Medi-Medi Training Handouts
Updated 3/11/13

Medi-Cal & Medicare Direct Line Staff Documentation Training

March 6, 2013

ACBHCS Quality Assurance Office

Objectives

- Identify core elements of Medical Necessity and the Clinical Loop
- Demonstrate the ability to assess and document client problem areas, symptoms, strengths, and impairments in an Assessment.
- Demonstrate the ability to develop client goals and objectives which are observable, and measureable with baseline and timeframes and document these in the Client Plan.
- Document the purpose of the intervention and how it links back to the identified mental health needs of the client in the Progress Note.

2

Participants

- LPHA—Licensed
- LPHA—Registered or Waivered

- MH Graduate Students

- MHRS

- Adjunct & Other Staff
  - Consumer Workers
  - Family Partners

3

What is Medical & Service Necessity?

- Definition:
  - A term used by ACBHCS that encompasses criteria that are essential for reimbursement of services.
  - Treatment services which may be justified as reasonable, necessary and/or appropriate based on clinical standards and practice.

4

Medical & Service Necessity: The Three I's

- Criteria involves 3 main components:
  - **I**ncluded diagnosis (see Handout)
  - **I**mpairments that are a result of the symptoms of the diagnosis
  - **I**nterventions that are aimed at diminishing the diagnostic symptoms and/or impairments.

5

Included Diagnosis

- Client must have an "Included" Diagnosis from the current DSM which is the primary focus of treatment.
- Refer to list of "Included" Diagnosis (i.e., qualifying mental disorders)

6

Included Diagnosis Continued

- Having a diagnosis that is not "included" does not exclude a client from having his/her services reimbursed AS LONG AS
  - He/She also has an "included" diagnosis as the primary diagnosis, and services/interventions are directed toward the impairment resulting from an "included" diagnosis.
- The primary diagnosis will be the diagnosis associated with a claim

7

Impairments

- Also, indicates the Problem Area
- A significant impairment in an important area of life functioning (e.g., home, work, school, social, family) as a result of the client's **mental health symptoms**.

8

Helping the Client Identify Impairments—Role play

- You said you've been feeling very sad, anxious and irritable. How does this play out at home, at work, with friends?
- What do you think is making it difficult for you to…
  - Do your work?
  - Take care of things at home?
  - Get along with others?
  - Do the things/activities that you once enjoyed?

9

Identifying Impairments Role Play Continued

- How do your (depressive/anxious) symptoms impact your:

- **Social/family relationships?**
  - Decreased contact with friends
  - Loss of intimate relationships
  - Affected family relationships
- **Performance at work? school?**
  - Cause avoidance of certain jobs
  - Being late to work due to depression
  - Decreased contact with co-workers
  - Failing grades due to depressive mood / poor concentration
- **Participation in hobbies, leisure activities?**
  - Avoidance of certain leisure activities

10

Interventions

- What must an intervention do to meet medical necessity?
  - Address an identified functional impairment.
  - Significantly diminish the impairment or prevent deterioration in an important area of life functioning.

11

Interventions continued

- Interventions must always link back to an identified mental health need(s) of the client
- Interventions must clearly show how what the STAFF did will:
  - improve the client's functioning, &/or
  - diminish the client's MH symptoms

12

The Golden Thread

- Definition:
  - The “Golden Thread” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are reimbursable.
  - The sequence of documentation on which medical necessity requirements converge is:
    - The Assessment
    - The Client Plan
    - The Progress Note

13

The Golden Thread

- Medical Necessity:
  - Completion of a Mental Health Assessment which documents:
    - Sx/behaviors/impairments to determine a diagnosis
    - Strengths / needs / barriers
  - Carry Assessment info forward into the Client Care Plan which documents:
    - Objectives linked to symptoms/behaviors/impairments
    - Interventions to achieve the identified objectives
  - Carry forward into the Progress Note which documents:
    - Goal-based interventions provided to the client

14

MH Assessment

Step 1 of the Golden Thread

- What is the purpose?
  - Learn the client client's story
  - Gather a lot of information about the client in a brief period of time in order to formulate a diagnosis, develop a conceptualization, and collaboratively create a treatment plan
  - Determine if the client meets medical necessity
    - (does he/she have an "included" diagnosis and an impairment in life functioning due to his/her mental health symptoms?)

15

MH Assessment

Step 1 of the Golden Thread *continued*

- Presenting Problems (symptoms/behaviors):
  - Document the intensity, frequency, duration and onset of current symptoms/behaviors
- Impairments in Life Functioning:
  - Document the connection between impairments and their relationship to symptoms/behaviors
    - e.g., difficulty keeping a job due to his depressed mood, lack of energy, and difficulties concentrating, which are significantly interfering with his work performance.
  - Document the client's activity level both **prior to** and **at the onset** of symptoms.

16

MH Assessment

Step 1 of the Golden Thread *continued*

- Assess for Substance use and abuse:
  - Document in past and current use in record.
- If appropriate establish AOD Dx
  - Cannot be primary Dx.
  - Address in Client Plan.

17

MH Assessment

Step 1 of the Golden Thread *continued*

- Must be completed within 30 days of the Episode Opening Date (EOD) *See handout*
- Who can established a diagnosis, complete & sign an Assessment?
  - Licensed LPHA
- Who can complete and sign an Assessment but not provide a Dx?
  - Waivered LPHA, Registered LPHA
  - Graduate Students with a co-signature of a licensed LPHA
  - Must indicate in the Assessment which licensed LPHA provided the Dx and the date it was assigned
- MHRS may ONLY gather demographic & client reported information.
  - Enter information into progress note, not into the assessment

18

MH Assessment

Step 1 of the Golden Thread *continued*

- If all information for the initial assessment is gathered in one assessment contact
  - Reference initial assessment completed in the Progress Note
    - "Completed Initial Assessment (see Initial Assessment dated xx/xx/xx in clinical record)"
  - Sign/date the assessment as of the date of the assessment contact
- If information for the initial assessment is gathered in multiple assessment contacts,
  - Reference sections of the initial assessment completed in each Progress Note
  - Sign/date the assessment as of the date of the last assessment contact

19

MH Assessment

Step 1 of the Golden Thread *continued*

- If information is gathered AFTER the initial assessment has been completed, an Assessment Addendum MUST be used instead of adding to the original Assessment
  - The Assessment Addendum should be used to update/confirm information on the original Assessment

20

MH Assessment

Step 1 of the Golden Thread *continued*

- 5 Axis Diagnosis
  - Primary diagnosis in the clinical record must match the primary diagnosis in INSYST
  - Must identify a primary from either Axis I or Axis II
    - May then select a secondary from Axis I or Axis II
  - If revised, must update INSYST

21

Client Plan

Step 2 of the Golden Thread

- What is the purpose?
  - Ensures a client's care is goal directed and purposeful
  - Allows anyone involved in a client's care to see, at a glance, what a client's services are aimed at and directed toward
  - Creates a "road map" for the client, family, and mental health / medical staff
  - Lists markers of progress; "is the client getting better?"
  - Ensures Service Necessity is met

22

Client Plan

Step 2 of the Golden Thread *continued*

- Must be completed:
  - Client Plan within 60 days (actual day count)
    - Best practice suggests that a Client Care Plan be completed prior to providing treatment services
  - A 6 month Assessment/Plan Update is due before the first day of the 6th month of services from the episode opening month and annually thereafter.
  - A 12 month Assessment/Plan Update is due before the first day of the first month of the EOD, and annually thereafter.
  - Four key assessment items must be reviewed and updated every time the Client Plan is renewed or reviewed: 1) Diagnosis, 2) Risk Situations, 3) Client Strengths & Resources, 4) Special Needs.
  - See Assessment & Plan due date handout.
  - By each program providing services to the client.
  - For all non-emergent, direct services
  - One time unplanned (crisis therapy) services do not need an objective
    - For an unplanned type of service--if the type of service is NOT already associated with an objective on the Client Care Plan, staff must determine if the service will be provided again and, if so, create an objective on the Client Care Plan for that type of service AND attain new signatures.

23

Client Plan

Step 2 of the Golden Thread *continued*

- **Long-Term Goal**
  - Exactly what the client says
  - All goals are valid (does not have to be “Mental Health” statements)
  - Invaluable for client engagement and buy-in to services
  - It will be the Providers role to assist the client in tying in the short term MH objectives to his/her long term goal!

24

Client Plan

Step 2 of the Golden Thread *continued*

- **Short-Term Objectives**
  - A way to see if the CLIENT is improving
  - Measurable change in helping the client achieve his/her long-term goals
    - Can address symptoms, behaviors or impairments identified in the Assessment
  - Should match where the client is at and be meaningful to the client
    - What is he/she identifying as the problem? Why did he/she reach out for help?
  - Must be SMART (Specific, Measurable, Attainable, Realistic and Time-Bound)
  - In developing objectives, it is important to look at how they might impact and build upon strengths and supports

25

Client Plan

Step 2 of the Golden Thread *continued*

- **Interventions**
  - How will STAFF contribute to achieving the behavioral changes
  - Describe the intervention(s), and their frequency, you are planning to use with your client.
    - Modalities (e.g., Medication Management, Psychotherapy, Case Management, etc.)
    - Best Practices (e.g., CBT, DBT, Motivational Interviewing, etc.)

26

Client Plan

Step 2 of the Golden Thread *continued*

Example - Symptoms / behaviors / impairments related to the primary diagnosis (from the Assessment)

- *"For the past month, client has been experiencing depressed mood with a loss of energy, loss of interest or pleasure in almost all activities, and social withdrawal"*
- *"Depressive symptoms are significantly interfering with client's academic/work performance, and impacting his social and family relationships"*

27

Client Plan

Step 2 of the Golden Thread *continued*

Example - OBJECTIVE targeting symptoms

- **Long-Term Goal:**
  - *"I want to be able to go out do things with my family/friends, again"*
- **Objective:**
  - ***"****To increase # of social interactions from 0x to 3x per week in the next # weeks/months"*
- **<u>Clinical Interventions:</u>**
  - *"Assisting the client in re-engaging in pleasant activities and learning new ways of dealing with distress"*
  - *"Teaching and reinforcing active problem-solving skills in order to increase client's self-efficacy and improve his/her mood."*
  - *"Helping the client to identify early warning signs of relapse, reviewing skills learned during therapy, and developing a plan for managing challenges in order to help prevent the relapse of depressive symptoms."*

28

Client Plan

Step 2 of the Golden Thread *continued*

Additional Examples of Objectives

- Identified impairments can become targets of improvement, which can be measured to determine the effectiveness of interventions
  - "To increase # of minutes engaging in pleasurable activities from 0/min to 30/min per day *in the # weeks/months*"
  - "To decrease # of days arriving late to work from 4x to 0x per week *in the # weeks/months*"

29

Client Plan

Step 2 of the Golden Thread *continued*

Verb	Measure	Target Person	Client's Behavior	Baseline Measure	Goal Measure	Time Frame
To Increase	# of min's	Client	Engages in pleasurable activities (social, physical, pleasant)	From 0x/day	To 30'/day	Within 6 mos.
To Increase	# of times	Client	Uses active problem-solving Skills	From 0x/week	To 5x/week	Within 6 mos.
To Increase	# of times	Client	Uses relaxation skills	From 0/week	To 5x/week	Within 6 mos.

30

Client Plan

Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write 4 SMART objectives such as:

- Insomnia
  - Improved ability to fall asleep within 30 minutes of... going to bed from 0 times per week to 5 times per week within the next 12 months.
  - Improved ability to stay asleep at least 6 hours once having fallen asleep from 0 times per week to 5 times per week within the next 12 months.
- Decreased Appetite
  - Improved appetite as evidence by eating two or three meals per day from 1 times per week to 5 times per week within the next 12 months.
- Anergy
  - Improve energy as evidence by leaving the home for outside activities 3 or more times per week, from 1 time every two weeks, within the next 12 months.
- Poor self-care/ADL's
  - Improved ability to care for self by showering or bathing 3 – 4 times per week, from 1 time per week, within the next 12 months.

