifies a lower level of payment then it is recouped. For example, the claim is for individual therapy and the documentation indicates that targeted case management services were also provided, then it should be recouped (Case Management is paid at a lower rate than other SMHS services.)

- In general: ACBH recommends that providers follow the following to meet the requirements listed above: When a service includes client contact, minimum requirements include descriptions of the following, as applicable (such as the B.I.R.P. format): <sup>(BHCSQA09) (DMHcontract1)</sup>
- Purpose/Presenting Problem (P) / Behavior (B):
  - Reason for that day’s contact.
  - That day’s assessment of client’s current clinical or behavioral presentation including current symptoms and/or impairments.
  - That day’s relevant history.
  - That day’s MH Objective that is being addressed.
    - Ideally all PN’s *specifically* reference the index #, name or actual description of objective that is being addressed.
- Intervention (I):
  - Specific mental health/clinical interventions by provider on that date of service, per type of service and scope of practice.
- Response (R):
  - Client’s response to interventions on that date of service.

- That day's relevant unresolved issues from previous contacts.
- Plan (P):
  - Plans, next steps, and/or clinical decisions. If little or no progress toward goals/objectives is being made, describe why. May include date of next planned contact and/or next clinician action, referrals made, mental health activities between sessions (aka "homework"), planned follow-up with collaterals, etc. Address any issues of risk. This section is often neglected. Do not simply always indicate the next planned contacts date.

When a service does not include client contact (e.g. collateral or case management), minimum requirements are description of:

- Problem (P):
  - Purpose, reason or need for that day's service
- Intervention (I):
  - Specific interventions that day by provider, per type of service and scope of practice and the reason to support the intervention.
- Response (R):
  - Response from contacts that day.
  - That day's relevant unresolved issues from previous contacts, if applicable.
  - Address any current issues of risk.
- Plan (P): Future steps regarding or following this intervention.
  - Plans, next steps, and/or clinical decisions. Include date of next planned contact, provider actions and referrals made, if applicable.

NOTE: Progress notes documenting the use of evidence-based practices such as motivational interviewing, Trauma-Focused Cognitive Behavior Therapy (TF-CBT) should describe how the technique used during the intervention addressed the reduction in impairments, restoration of functioning, the appropriate developmental progress, and/or preventing significant deterioration in an important area of life functioning as outlined in the client plan, and the beneficiary's response to the intervention.

Only Abbreviations approved by ACBH may be used to write the Progress Notes. See Appendix for a current list of ACBH [Approved Acronyms/Abbreviations](#).

#### 4. Special Situations: Progress Note Documentation Requirements (BHCSQA09)

Medicare Billable Services: Progress notes must contain the minimum requirements above, as well as the following in order to be potentially billable to Medicare:

- InSyst Code (3 digits) AND Medicare CPT Code (5 digits) of the service provided.
- Face-to-Face Time and Total time to provide the service.
- ICD-10 Diagnosis.

- Exam findings & Prior test results, if applicable.
- Patient's progress: Response to treatment and changes in treatment, patient's level of compliance, revision of diagnosis.
- Plan of care: Treatments, medication, patient/family education, follow up instructions and discharge plan.
- E/M Codes have distinct chart documentation requirements which must be met for Medicare claiming—see AMA CPT Manual.
- This is not an exhaustive list and all providers who claim to Medicare are responsible for meeting Medicare Clinical Documentation standards.