31

Client Plan

Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write 4 SMART objectives:

- Inability to maintain housing/placement
  - New:
  - New:
- Inability to (or maintain) study/work (behavior, attendance, achievement, functioning)
  - New:
  - New:
- Intrusive thoughts
  - New:
  - New:

32

Client Plan

Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write 4 SMART objectives:

- Thoughts (or actions) of... self/other harm
  - New:
  - New:
- Hallucinations (visual/auditory)
  - New:
  - New:
- Phobia/Anxiety as evidence by… (or self-report of...)
  - New:
  - New:

33

Client Plan

Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write 4 SMART objectives:

- Concentration as evidence by… (or self-report of...)
  - New:
  - New:
- Inattention as evidence by… (or self-report of...)
  - New:
  - New:
- Oppositional Behavior (provide example such as re compliance with authority)
  - New:
  - New:

34

Client Plan

Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write 4 SMART objectives:

- Anger Control as evidence by …. (or self report of...)
  - New:
  - New:
- Conduct/Anti-social Bx (shoplifting, lying, vandalism, cruelty to animals, etc.)
  - New:
  - New:
- Behavioral Regression as evidenced by…. (or caretaker report of……)
  - New:
  - New:

35

Client Plan

Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write 4 SMART objectives:

- Legal Problems
  - New:
  - New:
- Family/Relationship Problems
  - New:
  - New:
- Substance use habits as evidence by… (not primary goal)
  - New:
  - New:

36

Client Plan

Step 2 of the Golden Thread *continued*

- When adding a new OBJECTIVE to an existing Client Care Plan, have the client sign and date.
  - For all objectives, the client should always be encouraged to participate by signing. If client does not sign it, regular efforts must be attempted /documented to obtain approval with the plan.
- It is possible to combine different types of service interventions under the same objective (e.g. Medication Management and Case Brokerage).
  - However, staff must ensure that each type of service (e.g., MHS) will address the objective.

37

Progress Notes

Step 3 of the Golden Thread *continued*

- BIRP: *See Handout*
- **B**ehavior/Assessment,
- **I**ntervention by Staff,
- **R**esponse of Client to Intervention, and
- **P**lan for future services.
- What is the purpose?
  - Documents what is presently going on with the client (brief narrative)
  - Identifies what you did (i.e., what intervention was provided toward the client's objectives)
  - Identifies client's response toward the interventions and progress toward his/her objectives
  - Provides plan for continued services i.e. collaterals, coordination of care, continue with CBT techniques etc.

38

Progress Notes

Step 3 of the Golden Thread *continued*

- Ask yourself:
  - What did I do?
  - What was the purpose of what I did?
  - Why was the service provided?
  - What benefit was provided to the client?
  - Does the service/intervention match to an objective on the Client Care Plan?
- Progress Notes must:
  - Be linked/connected to an objective on the Client Care Plan
  - Be completed within one working day.
  - Be done prior to submission of a claim
  - May combine different types of services e.g., combining therapy and targeted case management in a single note (indicate service code for the predominant service)

39

Progress Notes

Step 3 of the Golden Thread *continued*

- Progress Notes are used to document a reimbursable service.
- If “YES” to the following, then you have a strong reimbursable Progress Note:
  - Is it clear that I took some action that will help my client?
  - Will the action work toward improving or maintaining my client’s mental health?
  - Did the service I provided relate directly back to the identified mental health needs / diagnosis / objectives of my client?

40

Progress Notes

Step 3 of the Golden Thread *continued*

Progress Note Staff Interventions

- All interventions must always link back to an identified mental health need(s) of the client
  - Decreasing symptoms or behaviors must always link back to the identified mental health need
  - Increasing adaptive behaviors / skill development must always link back to the identified mental health need
- The intervention documented should be about the purpose of the activity, not the activity itself.
  - When doing Problem Solving Treatment, the purpose is about skill building – which will strengthen the client's ability to exert control of his/her problems and improve his/her mood.
  - Document the stages of skill building that you're working on with your client rather than the client's specific problem that he/she is addressing to build the skill.

41

Progress Notes

Step 3 of the Golden Thread *continued*

Examples

- Engagement with Client at beginning of treatment
  - *"Engaged client to establish rapport, explain treatment rationale, clarify treatment process, and understand and address barriers to treatment to improve participation."*
- Psycho-education with Client:
  - *"Introduced Problem Solving Treatment to the client, established link between client's symptoms and depression, established the link between problems and depression, and facilitated a problem-solving orientation."*

42

Progress Notes

Step 3 of the Golden Thread *continued*

Quality of Writing

- Concise
- Clear
- Cohesive
- Reader-centered
- Written in language anyone can understand

Always keep in mind that the Clinical Record belongs to, and is about, the client!

43

Progress Notes

Step 3 of the Golden Thread *continued*

Key things to ask yourself

- What did you do? Why did you see the client? Is it reflected in the Progress Note?
- Does the Progress Note clearly relate back to an objective on the Client Care Plan?
- Did you sign, write your discipline, and date the Progress Note?
- Can the Progress Note be read by someone else (legible)?
- Did you separate out clerical, transportation, and interpretation services since they are NON-CLAIMABLE services?
- Did you turn in your Progress Note to be filed (or file it yourself) prior to turning in the claim?

44

Objective & Progress Note Exercise

- Objectives:
  - Participants will be able to understand how to link Medical Necessity, Client Plan Objective, and Interventions in a Progress Note.
  - Participants will be able to write a Progress Note which meets documentation standards.
- Smaller groups will review a vignette
  - Each group will collectively compose 2 objectives
  - Each group will collectively write a Progress Note based upon the BIRP model

45

Procedure Codes

Key things to ask yourself when choosing a Procedure Code

- Does the Procedure Code reflect what is written in the Progress Note?
- If there are no interventions documented towards the client, there should be no face-to-face time.
- Who was the service directed to/at?
  - Directed at client means there will be face-to-face time (presence of client does not assume face-to-face time)
  - Directed at inter-agency (not the same RU code) staff means collateral, assessment or plan development.

46

Procedure Codes continued

Collateral (311)

- Services provided to Significant Support person
  - Consultation and Training support person
  - Focus is in achieving goals on Client Plan
- Definition:
  - Gathering information from, or
  - Interpretation (or explanation) of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or
  - Advising them how to assist clients

47

Procedure Codes continued

323-90791– Psychiatric Diagnostic Evaluation (Initial & Reassessment)

- Evaluate current mental, emotional, or behavioral health.
  - Includes but is not limited to:
    - Mental Status
    - Clinical History
    - Relevant cultural issues
    - Diagnosis
    - Use of Testing Procedures for assessment purposes
- 565-90792 – Psychiatric Diagnostic Evaluation w/ Medical Component.
- 324-96151- Behavioral Evaluation (CFE or approved equivalent)

48

Procedure Codes continued

Plan Development (581)

- Definition: A stand alone service that includes:
  - Development of Client Plans
  - Approval of Client Plans
  - Monitoring and recording client's progress as it relates to the Client Plan
- Plan development may be done as part of a interdisciplinary inter-agency conference and/ or consultation in order to develop and/ or monitor the client's mental health treatment.
- Plan development may also be done as part of a contact with the client in order to develop and/ or monitor the client's mental health treatment.

49

REHABILITATION CAVEAT: DISTINCTION BETWEEN

REHABILITATION VS. PERSONAL CARE ACTIVITIES

Rehabilitation

- Enable client to overcome limitations due to mental disorder
- Example: Teaching client to prepare his/her meals, use utensil to eat meals

Personal Care Services

- Performing activities for the client who are unable to do for themselves
- Example: Feeding client, preparing client's meals.

50

Procedure Codes continued

Individual (381) or Group Rehab (391)

- Improving
- Maintaining
- Restoring
  - Functional skills
  - Daily living skills
  - Social skills
  - Leisure skills
  - Grooming and Personal hygiene skills
  - Obtaining support resources and obtaining medication education

51

Procedure Codes continued

Case Management/Brokerage (571)

- Help clients to access medical, educational, social, vocational, rehabilitative, or other community services that are identified in the Client Plan or Assessment.
- Services activities may include, but are not limited to:
- Communication with client & significant support person.
- Coordination of care.
- Referrals.
- Monitoring service delivery to ensure client's access to services.
- Monitoring client's progress toward making use of services.

52

Procedure Codes continued

Crisis Therapy (*formerly*, Intervention)
337-90839 (First 60 Minutes of Face **to Face Services)**
+378-90840 (For each additional 30 Minutes of Face to Face Services)

- A service lasting no more than 8 hours in a 24-hour period: Immediate response to client's acute psychiatric symptoms in order to alleviate problems which, if untreated, would present an imminent threat to the client, others, or property.
- The purpose is to stabilize the client.
- Service activities include but are not limited to one or more of the following: Crisis Intervention, Medication Support Services, Assessment, Evaluation Collateral, and Therapy. However, these activities are all documented as Crisis Intervention.

53

Procedure Codes continued

Psychotherapy

- A therapeutic intervention
- Focus primarily on symptom reduction
- Can be provided as individual, family, or group

54

Procedure Codes continued

Individual Therapy (441-90832 30'', 442-90834 45'', 443-90837 60'')

May use +491-90785 for Interactive Complexity

Group Therapy (456-90853)

May use +491-90785 for Interactive Complexity

Family Psychotherapy (449-90847 w/client present, 413-90846 w/out client present)

55

Procedure Codes continued

Interactive Complexity +491-90785

- 4 Specific communication factors during a visit that complicate delivery of the primary psychiatric procedure.
  - The need to manage maladaptive communication.
  - Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
  - Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party with initiation of discussion of the event.
  - Use of play equipment to overcome barriers to diagnostic or therapeutic interaction.

56

Procedure Codes continued

Medication Support Services

Medical Providers for Face to Face Services use E/M Codes and for Non Face to Face Services use 367.

RN/LVN/Psychiatric Technician use 369 for Face to Face and Non Face to Face.

57

Procedure Codes continued

- Medication Support Services may include, but are not limited to:
  - Evaluation of the need for medication;
  - Evaluation of clinical effectiveness and side effects;
  - Obtaining informed consent;
  - Medication Education
  - Instruction in the use, risks, and benefits of and alternatives for medication;
  - Assessment of the client
  - Collateral and Plan development related to the delivery of the service and/or
  - Prescribing, administering, dispensing and monitoring of psychiatric medications

58

Procedure Codes continued

Medication Support Services

- Contact and Site Requirements
  - Medication Support Services may be either face-to-face or by telephone with the client or with significant support person(s)
  - May be provided anywhere in the community
  - 469-90862 for Medication Management has been eliminated.

59

Procedure Codes continued

Group Services

Group Psychotherapy: 456-90853
Group Rehabilitation: 391

- Prorated Requirement:
  - When claiming for services in a group setting, time claimed must be prorated for each child/youth represented.
    - List all staff present with justification for their presence
    - List the number of clients present
    - List total time of group service, documentation time, and travel time
    - INSYST will calculate the billable time per client

60

Claims

MH Services Lockouts (see handout)

- "Lockouts" are services that cannot be reimbursed or claimed due to the potential duplication of claim ("double billing") or ineligible billing site.
- Mental Health Services Not Reimbursable:
  - On days when Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal,
  - except for the day of admission to the facility
- On days when the client resided in a setting where the client was ineligible for Medi-Cal, e.g.,
  - Institute for Mental Disease (IMD),
  - Jail or Prison
  - Juvenile hall, Unless…
    - There is evidence of post-adjudication for placement, (i.e., the court has ordered suitable placement in a group home or other setting other than a correctional setting, jail and other similar settings)

61

Claims

Non-Reimbursable Services/Activities

- No service provided: Missed appointment
- Solely transportation of an individual to or from a service
- Service provided solely payee related
- Services provided was solely clerical
  - Includes leaving or listening to voice mail.
- Socialization Group
  - which consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the clients involved
- Translation and/or interpretive services (including sign language)
- Activities or interventions whose purpose is solely to provide vocational training, academic education or recreational activity are not reimbursable.
- Completing CPS reports. Report writing is not a Mental Health intervention.

62

Vocational Setting

Reimbursable

Assisting the youth in considering how his/her supervisor's criticism affects him/her and strategies for handling the situation

Non-Reimbursable

Providing hands-on technical assistance to the youth regarding the new piece of equipment

63

Academic Setting

Reimbursable

Assisting a transitioned aged youth with arithmetic so he/she can manage the household budget which is an independent living skill (building independent functioning skills) so he/she can do it themselves.

Non-Reimbursable

Assisting the child with homework (such as quizzing, testing, monitoring, researching a topic, etc.)

64

CLINICAL RECORD DOCUMENTATION STANDARDS

This policy section defines the procedures and minimum standards for documentation of Medicare/OHC/Medi-Cal Specialty Mental Health Services at any site providing those services within Alameda County Behavioral Health Care Services and its Behavioral Health Plan's Provider Network.

Updated February 2013

Policy Title: CLINICAL RECORD DOCUMENTATION STANDARDS – MENTAL HEALTH

CONTENTS

Mental Health Policy & Documentation Standards

POLICY STATEMENT: MENTAL HEALTH

All service providers within the Alameda County Mental Health Services system shall follow the Clinical Record Documentation Standards Policy. This includes providers employed by BHCS and all contracted providers. Service providers may develop additional policies in order to adapt these standards to their specific needs. If variance from this policy is needed, approval must be obtained from the Quality Assurance Administrator.

PROCEDURE

This Section of the Quality Assurance 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.

TABLE OF CONTENTS *PAGE*

Definitions of Commonly Used Terms

***Specialty Mental Health Services*:** This is the broad umbrella of Medi-Cal services directed at the mental health needs of Medi-Cal beneficiaries. Specialty Mental Health Services include the smaller umbrella of Mental Health Services. (CCR09)

- ***Mental Health Services***: Assessment, Plan Development, Psychotherapy, Rehabilitation, and Collateral. (CCR08)
- Medication Support
- Case Management/Brokerage
- Psychiatrist & Psychologist Services
- EPSDT Supplemental Specialty Mental Health Services
- Day Treatment Intensive & Day Treatment Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment Services & Crisis Residential Treatment Services
- Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services (PHF), and Psychiatric Nursing Facility Services

(Mental Health Rehabilitation Centers [MHRC's] follow the documentation standards established in the California Code of Regulations, Title 9, Chapter 3.5, Section 786.15.) *(CCR02)*

This Policy addresses the documentation standards for all Specialty Mental Health Services except Psychiatric Inpatient, PHF and Nursing Facility Services.

***Types of Providers*:** 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 all possible services*.

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

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

Mental Health Plan Network Providers (submit claims to Authorization Services):

- Provider Network (office-based individual clinicians)
- Community Based Organizations with fee-for-service contracts
- HPAC Providers

A Word About Terminology: ACBHCS providers and administrative offices have the intention to be inclusive in the language used to refer to beneficiaries of the Mental Health Plan (e.g., consumers, clients, families, children, youth, transition-age youth, 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 ACBHCS 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. Therefore, in the interest of clarity, inclusion, and consistency with regulatory la
nguage, all beneficiaries will be referred to as "clients" in this Section.

General Management of Clinical Records

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

Applies to All Provider Contracts

For the purposes of these documentation standards, charts containing documentation of mental health services are referred to as Clinical Records or Records.

General Record Maintenance:

Per BHCS, the "best practices" outlined below should be followed:

- Records should be organized and divided into sections according to a consistent standard allowing for ease of location and referencing. (*BHCSQA09*)
- Records should be sequential and date ordered. (*BHCSQA09*)
- Records should be fastened together to avoid loss or being misplaced. No loose papers or sticky-sheets in the chart (may staple). (*BHCSQA09*)
- Progress Notes must be filed in clinical records. Psychotherapy notes (process notes) should be kept separately. *(CalOHI1)*
- All entries must be legible (including signatures). (See "Clinical Documentation Standards" section, "Signature Requirements.") (CCR30) *(DMHcontract3)*
- Use only ink (black or blue recommended). (*BHCSQA09*)
- Every page must have some form of client identification (name or identification number, etc.). (*BHCSQA09*)
- Do not use names of other clients in the record (may use initials or similar method of preserving other clients' identities). (*BHCSQA09*)
- Do not "rubber stamp" your record entries; tailor wording to the changing needs of each individual. (BHCSQA09)
- Correcting errors: Do not use correction tape/fluid, scribble over, etc. Instead, draw a single line through the error & initial, then enter correct material. (*BHCSQA09*)
  - Only original authors may make alterations.
  - Reviewers or supervisors may not edit original authors but may supply an addendum with dated signature.
- Acronyms & Abbreviations: Use only universal and County-designated acronyms and abbreviations. A list is available at www.acbhcs.org/providers under the QA tab. (*BHCSQA09*)

Record Storage:

Clinical records contain Protected Health Information (PHI) covered by both state and federal confidentiality laws. Providers are required to safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons. (CFR1) (CFR2) *(CC1)*

Alameda County BHCS requires that clinical records be stored in 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., transported in a locked box in a locked vehicle trunk and not left in an unattended vehicle). Electronic Health Records (EHR) must be stored in a password-protected computer located within a locked room. (*BHCSQA09*)

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.)

Record Retention:

Clinical records must be preserved for a minimum of seven (7) years following discharge/termination of the client from services, with the following exceptions: *(HS3)* (CCR31)

- The records of un-emancipated minors must be kept for at least one (1) year after such minor has reached age 18, and in any case, not less than seven (7) years.
- For psychologists: Clinical records must be kept for seven (7) years from the client's discharge/termination date; in the case of a minor, seven (7) years after the minor reaches age 18 (*DMH02*)
- Third party: If a provider uses a third party to perform work related to their BHCS contract, the provider must require the third party to follow these same standards. (*BHCSQA09*)
- Audit situations: Records shall be retained beyond the seven (7) year period if an audit involving those records is pending, until the audit findings are resolved. The obligation to insure the maintenance of records beyond the initial seven (7) year period exists only if the MHP notifies Contractor of the commencement of an audit prior to the expiration of the seven (7) year period. (*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 Destruction:

Clinical records are to be destroyed in a manner to preserve and assure client confidentiality. *(CC1)*

Medical Necessity: Providing the Rationale for Services

(CCR16) (CCR20)

Applies to All Provider Contracts

The Mental Health Plan requires substantiation of the need for mental health services in order for those services to qualify for reimbursement. This is known as establishing Medical Necessity (MN). (CCR16)

All providers use the following documents to document medical necessity for services: Initial Assessment, Initial/Annual Client Plan (or Consumer Plan, Life Plan, Treatment Plan, etc.), and 6-Month Review/Update to the Client Plan.

Relevance of Medical Necessity for Documentation

- Initial assessment documentation establishes Medical Necessity (MN).*
- Initial client plans are based on the Initial Assessment. A licensed signature on the Plan is attestation that MN is met.*
- Client plans serve as progress reports and support ongoing MN**.

- Progress Notes must contain evidence that the services claimed for reimbursement meet Medical Necessity. Claim submission is attestation that this requirement is met.

**If services other than for the purpose of assessment are provided prior to completion of the initial assessment document, the Medical Necessity rationale for those services must be provided in the corresponding progress notes.*
*** In the gap of time that may exist between the Initial Assessment's completion and while the Initial Client Plan is being developed, mental health services may be provided as long as the medical necessity for services is clearly identified in the Initial Assessment. If a clinical issue arises that is not identified in the Initial Assessment, each Progress Note addressing that issue must evidence medical necessity.*

Medical Necessity is determined by the following factors:

- The client has an "included" DSM or ICD-9 (current editions) diagnosis that is substantiated by chart documentation.) (CCR17)
    - A client's excluded diagnosis may 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.)
    - Identify the DSM diagnostic criteria for each diagnosis that is a focus of treatment.

- As a result of the included diagnosis, it must be documented that the client meets at least one of the following criteria: (CCR18)
    - A significant impairment in an important area(s) of life functioning.
    - A probability of significant deterioration in an important area of life functioning.
    - A probability that the child will not progress developmentally as individually appropriate.
    - For full-scope M-C beneficiaries under age 21, a condition as a result of the included diagnosis that can be corrected or ameliorated with mental health services.

- Identify how the proposed service intervention(s) meets both of the following criteria: *(CCR19)*
    - The focus of the proposed intervention(s) is to address the condition identified in No. 2. (a-c) above; or for full-scope M-C beneficiaries under age 21, a condition identified in No. 2 (d) above.
    - The expectation that the proposed intervention(s) will do at least one of the following:
        - Significantly diminish the impairment
        - Prevent significant deterioration in an important area of life functioning
        - Allow the child to progress developmentally as appropriate
        - For full scope M-C beneficiaries under age 21, to correct or ameliorate the condition.

- Documentation must support both of the following: *(CCR19)*
    - That the mental health condition could not be treated by lower level of care.
    - That the mental health condition would not be responsive to physical health care treatment.

- EPSDT ONLY - Medical Necessity Criteria (CCR20)
  If a youth does not meet the functional impairment criteria for MN, the services provided MUST correct or ameliorate at least one of the following:
  - A documented mental illness or condition,
    and/or
  - The documented risk of developing a mental illness or condition, or of not progressing developmentally as expected.

  (Note: EPSDT clients must still have an included DSM diagnosis that is a focus of treatment.)

Clinical Documentation Standards for Specialty Mental Health Services

[Citations noted under each subject.]

Applies to All Providers, per Type of Contract/Service

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

All providers:

1. ***Initial Assessments***
2. ***Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.)***
3. ***Progress Notes***
4. ***Discharge/Termination/Transition Documentation***

Master Contract Providers (except FSP's):

5. ***Community Functioning Evaluation (or approved equivalent)***

TBS providers:

6. ***Therapeutic Behavioral Services (TBS): All Documentation***

Signature Requirements: All providers (*DMHcontract2*)

- ***Complete Signature:*** Every clinical document must be followed by a "complete signature," which includes the writer's signature, appropriate credential and date. (*BHCSQA09*)
- ***Legibility:*** Signatures should be legible: If signatures are illegible, the associated document may be subject to disallowance. Therefore, the MHP recommends that the name and appropriate credential (see below) be typed under signature lines. Providers may also have an administrative "signature page" containing staff signatures with their typed name and credential. (CCR30) *(DMHcontract3)*
- ***Credentials:*** If applicable, professional licensure (e.g., ASW, LCSW, MFT-Intern, MFT, PhD, MD, etc.) or student status (currently in a degree program) is required to accompany the signature. Job title or educational degree is sufficient if there is no professional licensure. It is best practice to select the credential which best qualifies the person for the majority of mental health services they provide. *(DMHcontract3)*
- ***Dates:*** All signatures require a date (00/00/00). Exception: If a Progress Note date of service and date the note was written are the same, the date of service is sufficient. (*BHCSQA09*)

- ***Late entries:*** *It is the expectation of the MHP that all entries be written within 1 working day.* Supervisory sign off must happen within 5 working days. If an entry is late, provide complete signature using the date the late entry was written, not the date of service. (See above and "Progress Notes" below for more information.) (*BHCSQA09*)
- ***Completion Line:*** Nothing may be added within a document after it is signed. To indicate the end of an entry, draw a line up to the signature (n/a for electronic signatures). If additional information must be added, write an addendum. (*BHCSQA09*)
- ***Addendums:*** Include complete signature (see above). (*BHCSQA09*)

---

1. *Psychiatric Diagnostic Evals (Initial Assessments)* (*DMHcontract2*)

Applies to All Providers
Exception: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Assessments are forthcoming.

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 must support the Medical Necessity criteria defined above if the Initial Assessment determines that ongoing mental health services will be provided. (CCR04)

Assessment information must be in either a specific document or section of the clinical record, per MHP requirements. (*BHCSQA09*)

Master Contract Providers - County-Operated: must use BHCS Initial Assessment templates.

Master Contract Providers - CBO: Per the MHP requirements, organizational providers may develop their own Initial Assessment templates, as long as the BHCS minimum required content areas are addressed in the document. Note: The QA Office is unable to review and/or approve templates created by providers. (*BHCSQA09*)

Note to MHP Network Providers: The Request for Extended Service Review (RES) form meets the full requirements of the Initial Assessment. (Please see the MHP Network Documentation Manual available at www.acbhcs.org/providers under the Forms tab).

❖ ***Timeliness & Frequency of Initial Assessments, per Type of Provider*** (BHCSQA09)

All Providers: Per the MHP requirements, a completed and filed Initial Assessment is required within 30 days of the opening episode date. BHCS does not require an annual re-assessment; instead, four (4) assessment elements are included in the Client Plan requirements and so shall be reviewed/updated every time the Client Plan is reviewed or renewed: Diagnosis, Risk situations, Client strengths & resources, and Special needs.

- If it is not possible to address all required elements 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 30 days, with notations of when addendums with missing information are expected.

- If it is not possible to determine medical necessity within 30 days, the need for more time must be documented in a progress note and the deadline may be extended to 60 days.
- If the case is closed before 30 days, best practice is to complete the Initial Assessment as much as possible.
- Progress Notes for every billed Assessment service must be in the clinical record.

Exceptions:
Full Service Partnership Programs: Per the MHP requirements, a completed and filed Initial Assessment is due within 60 days of the opening episode date.

- If it is not possible to address all required elements 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 60 days, with notations of when addendums with missing information are expected.
- If the case is closed before 60 days, best practice is to complete the Initial Assessment as much as possible.
- Progress Notes for every billed service must be in the clinical record.

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 for these timeframes.

All Providers: Initial Assessments shall be updated, as necessary, via addendums to the document. [The following four assessment items are included in the BHCS Client Plan requirements and so shall be reviewed/updated every time the Client Plan is reviewed or renewed: Diagnosis, Risk situations, Client strengths & resources, and Special needs.]

Re. Returning Clients: If a beneficiary's episode is closed but he/she returns to the provider for additional services within 12 months of an Initial Assessment's completion, that Assessment may be updated with new information and signatures and re-used for the new episode opening. If the beneficiary returns for services after 12 months of an Initial Assessment's completion, the Initial Assessment must be re-done.

❖ ***Minimum Requirements for Initial Assessment Content***

Applies to All Providers
Exceptions: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Assessments are forthcoming.