Group Services: A note must be written for each client participating or represented in a therapy, rehabilitation, or collateral group that is claimed to ACBH. These notes must include the minimum PN requirements above, as well as: <sup>(CCR25)</sup>

- Summary of the group's behavioral health goals/purpose.
- Primary focus on the client's group interaction & involvement, as relevant to their Client Plan.
- The total number of clients served (regardless of insurance plan/status).
- Service time broken down by:
  - The client's face-to-face time in group (only the one client who you are charting to)
  - The time it takes to write progress notes for all Medi-Cal clients served
  - Total Time
- If more than one facilitator, the justification for two or more staff and the time broken down as described above for both staff.
- Unique interventions provided by all staff present.
- If the PN is co-staffed (one note written rather than each staff person writing a PN for each client) only one provider signature is required. NOTE, WHEN SUBMITTING THE CLAIM TO INSYST, A SEPARATE CLAIM ENTRY MAY SOON BE REQUIRED FOR EACH PROVIDER. WATCH FOR A MEMO FROM PROVIDER RELATIONS REGARDING CO-STAFF CLAIMING IN INSYST. See [Provider Memo](#) dated July 3, 2018.

Crisis Services: Crisis services may be necessary when a client is in a mental health crisis requiring more intensive services to prevent the necessity of a higher level of care. That is, without intervention, the client is at imminent risk of hospitalization due to danger to self, danger to others or grave disability as a result of their mental illness. Providers must document the need for such services in the clinical record. These services may be Crisis Therapy or Crisis Stabilization services as described below:

- Outpatient Providers may claim for Crisis Therapy (aka crisis management) services.
- Crisis Stabilization Programs (aka Psychiatric Emergency Services) are the only providers who may utilize "Crisis Stabilization" (which is different than Crisis

Therapy) services.

Progress Notes for crisis services must include the minimum requirements already described, as well as:

- The identified crisis must be the client's crisis, not a significant support person's crisis. (CCR24)
- The urgency and immediacy of the situation must be clearly documented and describe each of the following medical necessity requirements (CCR06) (CCR10) (CCR15)
  - How the crisis is related to a mental health condition
  - How the client is imminently or currently a danger to self or to others or is gravely disabled
  - Why the client either requires psychiatric inpatient hospitalization or psychiatric health facility services or that without timely intervention, why the client is highly likely to develop an immediate emergency psychiatric condition.
- Interventions delivered to decrease, eliminate, alleviate risk, reduce trauma, and/or ameliorate the crisis.
- The aftercare safety plan.
- Related collateral and community contacts to support follow-up services. (CCR06) (CCR10) (CCR15)

Documenting Missed Appointments: It is not permissible to submit a claim or charge clients for missed appointments; however, the missed appointment should be noted in the clinical record. ACBH suggests that providers follow up in a timely manner with clients when appointments are missed and document the findings. If a client is absent and not seen at their usual frequency it is absolutely required to provide outreach to re-engage the client and to consider modification of the Client Plan based on the current clinical presentation. (DMH05) (BHCSQA09)

Documenting Lockout Situations (See Appendix for [SMHS Lock-out Grid](#)): When a mental health service is provided to a client in a lockout situation (when Medi-Cal is suspended or when a client is in a facility that provides "bundled" mental health services), a Progress Note for that service should still be written and noted to be "non-billable" so that the clinical record documents all services provided. (CCR22) (CCR28) (DMH01)

Note: If a minor client is residing in Juvenile Hall, services are not billable to Medi-Cal unless the client has been adjudicated (client is only awaiting placement in a Short-Term Residential Therapeutic Programs, STRTP, or other setting). Due to risk of disallowance, evidence of a placement order must be obtained and filed in the clinical record prior to providing services. A copy of the court ordered placement, or another document indicating the date of adjudication, will serve as proof. If that proof is not available prior to providing necessary services, the clinician may use a Progress Note to document a client's adjudication status as reported by a reliable source that is identified in the Note. "Best practice" is to make ongoing efforts to obtain paper evidence of adjudication. (BHCSQA09)

Documenting the Creation of Clinical Documents: When claiming for the time spent writing clinical (treatment) documents a Progress Note must be written to substantiate

the claim. Examples of such documents are: Assessment, Client Plan, psychological testing report, comprehensive risk assessment, and safety plans, CANS/ANSA, discharge summary, etc. A copy of the dated clinical document must be filed in the record as evidence of the activity. Progress Notes for these claimed activities must briefly describe the purpose/mental health relevance of creating the clinical document, the time it took to complete, and reference where the copy is located in the clinical record.

If the document was written in one day it may simply indicate what was completed and reference it. "For example, MH Assessment completed--see document dated dd/mm/year." However, if the document was completed over multiple dates--each PN must document which section was completed by date (or alternatively list the data in the PN). "For example, completed MH Assessment--Psychosocial Section." If the data is not written into the document template, it may be entered into the PN and compiled into the document at a later date.

## **DISCHARGE I TERMINATION I TRANSITION DOCUMENTATION**

(DMHcontract2)

Definition: Discharge documentation describes the termination and/or transition of services. It provides closure for a service episode and referrals, as appropriate. ACBH accepts two (2) types of discharge documentation - one (1) of the following must be completed for each client: (BHCSQA09)

- Discharge Note: A brief Administrative Note to indicate that the case is closed. (This activity is considered administrative and is not billable to Medi-Cal.)
- Discharge Summary: A document that is clinically necessary in order to provide continuity of care for the next service providers. Or, a Discharge Summary which is reviewed with the client for treatment purposes. ACBH considers this activity to be a billable Plan Development (PD) service, if written by a person qualified to provide PD services. (BHCSQA09)

### **Timeliness of Discharge Summary and Discharge Note**

Cases/episodes must be closed within 90 days (3 months) after the client's last service, unless the rationale for maintaining an open case is written in the clinical record. A quarterly written rationale must be provided if the case will be kept open during continued non-contact. (BHCSQA09)

Discharge documentation must be entered into the clinical record within one (1) working day (and is a late entry after five business days) of the discharge decision, but prior to closing the episode, and must be clearly labeled as either "Discharge Summary" or "Discharge Note". (BHCSQA09)

### **Minimum Required Elements**

Discharge Note: A Progress Note that includes brief documentation of the following: (DMHcontract1) (BHCSQA09)

- Reason for discharge/transfer.
- Date of discharge/transfer.
- Referrals made, if applicable.

- Follow-up care plan.

(This is considered an administrative activity and is not billable to Medi-Cal, unless it is part of a final billable service with the client present which is then treated as a Discharge Summary as below.)

Discharge Summary: A document that must meet the requirements of a Discharge Note plus a summary of the following: <sup>(BHCSQA09)</sup>

- Treatment provided.
- Overall efficacy of interventions (including medications, their side effects/sensitivities and dosage schedules).
- Progress made toward the mental health goals/objectives.
- Clinical decisions/interventions:
  - Treatment planning recommendations for future services relevant to the final Client Plan; and
  - Referral(s) for aftercare services/community support services.

The MHP considers this a billable Plan Development service when clinically necessary for continuity of care (being forwarded to a referral), or when it is reviewed with the client as a treatment intervention. For example, the client is moving out of the area and the Discharge Summary is being sent to their new provider. Or, if a new provider is not yet identified, the Discharge Summary is provided to the client/guardian for delivering to the new provider when secured.

## OUTCOME ASSESSMENT

Definition: The Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) are standardized tools used to quantify document outcomes levels of functioning in common life domains for child and adult clients.

### 1. Timeliness of CANS/ANSA

The CANS/ANSA is completed at the time of admission, every six months thereafter and at closing. Additionally, it is conducted at the time of each Client Plan re-write. See Provider Website for additional requirements <http://www.ACBH.org/providers/CANS/cans.htm> .

### 2. Administration of CANS/ANSA

Administration of the CANS/ANSA may only be done by Licensed, Waivered or Registered LPHA's; RN's; or MH Trainees (Trainees required Licensed LPHA co-signature) who are CANS/ANSA certified. The appropriate CANS/ANSA version must be used by client age group.

Certain programs may be excluded from the CANS/ANSA. Consult contract AND ACBH [QA TA contact](#). See Appendix.