The following areas must be included in the Initial Assessment, as appropriate, as part of a comprehensive clinical record. (*DMHcontract1*)

a. ***Identifying information****:* Unless included in another document in the record (e.g., a face sheet or admission note), 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, self-identified gender & ethnicity, and marital 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

- Other identifying information, as applicable

b. ***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 interpreter, document that preference. Service-related correspondence with the client must be in their preferred language/format. (*BHCSQA09*)

c. ***Relevant physical health conditions*** reported by the client or by other report must be prominently identified and updated, as appropriate. (*DMHcontract1*)

d. ***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. (*DMHcontract1*)

e. ***Special status situations*** that present a risk to the client or to others must be prominently documented and updated, as appropriate. If a risk situation is identified, the Client Plan must include how it is being managed. (*DMHcontract1*)

f. ***Client's strengths*** in achieving anticipated treatment goals (e.g., client's skills and interests, family involvement and resources, community and social supports, etc.). (*DMHcontract1*)

g. ***Medications:***

- List medications prescribed by an MD 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 MD must be listed as above, per client or MD's report; provide the MD's name and telephone number. (*BHCSQA09*)

h. ***Allergies & adverse reactions/sensitivities***, per client or by report, to any substances or items, or the lack thereof, must be noted in the Initial Assessment (*DMHcontract1*) and prominently noted on the front of the chart. (BHCSQA09)

i. ***Substance use***, past & last use/current: Alcohol, caffeine, nicotine, illicit substances, and prescribed & over-the-counter drugs. (*DMHcontract1*)

j. ***Mental health history***, including previous treatment dates and providers; therapeutic interventions and responses; sources of clinical data; relevant family information; and results of relevant lab tests and consultation reports (as applicable to scope of practice). (*DMHcontract1*)

k. ***Other history:*** As relevant**,** include developmental history; social history; histories of employment/work, living situation, etc. (*BHCSQA09*)

l. ***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*)

m. ***Relevant Mental Status Examination:*** Includes signs and symptoms relevant to determine diagnosis and plan of treatment. (*DMHcontract1*)

n. ***Five-axis diagnosis*** from the most current DSM (or ICD), consistent with presenting problem, history, mental status examination, and/or other assessment data. (*DMHcontract1*)

- At least one diagnosis must be the focus of treatment and must be on the "included" Medical Necessity criteria list. (CCR16)
- Per the MHP requirements, only a licensed clinician may assign a psychiatric diagnosis. The name and license credential of the person who made the

diagnosis must be noted within this item, even if from a referral source; the signature is not required within this item. (*BHCSQA09*)

o. ***Complete signature*** of the person completing the Initial Assessment and the signature of a licensed or registered/waivered LPHA. (CCR21) (CCR11) *(BP1) (CCR01)*

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 Initial Client Plan. (BHCSQA09)

---

2. *Client Plans* (DMHcontract2) (CCR12)

Applies to All Providers
Exceptions: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Client Plans are forthcoming.

Definition: Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.) are plans for the provision of mental health services to clients who meet the Medical Necessity criteria. Services must address identified mental health barriers to goals/objectives. Client Plans are developed from the Initial Assessment must substantiate ongoing Medical Necessity and be consistent with the diagnosis/diagnoses that is the focus of mental health treatment. Client Plans must be maintained in a specific section of clinical records and must be clearly evident and identifiable, per the MHP. (CCR05) (BHCSQA09)

Strength-based and recovery/resiliency oriented treatment planning is strongly encouraged. (BHCSQA09)

The minimum required content areas of any Client Plan may not be left blank; instead, indicate the plan to complete those elements or indicate when they are not applicable. (BHCSQA09)

Master Contract Providers- County-Operated: must use BHCS Client Plan templates.

Master Contract Providers- CBO: Per the MHP requirements, Master Contract organizational providers may develop their own Client Plan templates as long as the BHCS minimum required content areas are addressed in the document. Note: The QA Office is unable to review and/or approve templates created by providers. (BHCSQA09)

Note to MHP Network Providers: The Request for Extended Service Review (RES) and Request for Concurrent Review (RCR) forms meet the full requirements of the Initial Client Plan, Annual Client Plan or 6-Month Update. Please see the MHP Network Documentation Manual available at www.acbhcs.org/providers under the Forms tab).

❖ ***Timeliness & Frequency of Client Plans, applies to all providers except FSP & Time-Limited Programs***

- Initial Client Plan: A completed and filed Initial Client Plan is required within 60 days of the opening episode date. If the case is closed before 60 days, a completed Plan is not required. The Initial Client Plan may be completed before the deadline. (*BHCSQA09*)
    - Until 11/1/10, the BHCS requirement was a 30-day deadline (higher than the DHCS standard of 60 days) and there was no need to count actual calendar days. However, providers must now adhere to the BHCS and DHCS 60-day deadline; therefore it is prudent to utilize the InSyst system prompt of the 60 day deadline that is sent automatically to providers. The following is an example of the 60 day count: An open episode date of 9/13/10 requires the Initial Client Plan to be completed by 11/11/10.
    - In the gap of time that may exist between the Initial Assessment's completion and while the Initial Client Plan is being developed, mental health services may be provided as long as the medical necessity for services is clearly identified in the Initial Assessment. If a clinical issue arises that is not identified in the Initial Assessment, each Progress Note addressing that issue must evidence medical necessity.
    - **Time-Limited Programs**: The due dates for a completed Initial Client Plan vary for Time-limited programs. They are based upon program length. Consult with your agency's MHP contract for these timeframes.

- Annual Client Plan: The Client Plan must be re-written at least once annually, just prior to the anniversary of the episode opening month (e.g., opened in March, so due every February); in other words, it must be completed in the month prior to the next authorization/utilization review period. If the case is closed before that month, a completed Plan is not required. (*DMHcontract1*) (*BHCSQA09*)

- 6-Month Client Plan Update: The 6-Month Update must be done annually, in the sixth month from the episode opening month (e.g., opened in March, so due every August); in other words, it must be completed in the month prior to the next authorization/utilization review period. If the case is closed before the end of the sixth month, no Update is required. (*BHCSQA09*)
    - Exception for Full-Service Partnership Programs: The 6-Month Client Plan Update is not required for FSP programs. (*BHCSQA09*)

- Other Updates to the Client Plan: The Client Plan must be updated whenever there are significant changes in the client's presentation and/or situation that affect planned treatment. (*BHCSQA09*)
    - HPAC: It is extremely important that a goal and progress towards referral back to the PCP be documented in the client plan.

- If unable to fully address each component of a Client Plan within the specified timeframe, the Plan must be finalized by the deadline date and indicate when the missing information will be added. (*BHCSQA09*)

- Note for Day Treatment Intensive Programs: Though these programs are authorized for services every 3 months, Client Plans follow the above schedule.

❖ ***Minimum Requirements for the Initial/Annual Client Plan and Updates***

Applies to All Providers
Exceptions: TBS Providers (See #6)
For providers of Medication Support Services, documentation standards for Client Plans are forthcoming.

The following elements must be fully addressed in the Initial and Annual Client Plans, as appropriate, as part of the clinical record.
Client Plan Updates must provide updated information, as applicable, for each element.

a. ***Client's goals*** (stated in own words, when possible) *(DMHcontract1) (BHCSQA09)*
b. ***Mental health goals/objectives*** that are specific and observable or measureable, and that are linked to the Assessment's clinical analysis and diagnosis (i.e. must be related to mental health barriers to reaching client's goals). Provide estimated timeframes for attainment of goals/objective. *(DMHcontract1) (BHCSQA09)*
   Note for Day Treatment (Intensive or Rehabilitation) and Minors in Group Home Programs: These Client Plans must identify the goal(s) that Day Treatment will assist the client to achieve, as well as the proposed duration of the Day Treatment Program. (DMH04)
c. ***Interventions and their focus*** must be consistent with the mental health goals/objectives and must meet the medical necessity requirement that the proposed intervention(s) will have a positive impact on the identified impairments (Item 3.b. in the Medical Necessity section of this Policy). *(DMHcontract1) (BHCSQA09)*
   Indicate:
   - Service Interventions, which are the planned mental health services (e.g., Family Psychotherapy).
   - "Best practice" to also indicate Clinician Interventions, which are the provider's actions during services to support the client's progress toward goals/objectives (e.g., "Offer stress reduction techniques to reduce anxiety" or "Support client to express unresolved grief to reduce depression").
d. ***Duration and Frequency*** of the service interventions. *(DMHcontract1) (BHCSQA09)*
e. ***Key Assessment Items:*** The following four key assessment items (included in the BHCS Client Plan template) shall be reviewed and updated every time the Client Plan is reviewed or renewed: 1) Diagnosis, 2) Risk situations, 3) Client strengths & resources, and 4) Special needs. *(BHCSQA09)*
f. ***Coordination of care:*** If applicable, it is "best practice" to include an objective in the Client Plan regarding coordination of a client's care with other identified providers. *(BHCSQA09)* For minors receiving Therapeutic Behavioral Services, the Client Plan must indicate coordination of services with the TBS provider. *(DMH03)*
g. ***Tentative Discharge Plan*** (termination/transition plan). *(BHCSQA09)*
h. **"Complete Signature"** (see also "Clinical Documentation Standards" section, "Signature Requirements") or the electronic equivalent by at least one of the following: (CCR13)
   - Person providing the service(s).
   - If psychiatric medication is prescribed by an organizational provider's Psychiatrist, that Psychiatrist must also sign the Client Plan. *(BHCSQA09)*

   If the above person providing the service(s) is not licensed or registered/waivered, a complete co-signature is required by at least one of the following:
   - Physician

- Licensed/registered/waivered psychologist
- Licensed/registered social worker
- Licensed/registered marriage and family therapist, or
- Registered nurse

i. ***Evidence of the client's degree of participation and agreement*** with the Client Plan must be addressed in the following ways: (CCR14) *(BHCSQA09)*
   - The client's (or legal representative's) dated signature on the Client Plan is required.
   - If the client (or legal representative) is unavailable or refuses to sign the Client Plan, the Plan must include the provider's dated/initialed explanation of why the signature could not be obtained, or refer to a specific Progress Note that explains why. In either case, include evidence on the Plan or in Progress Notes of follow-up efforts to obtain the signature.
   - If the provider believes that including the client in treatment planning would be clinically contraindicated, the Plan must include the provider's dated/initialed explanation or refer to a specific Progress Note that explains why, and the reason must be supported by the clinical record's documentation.

j. ***A copy of the Client Plan*** must be provided to the client (or legal representative) upon request and a statement to that effect must be either on the Plan or within informing materials signed by the client. *(DMHcontract1) (BHCSQA09)*

---

3. Progress Notes

Applies to All Providers, per Type of Service (*DMHcontract2*)

For providers billing Medicare, see "Special Situations: Progress Note Documentation Requirements" following this section.

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. Notes are filed in the clinical record and must contain the clinical details to support the medical necessity of each claimed service and its relevance to the Client Plan. (*BHCSQA09*)

In order to submit a service for reimbursement, there must be a complete and filed Progress Note for that service. Reimbursement submission is attestation that these criteria are met:

- Progress Notes must clearly relate to the mental health objectives & goals of the client as established 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)
- Each Progress Note must "stand on its own" regarding Medical Necessity; identifying a clear link to the Client Plan helps meet this rule. (*BHCSQA09*)

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

Alameda County BHCS expects that all providers will understand the content difference between Progress Notes and Psychotherapy Notes (also known as Process Notes) and the differences in privacy protection as described below. If a provider chooses to write

Psychotherapy Notes, they should maintain them in a separate file to protect the privacy of those notes.

Progress Notes, as noted generally above, 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.

Psychotherapy Notes are defined by CFR 45, Part 164.501 as: *"…*notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." *(CFR4)*

Examples of Psychotherapy Notes are a description of dream content, specific memories of child abuse, a clinician's thought process about the client's issues, a clinician's personal feelings or counter-transference, etc.

Psychotherapy Notes differ from regular clinical records and receive special protection under HIPAA (CFR 45, Part 164.524) from other clinical records which may be exchanged between providers and the MHP without specific permission from the client. Physically integrating the excluded information and protected information into one document does not make the excluded information protected. *(CFR5)*

Psychotherapy Notes that are not filed separately from the clinical record, or that contain excluded information, no longer receive special protection under HIPAA. Those notes are subject to review by the MHP and would be seen by the client if he/she so requested. Psychotherapy Notes that are maintained separately and do not contain excluded information would only be disclosed via legal action or with the client's release.