## THERAPEUTIC BEHAVIORAL SERVICES (TBS)

***Applies to TBS Providers Only*** <sup>(DMHcontract2) (CCR07) (BHCS2) (TBS1)</sup>

**All providers of Therapeutic Behavioral Services (TBS) must comply with:**

- The documentation standards noted as relevant to all providers in this Policy document;
- The documentation standards noted in the [TBS Documentation Manual](#) (see Appendix) published by the Department of Health Care Services (DHCS);
- The documentation standards noted in the [Therapeutic Behavioral Services Coordination of Care Manual](#) (see Appendix), DMH, July 2010, Version 1.0 **and**
- The ACBH items noted below:

In addition to the “TBS Manual” documentation standards, ACBH requires the following:

***Evidence of Adjudication for Clients in Juvenile Detention Facilities:***

Prior to providing TBS services to a client residing at Juvenile Hall but who is only there awaiting placement in a group home or other non-institutional setting (client has been adjudicated), evidence of adjudication must be obtained and filed in the clinical record. A copy of the court ordered placement or another document indicating the date of adjudication will serve as proof. If that proof is not available prior to providing billable TBS services, the clinician may use a Progress Note to document a client’s adjudicated status as reported by a reliable source that is identified in the Note. “Best practice” is to make ongoing efforts to obtain paper evidence of adjudication.

TBS assessment and plan development services only may be claimed until the interim or full assessment and client plan have been completed if the provider claims for both TBS and other SMHS. Additionally, the TBS assessment and TBS plan must be completed before TBS service interventions may be provided.

If the provider is claiming for TBS services only, then the TBS assessment and TBS plan must be completed before TBS service interventions may be provided.

1. *Initial MH Assessments: If only TBS services are provided, the TBS provider may pull in the clients primary providers MH Assessment initially and annually. There must be a copy in the TBS Medical Record.*
2. *Initial TBS Assessments: Initial Assessments for TBS are due within 60 days of the*

TBS episode opening date and must be completed and reviewed before TBS intervention services are authorized and provided.

- In addition to TBS Documentation Manual description, TBS Initial Assessments must address the following:
  - *Identifying information:* the Assessment must include: (BHCSQA09)
    - The date of initial contact and admission date;
    - The client’s name and contact information (including address/phone and emergency contact information);
    - The client’s: age, sex-assigned at birth, self-identified gender, sexual orientation, personal (aka preferred) pronoun, preferred name, ethnicity, and relationship status;
    - Information about significant others in the client’s life including guardian, conservator or other legal representatives;
    - The client’s school and/or employment information; and

- Other identifying information, as applicable.
- Communication needs are assessed for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter services, etc.). If required, indicate whether it was/will be provided, and document any linkage of the client to culture-specific and/or linguistic services in the community. <sup>(BHCSQA09)</sup>
- Providers are required to offer linguistic services and document the offer was made; if the client prefers a family member as interpreter, document that preference (see restrictions indicated earlier in this manual). Service-related correspondence with the client must be in their preferred language/format.
  - Allergies & adverse reactions/sensitivities, per client or by report, to any substances or items (especially medications), or the lack thereof, must be noted in the Assessment <sup>(DMHcontract1)</sup> and prominently noted on the front of the chart. <sup>(BHCSQA09)</sup>

### 3. TBS Client Plans

- Initial TBS Client Plans for TBS are due within 60 days of the date of the initial assessment appointment, and must be completed and reviewed before TBS intervention services are authorized and provided.
- Client Plan updates are required every 90 days, TBS Plan Development services may not be claimed if there is not a change to the Plan. Routine monthly summaries are not a M/C claimable service. (Contact the TBS Coordinator or your [QA TA Contact](#) regarding claimable and non-claimable services.)
- Interventions in the Client Plan must utilize the standard behavioral measurement known as Frequency, Intensity, and Duration (FID).

4. *Progress Notes*: Progress Notes must also utilize the standard behavioral measurement known as Frequency, Intensity, and Duration (FID).

## Unusual Occurrence and Death Reporting

ACBH tracks and reviews Unusual Occurrences and deaths of ACBH beneficiaries. The policy is designed to ensure that explanations of incidents and trends from [Unusual Occurrence and Death Reporting Forms](#) (UODR) are applied to the continuous quality improvement of all services offered by ACBH and its contractors.

Reporting will be used to identify and address areas including, but not limited to:

- Utilization patterns that suggest issues with access to services,
- Gaps within the service continuum,
- Linkage between services,
- Coordination of Care,

- Issues of concern which impact consumers, staff and the public, and
- Quality Improvement

All Unusual Occurrence and Death Reports and related materials submitted pursuant to the policy are covered by the confidential Quality Assurance (QA) process, subject to QA confidentiality, and are not subject to discovery in legal proceedings per regulation.

See Appendix for the [UODR Policy](#) and the [UODR Reporting Form](#) for provider requirements.

# Staff Qualifications for Service Delivery and Documentation (EPSDT1)

Staff qualifications for delivery of Medi-Cal Specialty Mental Health Services are dictated in general by the following standards and scope of practice as defined by California Code of Regulations Title 9, and ACBH.

Providers must ensure on an ongoing basis that all staff credentials are up-to-date and meet the criteria of the ACBH [Credentialing Policy](#) (see Appendix).

Providers must also maintain documentation of all staff persons' qualifications, and their supervision schedule (with Supervisor's name/Scope of Practice/frequency of supervision) to support their level of service provision.

The following staff qualifications are described in this section:

- Licensed Practitioners of the Healing Arts (LPHA),
- Waivered/Registered LPHAs (aka Board Registered/Waivered Interns),
- Graduate Students/Trainees,
- Mental Health Rehabilitation Specialists (MHRS), and
- Other Qualified Providers (aka Adjunct Staff).

All non-licensed LPHA's must be under the direction and supervision of a Licensed LPHA to provide and claim for SMHS services to ACBH beneficiaries.

## 1. Licensed Practitioners of the Healing Arts (LPHA)

- License/Education/Experience: A Licensed Practitioner of the Healing Arts (LPHA) possesses a valid California clinical licensure or certification in one of the following professional categories:
  - Physicians,
  - Psychologists,
  - Licensed Clinical Social Worker,
  - Licensed Marriage and Family Therapist,
  - Licensed Professional Clinical Counselor,
  - Advanced Practice Nurses (in accordance With the Board of Registered Nursing),
  - RN's, and
  - Registered Advance Practice Pharmacists (may not conduct a MSE or diagnose).
- Approved Activities - These individuals may perform the following activities within their scope of practice:

- May function as a "Head of Service" on agency application;
- May authorize and direct services as provided by ACBH;
  - Direction may include, but is not limited to, being the person directly providing the service, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans. Individuals are not required to be physically present at the service site to execute direction. The licensed professional directing service assumes ultimate responsibility for the SMHS provided is in compliance with Medi-Cal requirements.
- May conduct comprehensive assessments and provide a diagnosis without co-signature (except Pharmacists may not diagnose). [Note re. RN Staff (non-APN): In order to conduct a MH Assessment and provide a diagnosis without co-signature, RN staff must possess a Master's degree in Psychiatric or Public Health Nursing and two years of nursing experience in a mental health setting. Additional post-baccalaureate nursing experience in a mental health setting may be substituted on a year-for-year basis for the educational requirement.]
- May co-sign the work of other staff members, within their scope of practice; and
- May provide all service categories within their scope of practice.