❖ *Timeliness & Frequency of Progress Notes, per Type of Provider & Service*

Timeliness
Applies to All Providers
Progress Notes must be entered into the clinical record within one (1) working day of each service provided. Approval by the supervisor and clinician finalization must be completed within five (5) business days. Exception Inpatient Units: Notes must be entered every third day, nursing notes are required for each shift. *(DMHcontract1) (BHCSQA09)*

> Late Entries: In the infrequent situation when an emergency prevents timely recording of services, the service must be entered in the clinical record as soon as possible. The beginning of the note must clearly identify itself as a late entry for the date of service (e.g. "Late entry for *date of service*."). Signatures for late entries must include the date the note is written. The note must be filed chronologically in the clinical record per the date it was written, not per the date of service. *(BHCSQA09)*

Frequency: Applies per Type of Service
Every service contact for: Mental Health Services (see page 4)

Medication Support Service
Crisis Intervention
Case Management/Brokerage
Therapeutic Behavioral Services (TBS)

Daily for: Crisis Residential
Crisis Stabilization (one per 23-hr. period)
Day Treatment Intensive

Weekly for: Day Rehabilitation
Adult Residential
Day Treatment Intensive Weekly Summary (Must be co-signed by one of the following: Licensed/Registered Social Worker or Marriage & Family Therapist, Licensed/Waivered Psychologist, Physician, or Registered Nurse.)

❖ ***Minimum Requirements for Progress Note Contents***

Applies to All Providers
Exception: TBS Providers (See #6)
For providers billing Medicare, see "Special Situations: Progress Note Documentation Requirements" following this section.

Progress notes are documentation of services provided to or on behalf of clients. Services may or may not include direct contact with clients. *Not all providers are contracted to provide all of the services described in this section.* (BHCSQA09)

➢ ***Minimum requirements for Progress Notes:***

a. ***Date of service*** (00/00/00). If the date of service and the date on which the note is written are the same, the date of service is sufficient. (See "Timeliness" section above, "Late Entries" paragraph.) (DMHcontract1)
b. ***Service intervention*** or service code (e.g. psychotherapy, collateral, rehabilitation, medication support, etc.). (DMHcontract1)
c. ***Location*** of the service provided. (BHCSQA09)
   MHP Network Providers: Location is required only if location is other than office. (Service is expected to be office-based; approval from Authorization Services is required for other locations.)
d. ***Time*** spent providing a *billable* service. Varies per provider type, as below: (CCR26)
   - Master Contract Providers: Enter claims only by the minute. Add the length of service time to documentation time. Include time spent travelling to/from a location (other than home) to provide service. If travel time exceeds service time, indicate face-to-face time with the client, per Federal guidelines. (CCR26)
     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.
   - MHP Network Providers: The time spent to provide a service determines which code is selected for claiming (e.g., Individual Psychotherapy for 30

minutes requires a different service code than for 60 minutes). This type of contract allows for the inclusion of the "community standard" of 10 minutes for documentation with a 50 minute session. This type of contract does not provide for reimbursement of travel time.

e. ***Documentation of specific services/interventions:*** Succinct description of clinically relevant information. (BHCSQA09) (*DMHcontract1*)
In general:
- When a service includes client contact, minimum requirements are description of the following, as applicable:
  - Reason for the contact.
  - Assessment of client's current clinical presentation.
  - Relevant history.
  - Specific mental health/clinical interventions by provider, per type of service and scope of practice.
  - Client's response to interventions.
  - Unresolved issues from previous contacts.
  - Plans, next steps, and/or clinical decisions. If little or no progress toward goals/objectives is being made, describe why. Include date of next planned contact and/or next clinician action. Indicate referrals made. Address any issues of risk.
- When a service does not include client contact, minimum requirements are description of:
  - Specific interventions by provider, per type of service and scope of practice.
  - Unresolved issues from previous contacts, if applicable.
  - Address any issues of risk.
  - Plans, next steps, and/or clinical decisions. Include date of next planned contact, clinician actions and referrals made, if applicable.

f. ***Signature:*** The person who provided the service must write and sign all notes; and co-signature, if required (see ***Staff Qualifications for Service Delivery and Documentation*** in this Policy). (See also "Clinical Documentation Standards" section, "Signature Requirements.") (*DMHcontract1*)

g. ***HPAC***: It is extremely important that a goal and progress towards referral back to the PCP be documented in each progress note.

❖ ***Special Situations: Progress Note Documentation Requirements*** (BHCSQA09) *[Other citations noted at specific lines]*

Applies to All Providers

Medicare Billable Services: Progress notes must contain the minimum requirements above, *as well as the following* in order to be potentially billable to Medicare:
- Medicare CPT code of the service provided.
- Face-to-Face Time and Total time to provide the service.
- ICD-9 Diagnosis.
- Physical 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.

Group Services: A note must be written for each beneficiary client participating or represented in a therapy or rehabilitation group. These notes must include the minimum requirements above, as well as: *(CCR25)*

- 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).
- Total service time: The addition of group time to the time it takes to write progress notes for all clients served (regardless of insurance plan/status).

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. Providers must document the need for such services in the clinical record. These services may be Crisis Therapy or Crisis Stabilization services, or an increased number/duration of services, per type of provider, as described below:

- Only Master Contract Provider's may claim for Crisis Therapy services.
- MHP Network providers may provide services in excess of the current authorization when warranted. These providers must contact Authorization Services for authorization of the amended treatment plan for an estimated period of crisis. Each service provided during the period of crisis must be documented as crisis services.
- Crisis Stabilization Programs are the only providers who may utilize Crisis Stabilization services.

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

- Relevant clinical details leading to the crisis
- The identified crisis must be the client's crisis, not a significant support person's crisis. (CCR24)
- The urgency & 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 done to decrease or eliminate or alleviate danger, reduce trauma and/or ameliorate the crisis.
- The aftercare safety plan.
- Collateral and community contacts that will participate in follow-up. (CCR06) (CCR10) *(CCR15)*

**Due to changes in the Medicare CPT codes, crisis "intervention" is now called "Crisis Therapy". Who can provide the service has not changed despite the name change.

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. The MHP suggests that providers follow up in a timely manner with clients when appointments are missed and document the findings. (DMH05) (BHCSQA09)

Documenting Lockout Situations: If 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 group home or other non-institutional 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 who 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 (Master Contract Providers only): When claiming for the time spent writing clinical documents, a Progress Note must be written to substantiate the claim. Examples of such documents are: Assessment, Client Plan, a clinical summary to Social Services/court that is required for treatment purposes, psychological testing report, 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.

---

4. Discharge / Termination / Transition Documentation

Applies to All Providers *(DMHcontract2)*
Exception: TBS Providers (See #6)

Definitions: Discharge documentation describes the termination and/or transition of services. It provides closure for a service episode and referrals, as appropriate. There are two (2) types of clinical discharge documentation – one (1) of the following must be completed, per type of provider: *(BHCSQA09)*

Master Contract Providers:

- Discharge Note: A brief Progress Note to indicate that the case is closed, per the Minimum Requirements below. (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*.)
- Discharge Summary: A comprehensive document that is **clinically necessary** in order to provide continuity of care for the next service provider, per the Minimum Requirements below. The MHP considers this to be a billable Plan Development service. *(BHCSQA09)*

MHP Network Providers:

- Discharge Note: A Progress Note for the last face-to-face service with the client, per the Minimum Requirements below. This is billable to Medi-Cal if included in a progress note for the final session with a client. *(DMHcontract1)*

❖ ***Timeliness of Discharge Summary & 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 of the discharge decision, but prior to closing the episode, and must be clearly labeled as either "Discharge Summary" or "Discharge Note". *(BHCSQA09)*

❖ ***Minimum Requirements***

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

a. Reason for discharge/transfer.
b. Date of discharge/transfer.
c. Referrals made, if applicable.
d. Follow-up care plan.

(Reminder for Master Contract providers: 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*.)

Discharge Summary: A document that must meet the requirements of a Discharge Note **plus a summary of the following**: *(BHCSQA09)*

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

(Reminder for Master Contract providers: The MHP considers this a billable Plan Development service when **clinically necessary for continuity of care**.)

---

5. *Community Functioning Evaluation or Equivalent*

Applies to Master Contract Providers Only *(BHCS1) (BHCSQA09)*
Exception: Full Service Partnership programs & TBS providers

Definition: The Community Functioning Evaluation (CFE) is a tool developed by BHCS to quantify levels of functioning in common domains in the community for child and adult clients. (Child & Adult versions are available at www.acbhcs.org/providers under the QA tab.)

❖ **Timeliness:** The CFE is completed at the time of admission for services and annually thereafter.
School-Aged Children and Youth Version: This form must be completed and submitted by the clinician during the following periods in which a child/youth is receiving services: 1) at intake, 2) at the end of the school year (school-based services) *or* at 6 months review (community-based services), and 3) at discharge. If the client is discharged prior to 6 month review or the end of the school year, the form need only be completed at intake and discharge.

---

6. Therapeutic Behavioral Services (TBS) Documentation

Applies to TBS Providers Only *(DMHcontract2)* (CCR07) *(BHCS2) (TBS1)*

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" published by the California Department of Mental Health (DMH); **and**
- The BHCS items noted below:

In addition to the "TBS Manual" documentation standards, BHCS 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 who is identified in the Note. "Best practice" is to make ongoing efforts to obtain paper evidence of adjudication.

Initial Assessments:

- Initial Assessments for TBS are due within 30 days of the TBS episode opening date.
  - If it is not possible to complete the Assessment within 30 days, the need for more time must be documented in a progress note and the deadline may be extended to 60 days.
- Initial Assessments must address the following, in addition to TBS Documentation Manual description:
  - ***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 interpreter, document that preference. Service-related correspondence with the client must be in their preferred language/format. (*BHCSQA09*)
  - ***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(*DMHcontract1*) and prominently noted on the front of the chart.(BHCSQA09)

Client Plans:

- Initial Client Plans for TBS are due within 60 days of the episode opening date and must be completed and reviewed before services are authorized.
- Monthly Summaries of the Client Plan are required (function as Client Plan Updates).
- Interventions in the Client Plan and Monthly Summary must utilize the standard behavioral measurement known as Frequency, Intensity, and Duration (FID).

Progress Notes:

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

Staff Qualifications for Service Delivery and Documentation

(EPSDT1)

Applies to All Providers, per Type of Contract

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 BHCS.

In addition, the "Guidelines for Scope of Practice" handout is available on the ACBHCS Provider Website as a resource.

****Providers must ensure, on an ongoing basis that all staff credentials are up-to-date and meet the criteria of the BHCS Credentialing Policy.***

Providers must also maintain documentation of all staff persons' qualifications to support their level of service provision.

The following staff qualifications are described in this section:

Licensed Practitioner of the Healing Arts (LPHA)
Waivered/Registered LPHA
Graduate Student Intern/Trainee
Mental Health Rehabilitation Specialist (MHRS)
Adjunct Mental Health Staff & Other Staff Not Meeting Above Category Qualifications

Licensed Practitioner of the Healing Arts (LPHA)

A Licensed Practitioner of the Healing Arts (LPHA) possesses a valid California clinical licensure in one of the following professional categories:

a. Physician
b. Licensed Clinical Psychologist
c. Licensed Clinical Social Worker
d. Licensed Marriage and Family Therapist

e. Registered Nurse

Approved Activities

- Can function as a "Head of Service" on agency application;
- Can authorize services as directed by BHCS;
- Can conduct comprehensive assessments and provide a diagnosis without co-signature.
  (Note re. RN Staff: In order to provide a diagnosis without co-signature, RN staff must possess a Masters 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.)
- Can co-sign the work of other staff members, within their scope of practice; and
- Can provide all service categories within their scope of practice.

Waivered/Registered LPHA

"Licensed waivered staff" members includes the following:

a. Registered Psychologists and Psychological Assistants:

Each psychologist candidate must obtain a waiver—even if he/she is registered with his/her licensing board.

In order to be eligible for such a waiver, the psychologist candidate must have successfully completed 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.

There is no statutory provision for extension of psychologist candidate waivers beyond the five-year limit.

Psychologist interns are individuals registered with the Board of Psychology as "Registered Psychologists" or "Registered Psychological Assistants" that possess an earned doctorate degree in psychology or educational psychology, or in education with specialization in counseling psychology or educational psychology. These interns must obtain supervised post-doctoral clinical hours towards licensure as a psychologist. The waiver for Registered Psychologists or Psychological Assistants is issued by DMH and is granted up to five years from the initial date of registration with the Department. The waiver allows these staff to function as an LPHA while acquiring experience towards clinical licensure. Please see the Waiver Policy and Procedures in the QA Manual for further instructions.

Note: Registered Psychologist/Psychological Assistants are granted waiver by DMH. Registered MFT Interns and ASWs are over seen and monitored by the hiring provider and the BBSE.

Approved Activities

Registered Psychologists, Psychological Assistants, Registered Marriage Family Therapist Interns, and Associate Social Workers may perform the following activities under the supervision of a licensed professional within their scope of practice:

- Can function as a LPHA staff for the time dictated by their respective Boards and DMH;
- Cannot function as the Head of Service unless they meet qualifications dictated by the California Code of Regulations;

- Can authorize services as directed by BHCS;
- Can conduct/create comprehensive assessments and sign them. Per BHCS, may not provide a diagnosis without co-signature while under waiver (see Assessment section);
- Can create Client Plans but require co-signature by licensed LPHA;
- Can co-sign the work of other staff members within their scope of practice, except for other staff in their same category and graduate students performing psychotherapy;
- Can claim for all Mental Health Services, Unplanned 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.)

Graduate Student Intern/Trainee

A "Graduate Student Intern/Trainee" 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 program that will prepare the student for licensure within his/her professional field. There is no minimum experience required for graduate students.

Some graduate students may qualify as "Mental Health Rehabilitation Specialists," if employed by the provider and if their experience permits. (Individuals enrolled in other degree programs may qualify as "Adjunct Mental Health Staff," as described below.)

Approved Activities

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

- Can conduct/create comprehensive Assessments and Client Plans, 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
- Can claim for any service within the scope of practice of the discipline of his/her graduate program.

Note: Waivered/Registered Professional staff cannot co-sign for a graduate student's psychotherapy progress notes. Those notes must be co-signed by a licensed LPHA.

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 degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.
- Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis.
- Up to two years of post-Associate Arts (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.

Approved Activities

MHRS staff may perform the following activities:

- Can function as a "Head of Service" on agency/provider application with BHCS approval. (Note: Does not qualify as "Director of Local Mental Health Services" unless approved by DMH);
- Can provide and collect information for Assessments;
- Can create Client Plans (require co-signature by licensed LPHA) and Progress Notes; and
- Can claim for all Mental Health Services (except Psychotherapy), Unplanned Services, and Case Management within their scope of practice.

Adjunct Mental Health Staff & Other Staff Not Meeting Above Category Qualifications

Master Contract Providers have the prerogative and program flexibility to integrate and define other staff who can provide direct or supportive specialty mental health services, as determined by their BHCS 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 (i.e., 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. *BHCS strongly advises that all adjunct mental health staff documentation be co-signed by a licensed LPHA.*

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.

Approval Date: January 1, 1989
Revision Date: March 6, 1995
Revision Date: December 20, 2010
Revision Date February 25, 2013
Application: All Alameda County Behavioral Health Care Services Providers

Citations

Citations for documentation standards and requirements are included with each subject heading, and for specific items, if warranted:

BHCS	**Behavioral Health Care Services**
BHCS1	BHCS Requirement
BHCS2	BHCS Office of the Medical Director, Guidelines for Psychotropic Medication Practices can be found at, http://www.acbhcs.org, under tab "Office of the Medical Director"
BHCSQA	**Behavioral Health Care Services, Quality Assurance** can be found at http://www.acbhcs.org, in tab "Quality Assurance"
BHCSQA09	BHCS/QA Requirement, 2009 or earlier
BHCSQA10	BHCS/QA Requirement, 2010
BP	**Business and Professions Code** can be found at http://www.leginfo.ca.gov
BP1	BP, Section 4996.9, Section 4996.15, Section 4996.18(e)
CalOHI	**California Office of HIPAA Implementation** can be found at http://www.ohi.ca.gov under California Implementation
CalOHI1	CalOHI Chapter 4
CC	**California Civil Code** can be found at http://www.leginfo.ca.gov
CC1	CC 56.10
CC2	CC 1798.48
CCR	**California Code of Regulations**, Title 9 and Title 22 can be found at the DMH (Department of Mental Health) website http://www.dmh.ca.gov
CCR01	CCR, Title 9, Chapter 3, Section 550
CCR02	CCR, Title 9, Chapter 3.5, Section 786.15
CCR03	CCR, Title 9, Chapter 4.0, Sections 851 & 852
CCR04	CCR, Title 9, Chapter 11, Section 1810.204
CCR05	CCR, Title 9, Chapter 11, Section 1810.205.2
CCR06	CCR, Title 9, Chapter 11, Section 1810.216
CCR07	CCR, Title 9, Chapter 11, Section 1810.225
CCR08	CCR, Title 9, Chapter 11, Section 1810.227
CCR09	CCR, Title 9, Chapter 11, Section 1810.247
CCR10	CCR, Title 9, Chapter 11, Section 1810.253
CCR11	CCR, Title 9, Chapter 11, Section 1810.254
CCR12	CCR, Title 9, Chapter 11, Section 1810.440
CCR13	CCR, Title 9, Chapter 11, Section 1810.440(c)(1)
CCR14	CCR, Title 9, Chapter 11, Section 1810.440(c)(2)
CCR15	CCR, Title 9, Chapter 11, Section 1820.205
CCR16	CCR, Title 9, Chapter 11, Section 1830.205
CCR17	CCR, Title 9, Chapter 11, Section 1830.205(b)(1)
CCR18	CCR, Title 9, Chapter 11, Section 1830.205(b)(2)
CCR19	CCR, Title 9, Chapter 11, Section 1830.205(b)(3)
CCR20	CCR, Title 9, Chapter 11, Section 1830.210
CCR21	CCR, Title 9, Chapter 11, Section 1830.215
CCR22	CCR, Title 9, Chapter 11, Section 1840.312

Citations

CCR23	CCR, Title 9, Chapter 11, Section 1840.314
CCR24	CCR, Title 9, Chapter 11, Section 1840.314(b)
CCR25	CCR, Title 9, Chapter 11, Section 1840.314(c)
CCR26	CCR, Title 9, Chapter 11, Section 1840.316
CCR27	CCR, Title 9, Chapter 11, Section 1840.346
CCR28	CCR, Title 9, Chapter 11, Section 1840.360 - 374
CCR29	CCR, Title 22, Chapter 2, Section 71551(c)
CCR30	CCR, Title 22, Chapter 7.2, Section 75343
CCR31	CCR, Title 22, Chapter 9, Section 77143
CFR	**Code of Federal Regulations** can be found at http://www.gpoaccess.gov/cfr
CFR1	CFR, Title 45, Parts 160 and 164 (HIPAA)
CFR2	CFR, Title 45, Parts 160, 162 and 164 (HIPAA)
CFR3	CFR, Title 45, Part 164
CFR4	CFR, Title 45, Part 164.501
CFR5	CFR, Title 45, Part 164.524
DMH	**Department of Mental Health** Information Notices & Letters can be found at http://www.dmh.ca.gov
DMH01	DMH Information Notice No. 02-06, page 3
DMH02	DMH Information Notice No. 06-07
DMH03	DMH Information Notice No. 02-08
DMH04	DMH Letter No. 02-01
DMH05	DMH Letter No. 02-07
DMH contract	**Department of Mental Health Contract** with the Mental Health Plan; the boilerplate contract with DMH can be found at http://www.dmh.ca.gov
DMHcontract1	DMH Contract with MHP
DMHcontract2	DMH Contract with MHP, Exhibit A, Attachment 1, Appendix C
DMHcontract3	DMH Contract with MHP, Exhibit A, Attachment 1, Appendix C, page 39
EPSDT	**Early and Periodic Screening Diagnosis and Treatment (EPSDT)** Chart Documentation Manual, 2007 can be found at http://www.cimh.org
EPSDT1	EPSDT Chart Documentation Manual, 2007
HS	**Health and Safety Code** can be found at http://www.leginfo.ca.gov
HS1	H&S, 123105, 123145 and 123149
HS2	H&S, 123105(b) and 123149
HS3	H&S, 123145
RMS	**Risk Management Services**
RMS1	Risk Management Services 2010
TBS	**Therapeutic Behavioral Services Documentation Manual**, first published online in October 2009; can be found, along with future updates, at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp.
TBS1	TBS Documentation Manual

AB	ABORTION
ABS	ABSENT
abst.	ABSTRACT
AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
ADL	ACTIVITIES OF DAILY LIVING
ACTH	ADRENOCORTICOTROPIC HORMONE
APS	ADULT PROTECTIVE SERVICES
p	*(post)* AFTER
p.c.	I *(post cibum)* AFTER
P.M. or p.m.	*(post meridiem)* AFTERNOON, EVENING
AMA	AGAINST MEDICAL ADVICE
ARC	AIDS RELATED COMPLEX
ACSC	ALAMEDA COMMUNITY SUPPORT CENTER
ACBHCS	ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ACHCSA	ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
ACSD	ALAMEDA COUNTY SHERIFF'S DEPARTMENT
A/G ratio	ALBUMIN/GLOBULIN RATIO
ETOH or etoh	ALCOHOL
AOD	ALCOHOL AND OTHER DRUGS
AA	ALCOHOLICS ANONYMOUS
AKA	ALSO KNOWN AS
Amb.	AMBULATORY
Amt.	AMOUNT
amp	AMPLE
A	ANALYSIS
e	AND
&	AND
a.c.	Ante Cubum, BEFORE MEALS

Ap	ANTE POSTERIOR
ADH	ANTIDIURETIC HORMONE
appt	APPOINTMENT
approp	APPROXIMATE
Approx.	APPROXIMATE
ASCVD	ARTERIOSCLEROTIC HEART DISEASE
ad lib	AS DESIRED
prn	AS NECESSARY
PRN	AS NEEDED
ASAP	AS SOON AS POSSIBLE
ACMHC	ASIAN COMMUNITY MENTAL HEALTH CENTER
AHS	ASIAN HEALTH SERVICES
AB3632	ASSESSMENT AND TREATMENT SERVICES SCHOOL CHILDREN (K-12)
ASSN	ASSOCIATION
@	AT
hs	AT BEDTIME (hours of sleep)
STAT, stat	AT ONCE, IMMEDIATELY
AV	ATRIOVENTRICULAR
ADHD	ATTENTION DEFICIT/HYPERACTIVITY DISORDER
A/H	AUDITORY HALLUCINATIONS
AWOL	ABSENT WITHOUT LEAVE
BCG	BACILLUS CALMETTE-GUERIN
BACS	BAY AREA COMMUNITY SERVICES
b/c	BECAUSE
a	BEFORE
beh	BEHAVIOR
benzos	BENZODIAZEPINES
BMHS	BERKELEY MENTAL HEALTH SERVICES
bilat	BILATERAL
B.D.	BIRTH DATE
B	BLACK
BP	BLOOD PRESSURE
B&C	BOARD AND CARE
OU	BOTH EYES
BF	BOYFRIEND

BRO.	BROTHER
BLDG.	BUILDING
BBB	BUNDLE BRANCH BLOCK
po	*(per os)* BY MOUTH
CHP	CALIFORNIA HIGHWAY PATROL
C/A	CANCELLED APPOINTMENT
CO_2	CARBON DIOXIDE
CPR	CARDIOPULMONARY RESUSCITATION
CM	CASE MANGER, CASE MANAGEMENT
CDC	CENTERS FOR DISEASE CONTROL (AND PREVENTION)
CSF	CEREBROSPINAL FLUID
CVA	CEREBROVASCULAR ACCIDENT
s	CHANGE
4	CHECK
CD	CHEMICAL DEPENDENCY
CXR	CHEST X-RAY
cc	CHIEF COMPLAINT
CPS	CHILD PROTECTIVE SERVICES
Cpz	CHLORPROMAZINE
chr	CHRONIC
COPD	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CRF	CHRONIC RENAL FAILURE
ct	CLIENT
co tp	CO-THERAPIST
col	COLLATERAL
CCRP	COMMUNITY CRISIS RESPONSE PROGRAM
CSC	COMMUNITY SUPPORT CENTER
CSS	COMMUNITY SUPPORT SERVICES
C/O	COMPLAINS OF, COMPLAINTS OFFERED
Congen.	CONGENITAL

CHF	CONGESTIVE HEART FAILURE
Con't	CONTINUED
CCU	CORONARY CARE UNIT
CESDC	COUNSELING ENRICHED SPECIAL DAY CLASS
cr	CREATINE
CPX	CREATINE PHOSPHOKINASE
CLC	CREATIVE LIVING CENTER
CJ	CRIMINAL JUSTICE
CJMH	CRIMINAL JUSTICE MENTAL HEALTH
CJP	CRIMINAL JUSTICE PSYCHIATRY
C & S	CULTURE AND SENSITIVITY
DOB	DATE OF BIRTH
dtr	DAUGHTER
DOA	DEAD ON ARRIVAL
DEA	DRUG ENFORCEMENT AGENCY
fl	DECREASE
decr	DECREASE
DTR	DEEP TENDON REFLEX
∞	DEGREE
∞C	DECREES CENTIGRADE
∞F	DEGREES FAHRENHEIT
DTs	DELIRIUM TREMENS
demo	DEMONSTRATES
DNA	DEOXYRIBONUCLEIC ACID
Dep	DEPENDENT
D.P.O.	DEPUTY PROBATION OFFICER
Detox	DETOXIFICATION