## 2. Unlicensed Waivered/Registered LPHAs

- License/Education/Experience:
  - Unlicensed LPHAs include in-state waived psychologist; AMFT (aka RAMFT); ASWs; APCC (aka RAPCC); & waived: Psychologist, LCSW, LMFT, or LPCC who have been recruited from outside of California.
  - It is recommended that in-state psychology students NOT seek Waivered status until they have a-Doctoral Internship placement—as they operate under the same Scope of Practice as Second Year (and above) MH Student Trainees. The earliest at which in-state psychology students may apply for Waivered status is as a pre-doctoral Intern with at least 6 months completed in the internship. Individuals who have successfully completed the requirement for their PhD or PsyD must obtain a waiver.
  - Licensed individuals (psychologist, LCSW, MFT, LPCC) who have been recruited from outside of California and have been approved to sit for the appropriate CA licensing examinations must also be Waivered.
  - AMFT (aka RAMFT), ASWs, and APCC (RAPCC) Interns are individuals who have completed a Master's or Doctoral degree and are registered with the BBS in order to obtain supervised clinical hours and are acquiring clinical experience toward licensure.
  - Waivered/registered mental health professionals may only direct services under the supervision of a Licensed Mental Health Professional (LMHP) in accordance with applicable laws and regulations governing the registration or waiver.
    - Direction may include, but is not limited to, being the person directly

providing the service, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans. Individuals are not required to be physically present at the service site to execute direction. The licensed professional directing service assumes ultimate responsibility for the SMHS provided is in compliance with Medi-Cal requirements.

- Approved Activities:

These individuals may perform the following activities under the supervision of a licensed professional within their scope of practice (see supervision requirements):

- Can function as an LPHA staff for the time dictated by their respective Boards and DHCS;
- Cannot function as the Head of Service unless they meet qualifications dictated by the California Code of Regulations;
- Can authorize services as directed by ACBH;
- Can conduct a MSE and establish a diagnosis but must be co-signed by a licensed LPHA;
- Can conduct comprehensive assessments and sign them (making a diagnosis requires a Licensed LPHA co-signature);
- Can create Client Plans;
- Can supervise and co-sign the work of other staff members (MHRS and Adjunct Staff) within their scope of practice, except for other staff in their same category and graduate students performing psychotherapy;
- Can claim for all Specialty Mental Health Services, and Case Management within their scope of practice; and
- Cannot hold themselves out as independent practitioners and claim as a Fee-for-Service provider. (May be employed by a Fee-for-Service organization/agency with appropriate supervision, but may not be employed by an individual/group private practice provider.)

- Supervision Requirements:

- Supervision (and co-signature) requirements that meet their corresponding CA Licensing Board for: ASW, AMFT (aka RAMFT) and APCC (aka RAPCC) and Waivered Psychologist accruing hours for licensure and minimum of two hours of group supervision (ration no greater than 8:1) or one hour of individual supervision. Supervision must be by a licensed LPHA.
- Co-signatures continue to be required by a licensed LPHA If they have accrued their requisite number of hours for licensure and are in the process of taking their licensure exams. As well, they must maintain the same level of supervision required by the Board as an Intern to continue to work within this scope of practice with ACBH clients [at a minimum requires two hours of group supervision (ration no greater than 8:1) or one hour of individual supervision.] Supervision must be by a licensed LPHA.
- 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 their scope of practice:

- Licensed Vocational Nurses
- Licensed Psychiatric Technicians;
- Physician Assistants;
- Pharmacists; and
- Occupational Therapists.

### 3. Graduate Students/Trainees

A Graduate Trainee/Student is an individual participating in a field intern/trainee placement while enrolled in an accredited Masters in Social Work (MSW), Masters of Art (MA), Masters of Science (MS), or clinical/educational psychology doctorate degree (PsyD or PhD) program that will prepare the student for licensure within their Mental Health professional field. There is no minimum experience required for graduate students.

Some graduate students will only qualify as "Mental Health Rehabilitation Specialists," if employed by the provider and enrolled in degree programs not leading to licensure as above.

The scope of practice depends on the particular program in which the student or trainee is enrolled and the requirements for that particular program, including any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations. In accordance with the Business and Professions Code, the Board of Psychology, and the Board of Behavioral Sciences, non-licensed trainees, interns, and assistants must be under the immediate supervision of a LPHA who shall be responsible for ensuring that the extent, kind, and quality of the services performed are consistent with his or her training and experience and be responsible for his or her compliance with applicable state law.

An individual participating in a field internship/trainee placement, while enrolled in an accredited and relevant graduate program, working "under the direction" of a licensed, registered, or waived mental health professional and determined to be qualified by the MHP ACBH, may conduct the following service activities: MH assessments (excluding conducting mental status exams and diagnosis without additional credentialing—see below); development of client plans; individual and group services, Rehabilitation, TCM, IHBS, ICC, psychotherapy; write progress notes; and, claim for any service within the scope of practice of the discipline of his/her graduate program.

If students and trainees do not meet the definition of any of the other defined providers under the State Plan, they may provide services as MHRS (if appropriate education and experience) or Adjunct Staff (Other Qualified Providers) under the direction of a LMHP who is authorized to direct services.

- License/Education/Experience: A Graduate Trainee/Student is an individual participating in a field intern/trainee placement while enrolled in an accredited Masters in Social Work (MSW), Masters of Art (MA), Masters of Science (MS), or clinical/educational psychology doctorate degree (PsyD or PhD) program that will prepare the student for licensure within his/her professional field.

- Approved Activities- Graduate students may perform the following activities under the supervision of an LPHA within their scope of practice:

Graduate students may perform the following activities under the supervision of a licensed clinician within their scope of practice:

- A second year Graduate Trainee/Student (Defined as: having completed one full time year of education or equivalent in their MH Degree Program—not one part time year) with appropriate training and experience can conduct the Mental Status Exam (MSE) and establish a diagnosis (require a licensed LPHA co-signature) with:
  - A written attestation (placed in his/her personnel file) by the current Licensed Clinical Supervisor of the Trainee/Student must state that the student has sufficient education, training, and experience to diagnose independently (includes conducting a MSE) with the Licensed Supervisor’s on-going full record review, supervision, and co-signature. When a Graduate Trainee/Student, whose scope of practice does NOT include diagnosis completes the MH Assessment, they must indicate which LPHA made the current diagnosis (not historical) and on what date.
- Can conduct comprehensive Assessments and Client Plans (exceptions indicated above), but require a co-signature by a licensed LPHA;
- Can write Progress Notes but require a co-signature by a licensed LPHA;
- Can claim for individual and group psychotherapy but require oversight and co-signature of a licensed LPHA staff member; and

Note: Waivered/Registered Professional staff cannot co-sign for a graduate student’s psychotherapy progress notes, assessments or treatment plans. Those must be co-signed by a licensed LPHA.

- Supervision Requirements:
  - Supervision (and co-signature) requirements that meet both their corresponding CA Licensing Board for MH Practicum/Trainee Students and their University. Co-signatures are required by a licensed LPHA for all chart documentation. Once Board and University program supervision requirements are met, minimum supervision requirements include weekly one hour of 1:1 supervision by a Licensed, Waivered or Registered LPHA or two hours of group supervision by a Licensed, Waivered or Registered LPHA with a ratio no greater of 1:8 (supervisor to supervisees). At least one week of supervision each month must be provided by a Licensed LPHA.

#### 4. Mental Health Rehabilitation Specialists (MHRS)

A “Mental Health Rehabilitation Specialist” (MHRS) is an individual who meets one of the following requirements:

- MHRS staff must have a baccalaureate (BA/BS) degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.
- Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis. (e.g. Master’s degree with

two years MH experience).

- Up to two years of post-Associate Arts (AA degree) clinical experience may be substituted for the required educational experience, in addition to the requirement of four years' experience in a mental health setting. (e.g. Associate degree plus six years MH experience).

- Approved Activities

MHRS staff may perform the following activities:

- Can function as a "Head of Service" on agency/provider application with ACBH approval. (Note: Does not qualify as "Director of Local Mental Health Services" unless approved by DHCS);
- Can provide and collect self-report information in the areas of: mental health and medical history, substance exposure and use, identifying strengths, risks and barriers to achieving goals, and demographic information, IF the agency/clinic determines it is within their scope of ability, training, and experience. The Assessment data must be entered into a Progress Note – not the MH Assessment form;
- Can create Client Plans (although not recommended AND requires co-signature by licensed LPHA) and Progress Notes (co-signatures by licensed LPHA are highly recommended); and
- Can claim for all Mental Health Services (except Psychotherapy), Unplanned Services, and Case Management within their scope of ability.