D.D.	DEVELOPMENTALLY DISABLED
Dx	DIAGNOSIS
DRGs	DIAGNOSIS RELATED GROUPS
diff	DIFFERENTIAL BLOOD COUNT
D & C	DILATION AND CURETTAGE
D/C	DISCHARGE
DC	DISCHARGE
D/O	DISORDER
▪	DOT above any number indicates a time derivative
Z	DRAM
gtt(s)	DROPS
D.Dx	DUAL DIAGNOSIS
ENT	EAR, NOSE, AND THROAT
ECSC	EDEN COMMUNITY SUPPORT CENTER
EDT	EDEN DAY TREATMENT
ECG	ELECTROCARDIOGRAM
EKG	ELECTROCARDIOGRAM
ECT	ELECTROCONVULSIVE THERAPY
EEG	ELECTROENCEPHALOGRAM
ER	EMERGENCY ROOM
=	EQUAL
ED	ERECTILE DYSFUNCTION
ESR	ERYTHROCYTE SEDIMENTATION RATE
e.g.	*(exempli gratia)* FOR THE SAKE OF EXAMPLE, FOR EXAMPLE
EVAL	EVALUATION
Q, q	EVERY

qhs, QHS	EVERY BEDTIME
qd	EVERY DAY, DAILY
qod	EVERY OTHER DAY
q___hrs.	EVERY___HOURS
ext.	EXTERNAL, EXTERIOR
EPS	EXTRA PYRAMIDAL SYNDROME
fh	FAMILY HISTORY
FBS	FASTING BLOOD SUGAR
fa	FATHER
F or ♀	FEMALE
FSH	FOLLICLE STIMULATING HORMONE
F/U	FOLLOW-UP
Fo	FOSTER
qid or QID	*(quarter in die)* FOUR TIMES A DAY
14 D. CERT	FOURTEEN- DAY CERTIFICATION
Fx	FRACTURE
FTI	FREE TYROXINE INDEX
freq	FREQUENT
GI	GASTROINTESTINAL
GA	GENERAL ASSISTANCE (WELFARE FUNDS)
GU	GENITOURINARY
GF	GIRLFRIEND
GD Tx	GLADMAN DAY TREATMENT
GDJ	GLENN E. DYER JAIL
gr	GRAINS
gfa. Or gdfa	GRANDFATHER

gmo. Or gdmo	GRANDMOTHER
>	GREATER THAN/ MORE THAN
grp	GROUP
GSW	GUN SHOT WOUND
GYN	GYNECOLOGY
ss	HALF
HEENT	HEAD, EYES, EARS, NOSE, AND THROAT
HQTRS	HEADQUARTERS
HR	HEART RATE
ht	HEIGHT
Hct	HEMATOCRIT
HBP	HIGH BLOOD PRESSURE
HGH	HIGHLAND HOSPITAL
hx	HISTORY
Hx	HISTORY
H&P	HISTORY AND PHYSICAL EXAMINATION
HPI	HISTORY OF PRESENT ILLNESS
h.w.	HOMEWORK
HI	HOMICIDAL IDEATION
Hosp	HOSPITAL
hrs	HOURS
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HYPER	HYPERACTIVE
SMA	I.E. SMA 6, 12, 20-STANDARD LABORATORY TESTS
I.P.	IDENTIFIED PATIENT
IST	INCOMPETENT TO STAND TRIAL

incont.	INCONTINENT
>	INCREASE
incr.	INCREASE
IND.	INDIVIDUAL
IEP	INDIVIDUAL EDUCATION PLAN
info.	INFORMATION
IDU	INJECTION DRUG USER
INPT	INPATIENT
IMD	INSTITUTE OF MENTAL DISEASE (SNF with more than 50% MH PATIENTS)
IDDM	INSULIN DEPENDANT DIABETES MELLITUS
I&O	INTAKE AND OUTPUT
IQ	INTELLIGENCE QUOTIENT
ICF	INTENSIVE CARE FACILITY
ICU	INTENSIVE CARE UNIT
IM	INTRAMUSCULAR
IV	INTRAVENOUS
irreg.	IRREGULAR
INH	ISONIAZID (ISONICOTINIC ACID HYDRAZEDE)
IVDA	INTRAVENOUS DRUG ABUSER
JGPP	JOHN GEORGE PSYCHIATRIC PAVILION
JGP	JOHN GEORGE PAVILION
JCAHO	JOINT COMMISSION FOR THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS
JUV. HALL	JUVENILE HALL
K.S.	KAPOSI'S SARCOMA
kg	KILOGRAM

km	KILOMETER
Lab	LABORATORY
LDH	LACTIC DEHYDROGENASE
LPS	LANTERMAN, PETRIS, SHORT ACT – the law providing for involuntary detention for psychiatric reasons.
L.D. OR L.H.	LEARNING DISABLED, LEARNING HANDICAPPED
L	LEFT
OS	*(OCULucs sinister)* LEFT EYE
LOS	LENGTH OF STAY; the period of time between admission and discharge
<	LESS THAN
L	LITER
Li_2CO_2	LITHIUM CARBONATE
LFT	LIVER FUNCTION TESTS
LMHD	LOCAL MENTAL HEALTH DIRECTOR
L-FACILITY	LOCKED FACILITY –type of skilled nursing facility, but sometimes used for refer to a locked inpatient facility
LSD	LYSERGIC ACID DIETHYLAMIDE
♂	MALE
‰	PER MILE (THOUSAND)
M	MALE, MARRIED
mat.	MATERIAL
max.	MAXIMUM
M.D., MD	MEDICAL DOCTOR, PHYSICIAN
MIA	MEDICALLY INDIGENT ADULT
Meds	MEDICATIONS
mtg	MEETING

MHB	MENTAL HEALTH BOARD
MDO	MENTALLY DISORDERED OFFENDER
MDSO	MENTALLY DISORDERED SEX OFFENDERS
M.R.	MENTALLY RETARDED
Mess or msg.	MESSAGE
mcg	MICROGRAM
MOM	MILK OF MAGNESIA
mEq	MILLIEQUIVALENT
mg, mg.	MILLIGRAM
ml	MILLILITER
mm	MILLIMETER
(B)	MINUS
Min	MINUTE
Mins	MINUTE
M-F	MONDAY THROUGH FRIDAY
MAO	MONOAMINE OXIDASE
mo.	MOTHER
NSH	NAPA STATE HOSPITAL
NA	NARCOTICS ANONYMOUS
Nat. Am.	NATIVE AMERICAN
N & V	NAUSEA AND VOMITING
O OR (-)	NEGATIVE
neg	NEGATIVE
Neuro	NEUROLOGICAL
noc	NOCTURNAL, NIGHT

NKA	NO KNOW ALLERGIES
N/S	NO SHOW
N/C	NON- CONTRIBUTORY
norm	NORMAL
N/A	NOT APPLICABLE
NGI	NOT GUILTY BY REASON OF INSANITY
N/K	NOT KEPT
N/E	NOT EVALUATED
NPO	NOTHING BY MOUTH
#	NUMBER
NF	NURSING FACILITY
OCS	OAKLAND CHILDREN'S SERVICES
OCSC	OAKLAND COMMUNITY SUPPORT CENTER
OISC	OAKLAND INDEPENDENT SUPPORT CENTER
O	OBSERVATION
OCD	OBSESSIVE COMPULSIVE DISORDER
OT	OCCUPATIONAL THERAPY
OD	OFFICER OF THE DAY
O/V	OFFICE VISIT
OBS	ORGANIC BRAIN SYNDROME
oz.	OUNCE
Z	OUNCE
OP	OUT PATIENT
outpt	OUTPATIENT
OPD	OUTPATIENT DEPARTMENT
OTC	OVER THE COUNTER (MEDICATION)

O.D.	OVERDOSE
OA	OVEREATERS ANONYMOUS
PI	PARANOID IDEATION
PHP	PARTIAL HOSPITALIZATION PROGRAM
pat.	PATERNAL
pt.	PATIENT
Peds	PEDIATRICS
/	PER
%	PERCENT
PVD	PERIPHERAL VASCULAR DISEASE
P-CON	PERMANENT CONSERVATORSHIP
P.E.	PHYSICAL EXAMINATION
P.T.	PHYSICAL THERAPY
Pin. dev.	PLAN DEVELOPMENT
P	PLANNING
(+)	PLUS OR POSITIVE
pos.	POSITIVE
pp	*(post-prandia)* AFTER MEALS
lb	POUNDS
lbs., (# - after a number)	POUNDS
Preg	PREGNANT
PVS	PREMATURE VENTRICULAR SYNDROME
PMS	PRE-MENTAL SYNDROME
Rx	*(recipe)* PRESCRIPTION
Prev	PREVENTION
1 ∞	PRIMARY

PTA	PRIOR TO ADMINISTRATION
P.O.	PROBATION OFFICER
prob	PROBLEM
Prov.	PROVISIONAL
Y	PSYCHE(pertaining to history of psychiatric disorder; may refer to mental health therapist.)
PES	PSYCHIATRIC EMERGENCY SERVICES
PHF (Puff)	PSYCHIATRIC HEALTH FACILITY
Psych	PSYCHOLOGICAL
P	PULSE
qt.	QUART
RPR	RAPID PLASMA REAGIN TEST (FOR SYPHILIS)
RE, re	REGARDING
reg ed	REGULAR EDUCATION
rel	RELATED
ES	RESOURCE SPECIALIST
RSP	RESOURCE SPECIALIST PROGRAM
R	RESPIRATION
RR	RESPIRATION RATE
R/S	RESTRAINT AND SECLUSION
RTC	RETURN TO CLINIC
R	RIGHT
Rt	RIGHT
OD	*(oculus dexter)* RIGHT EYE
R/O	RULE OUT
SRJ	SANTA RITA JAIL
2∞	SECONDARY

Sz	SEIZURE
SED	SERIOUSLY EMOTIONALLY DISTURBED—AB3632 services to certain special education children identified by the school districts.
SGOT	SERUM GLUTAMIC OXALACETIC TRANSAMINASE
SGPT	SERUM GLUTAMIC PYRUVIC TRANSAMINASE
SMI	SEVERE MENTAL ILLNESS – individuals with seriously debilitating and chronic mental disorders.
S.E.D.	SEVERELY EMOTIONALLY/ EDUCATIONALLY DISTURBED
STD	SEXUALLY TRANSMITTED DISEASE
SOB	SHORT OF BREATH
SD	SHORT-DOYLE
SD/MC	SHORT-DOYLE/ MEDI-CAL
sib	SIBLING
sib(s)	SIBLINGS
sig.	SIGNATURE
SRO	SINGLE ROOM OCCUPANCY HOTEL
sis.	SISTER
SNF	SKILLED NURSING FACILITY
SSI	SOCIAL SECURITY INCOME
Soc Serv	SOCIAL SERVICE
SSA	SOCIAL SERVICE AGENCY
s.w.	SOCIAL WORKER
SDC	SPECIAL DAY CLASS
Sp. Ed	SPECIAL EDUCATION
m^2	SQUARE METER
SDI	STATE DISABILITY INSURANCE

st-br	STEP-BROTHER
st-fa	STEP-FATHER
st-mo	STEP-MOTHER
SOAP	SUBJECTIVE, OBJECTIVE, ASSESSMENT PLAN
SIDS	SUDDEN INFANT DEATH SYNDROME
SI	SUICIDAL IDEATION
SRP	SUPPLEMENTAL RATE PROGRAM
SX, sx	SYMPTOMS
TBSP	TABLESPOON
Tab	TABLET
tchr	TEACHER
tsp	TEASPOON
T/C	TELEPHONE CALL
T	TEMPERATURE
T-Con	TEMPORARY CONSERVATORSHIP
T4	TETRAIDOTYRONINE
i.e.	*(id est)* THAT IS *(to say)*
Tp	THERAPIST
tid ORTID	THREE TIMES DAILY
TFT	THYROID FUNCTION TESTS
TSH	THYROID STIMULATING HORMONE
X	TIMES
< ->	TO AND FROM
Tox	TOXICOLOGICAL
T3	TRIIODOTHYRONINE
TB	TUBERCULOSIS

UC	UNIVERSITY OF CALIFORNIA
unk	UNKNOWN
∅≠	UP AND DOWN
URI	UPPER RESPIRATORY INFECTION
VCSC	VALLEY COMMUNITY SUPPORT CENTER
VD	VENEREAL DISEASE
VDRL	VENEREAL DISEASE RESEARCH LAB (test for syphilis)
VO	VERBAL ORDER
vs.	VERSUS
VA	VETERAN'S ADMINISTRATION
VAH	VETERAN'S ADMINISTRATION HOSPITAL
per	VIA, BY
VF	VILLA FAIRMONT
VH	VISUAL HALLUCINATIONS
VS	VITAL SIGNS
H_2O	WATER
wk	WEEK
wt	WEIGHT
wc	WHICH
W	WHITE
WBC	WHITE BLOOD CELLS
w/ or c	WITH
WNL	WITHIN NORMAL LIMITS
s or w/o	WITHOUT
y.o.	YEAR OLD
yr(s)	YEARS

STATE DEPARTMENT OF MENTAL HEALTH MEDI-CAL MANAGED CARE

Medical Necessity for Specialty Mental Health Services that are the Responsibility of the Mental Health Plan

Must have all, A, B, and C:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included.)
- Tic Disorders
- Delirium, Dementia and Amnestic and other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions, including V-codes, that may be a focus of Clinical Attention. (Except medication induced movement disorders which are included.)