- Supervision Requirements:

Co-signatures are highly recommended by a Licensed, Waivered or Registered LPHA for all chart documentation (and a Licensed LPHA co-signature is required on Client Plans). Minimum supervision requirements include one hour of 1:1 weekly supervision OR two hours of weekly group supervision with a ratio of no greater of 1:8 (supervisor to supervisees). One of these supervision sessions each month must be by a Licensed LPHA. The other weekly supervision supervisions may be facilitated by a staff person with sufficient education, training and experience to supervise MHRS work with the scope of practice of Licensed, Waivered, or Registered LPHA; MH Student Trainee; or a Senior MHRS.

## 5. Adjunct Mental Health & Other Staff Not Meeting Above Category Qualifications

Master Contract Providers have the prerogative and program flexibility to integrate and define other staff that can provide direct or supportive specialty mental health services, as determined by their ACBH contract. Bachelor's level staff may qualify for this designation. It should be noted that it is not a requirement that staff are paid for services provided and claimed to Medi-Cal (e.g. staff may include unpaid graduate students/trainees/interns, volunteers or advocates), as long these unpaid persons meet Medi-Cal rules and regulations regarding claiming and scope of practice.

- Approved Activities:

Adjunct mental health staff and other staff not meeting the above category

qualifications may provide services (except Psychotherapy) and follow the same clinical documentation rules as for MHRS staff (above), with evidence of on-going supervision, within the scope of the staff member's ability. ACBH strongly advises that all adjunct mental health staff documentation be co-signed by a Licensed, Waivered or Registered LPHA. (Client Plans must be co-signed by a Licensed LPHA.)

- Supervision Requirements:

Co-signatures are required by a licensed LPHA for all Client Plans. Minimum supervision requirements include one hour of 1:1 weekly supervision OR two hours of weekly group supervision with a ratio of no greater of 1:8 (supervisor to supervisees). One of these supervision sessions each month must be by a Licensed LPHA. The other weekly supervision sessions may be facilitated by a staff person with sufficient education, training and experience to supervise Adjunct Staff work with the scope of practice of Licensed, Waivered, or Registered LPHA; MH Student Trainee or a Senior MHRS or Senior Adjunct Staff.

Note: Mental Health Services, Day Rehabilitation Services, Day Treatment Intensive Services, Crisis Intervention Services, Case Management, and Adult Residential Treatment Services may be provided by any person determined by the hiring provider to be qualified to provide the service, consistent with state law and their scope of practice. The hiring provider must retain personnel materials that justify their determination.

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## Appendix

[ACBH Approved Acronyms and Abbreviations](#)

*ACBH Credentialing Forms & Guidelines- PENDING*

[ACBH Credentialing Policy](#)

[ACBH Procedure Code Table](#)

[ACBH Scope of Practice Table](#)

[ACBH Medication Consent Forms](#)

[ACBH/DHCS Reasons for Recoupment](#)

Client Plan Template ([Universal](#) and [Psychiatric](#))

[Comprehensive Risk Assessment & Safety Plan Template](#)

[CQRT & Authorization Manual, Policy & Procedure](#)

CQRT Forms ([Adult](#) and [Child](#))

MH Assessment Templates ([Short](#), [Long](#) and [Psychiatric](#))

*MH [Student](#) Trainee Attestation- PENDING*

[QA Technical Assistance Contacts](#)

[PN Template](#)

[SMHS Chart Audit Tool](#)

[SMHS Service Descriptions and Examples](#)

[SMHS Lock-Out Grid](#)

SMHS Outpatient Medi-Cal Included (Covered) Diagnoses Lists ([Numeric](#) and [Alpha](#))

[TBS Coordination of Care Manual](#)

[TBS Documentation Manual](#)