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have one of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria:
Must have one, 1, 2, or 3:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have all, 1, 2, and 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

MEDI-CAL INCLUDED DIAGNOSIS

295.10	Schizophrenia, Disorganized Type	302.3	Transvestic Fetishism
295.20	Schizophrenia, Catatonic Type	302.4	Exhibitionism
295.30	Schizophrenia, Paranoid Type	302.6	Gender Identity Disorder NOS
295.40	Schizophreniform Disorder	302.81	Fetishism
295.60	Schizophrenia, Residual Type	302.82	Voyeurism
295.70	Schizoaffective Disorder	302.83	Sexual Masochism
295.90	Schizophrenia Undifferentiated Type	302.84	Sexual Sadism
296.00	Bipolar I Disorder Single Manic Episode	302.85	Gender Identity Disorder in Adolescents or Adults
296.01 - .06	Bipolar I Disorder	302.89	Frotteurism
296.20 - .26	Major Depressive Disorder Single Episode	302.9	Paraphilia/Sexual Disorder NOS
296.30 - .36	Major Depressive Disorders, Recurrent	307.1	Anorexia Nervosa
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	307.3	Stereotypic Movement Disorder
296.40 - .46	Bipolar I Disorder Most Recent Episode Manic	307.50	Eating Disorder NOS
296.50 - .56	Bipolar I Disorder Most Recent Episode Depressed	307.51	Bulimia Nervosa
296.60 - .66	Bipolar I Disorder Most Recent Episode Mixed	307.52	Pica
296.7	Bipolar I Disorder, Most recent episode Unspecified	307.53	Rumination Disorder
296.80	Bipolar Disorder NOS	307.59	Feeding Disorder of Infancy or Early Childhood
296.89	Bipolar II Disorder	307.6	Enuresis (Not Due to a General Medical Condition)
296.90	Mood Disorder NOS	307.7	Encopresis Without Constipation Incontinence
297.1	Delusional Disorder	307.80	Pain Disorder Associated With Psychological Factors
297.3	Shared Psychotic Disorder	307.89	Pain Disorder Associated with Psych & Medical Condition
298.8	Brief Psychotic Disorder	308.3	Acute Stress Disorder
298.9	Psychotic Disorder NOS	309.0	Adjustment Disorder With Depressed Mood
299.10	Childhood Disintegrative Disorder	309.21	Separation Anxiety Disorder
299.80	Asperger's Disorder/Rett's Disorder	309.24	Adjustment Disorder With Anxiety
299.80	Pervasive Developmental Disorder NOS	309.28	Adjustment Disorder With Mixed Mood
300.00	Anxiety Disorder NOS	309.3	Adjustment Disorder With Disturbance of Conduct
300.01	Panic Disorder Without Agoraphobia	309.4	Adjustment Disorder With Mixed Emotions & Conduct
300.02	Generalized Anxiety Disorder	309.81	Posttraumatic Stress Disorder
300.11	Conversion Disorder	309.9	Adjustment Disorder Unspecified
300.12 - .15	Dissociative Amnesia	311	Depressive Disorder NOS
300.16	Factitious Disorder w/Predominantly Psychological	312.30	Impulse-Control Disorder NOS
300.19	Factitious Disorder NOS	312.31	Pathological Gambling
300.21	Panic Disorder With Agoraphobia	312.32	Kleptomania
300.22	Agoraphobia Without History of Panic Disorder	312.33	Pyromania
300.23	Social Phobia	312.34	Intermittent Explosive Disorder
300.29	Specific Phobia	312.39	Trichotillomania
300.3	Obsessive-Compulsive Disorder	312.8	Conduct Disorder
300.4	Dysthymic Disorder	312.9	Disruptive Behavior Disorder NOS
300.6	Depersonalization Disorder	313.23	Selective Mutism
300.7	Body Dysmorphic Disorder/Hypochondriasis	313.81	Oppositional Defiant Disorder
300.81	Somatization Disorder/Somatoform Disorder	313.82	Identity Problem
301.0	Paranoid Personality Disorder	313.89	Reactive Attachment Disorder
301.13	Cyclothymic Disorder	313.9	Disorder of Infancy, Childhood, or Adolescence NOS
301.20	Schizoid Personality Disorder	314.00	Attention-Deficit/Hyperactivity Disorder, Inattentive
301.22	Schizotypal Personality Disorder	314.01	Attention-Deficit/Hyperactivity Disorder Combined
301.4	Obsessive-Compulsive Personality Disorder	314.9	Attention-Deficit/Hyperactivity Disorder NOS
301.50	Histrionic Personality Disorder	332.1	Neuroleptic-Induced Parkinsonism
301.6	Dependent Personality Disorder	333.1	Medication-Induced Postural Tremor
301.81	Narcissistic Personality Disorder	333.7	Neuroleptic-Induced Acute Dystonia
301.82	Avoidant Personality Disorder	333.82	Neuroleptic-Induced Tardive Dyskinesia
301.83	Borderline Personality Disorder	333.90	Medication-Induced Movement Disorder NOS
301.9	Personality Disorder NOS	333.92	Neuroleptic Malignant Syndrome
302.2	Pedophilia	333.99	Neuroleptic-Induced Acute Akathisia
		787.6	Encopresis, With Constipation/Incontinence

Lockouts

A "lockout" means that a service activity is not reimbursable through Medi-Cal because the client resides in and/or receives mental health services in one of the settings listed below. A clinician may provide the service (e.g., CM for a client residing in an IMD), but it would not be reimbursable.

- ❖ Jail/Prison
- ❖ Juvenile Hall/Ranch (not adjudicated)
- ❖ IMD

No service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge).

- ❖ Psychiatric Inpatient
- ❖ Psychiatric Nursing Facility

No other service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge).

Exception: Case Management for placement-related services provided 30 days prior to discharge is reimbursable

- ❖ Adult Residential Treatment
- ❖ Crisis Residential Treatment

No other service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge)

Exception: MSS and CM are reimbursable

❖ Crisis Stabilization (EPS)	❖ Day Rehabilitation ❖ Day Treatment Intensive
No other service activities are reimbursable during the same time period that the client is at EPS. (Except for the day of admission and discharge)	MHS are not reimbursable if provided by the DR/DTI staff during the same time period that DR/DTI is open.

Assessment & Plan Due Dates

EPISODE OPENING MONTH	INITIAL ASSESSMENT DUE	INITIAL PLAN CREATED, SIGNED & DUE IN:	6 MOS. PLAN UPDATE CREATED & SIGNED IN:	ANNUAL PLAN CREATED AND SIGNED IN:
January	30 Days	60 Days	June	Dec.
February	30 Days	60 Days	July	Jan.
March	30 Days	60 Days	Aug.	Feb.
April	30 Days	60 Days	Sept.	March
May	30 Days	60 Days	Oct.	April
June	30 Days	60 Days	Nov.	May
July	30 Days	60 Days	Dec.	June
August	30 Days	60 Days	Jan.	July
September	30 Days	60 Days	Feb.	Aug.
October	30 Days	60 Days	March	Sept.
November	30 Days	60 Days	April	Oct.
December	30 Days	60 Days	May	Nov.

Regulatory Compliance

Provider Name:

Chart Review	
1. Chart ID	
2. Clinician 1	
3. Clincian 2	
4. MD	
5. Reviewer	

Medical Necessity	Yes	No	N/A
6. 5-axis diagnosis from current DSM & primary diagnosis is "included."	☐	☐	☐
7. Documentation supports primary diagnosis(es) for tx.	☐	☐	☐
8. Impairment Criteria: *Must have one of the following as a result of dx*			
8A. Signif. impairment in important area of life functioning, or	☐	☐	☐
8B. Probable significant deterioration in an important area of life functioning, or	☐	☐	☐
8C. Probable the child won't progress developmentally, as appropriate, or	☐	☐	☐
8D. If EPSDT: MH condition can be corrected or ameliorated.	☐	☐	☐

9. Intervention Criteria: Must have: 9A and 9B, or 9C, or 9D			
9A. Focus of proposed intervention: Address condition above, and	☐	☐	☐
9B. Proposed intervention will diminish impairment/prevent signif. deterioration in important area of life functioning, and/or	☐	☐	☐
9C. Allow child to progress developmentally as appropriate, or	☐	☐	☐
9D. If EPSDT, condition can be corrected or ameliorated.	☐	☐	☐

Service Necessity: Must have both 10 and 11			
10. The mental health condition could not be treated by a lower level of care? (true = yes)	☐	☐	☐
11. The mental health condition would not be responsive to physical health care treatment? (true=yes)	☐	☐	☐

Informing Materials:			
12. Informing Materials signature page is signed annually (Tx Consent, Free.Choice, Conf/Priv., BenefProblemRes., HIPAA/HiTech, AdvDir.)	☐	☐	☐
13. Releases of information, when applicable.	☐	☐	☐
14. Informed Consent for Medication(s), when applicable.	☐	☐	☐

Special Needs:			
15. Client's cultural/comm. needs noted	☐	☐	☐
16. Client's cultural/comm. needs addressed	☐	☐	☐
17. Client's physical limitations are noted	☐	☐	☐
18. Client's physical limitations are addressed	☐	☐	☐

Chart Maintenance			
19. Writing and signatures are legible.	☐	☐	☐
20. Admission date is noted.	☐	☐	☐
21. Clinical record filing is appropriate.	☐	☐	☐
22. Client identification on each page in clinical record.	☐	☐	☐
23. Discharge/termination date noted, when applicable.	☐	☐	☐
24. Face Sheet info, esp. emergency contact info prominent.	☐	☐	☐

Med Order Sheet ("pink sheet")			
Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gardens, MD)	☐	☐	☐
25. Date	☐	☐	☐
26. Drug name	☐	☐	☐
27. Drug Strength/Size	☐	☐	☐
28. Instructions/ Frequency	☐	☐	☐
29. Signatures/Initials	☐	☐	☐

Assessment:			
30. Initial Assessment done by 30 days of episode opening date. (FSP/Brief Service by 60 days; Level 3 by 4th visit.)	☐	☐	☐
31. Psychosocial history.	☐	☐	☐
32. Presenting problems & relevant conditions.	☐	☐	☐
33. Risk(s) to client and/or others assessed.	☐	☐	☐
34. Client strengths/supports.	☐	☐	☐
35. MHP MD Rx's: Doses, initial Rx dates.	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 36. Noted in chart	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 37. Noted prominently on chart's cover.	☐	☐	☐
38. Relevant medical conditions/hx noted & updated.	☐	☐	☐
39. Mental health history.	☐	☐	☐
40. Relevant mental status exam (MSE).	☐	☐	☐
41. Past/present use: Tobacco, alcohol, caffeine, illicit/Rx/OTC drugs.	☐	☐	☐
42. Youth: Pre/perinatal events & complete dev. hx.	☐	☐	☐
43. Annual Community Functioning Evaluation (ACFE) N/A for FSP/Brief Service Programs & Level 3)	☐	☐	☐

Client Plan:	Yes	No	N/A
44. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit)	☐	☐	☐
45. Plan reviewed every 6 months from opening episode date. (N/A=FSP/Brief Svcs.) (Level 3 from first f-to-f)	☐	☐	☐
46. Client Plan revised/rewritten annually.	☐	☐	☐
47. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	☐	☐	☐
48. Client Plan is consistent with diagnosis.	☐	☐	☐
49. Goals/Objectives are observable or measureable with timeframes.	☐	☐	☐
50. Plan identifies proposed interventions & their frequency to address identified impairments.	☐	☐	☐
51. Updates Ct. strengths, Dx & special needs, if applicable.	☐	☐	☐
52. Risk(s) to client/others have plan for containment.	☐	☐	☐
53. Plan signed/dated by LPHA (if licensed, use desig.).	☐	☐	☐
54. Plan signed/dated by MD, if provider prescribes MH Rx.	☐	☐	☐
55. Coordination of care is evident, when applicable.	☐	☐	☐
56. Plan signed/dated by client, or documentation of client refusal or unavailability.	☐	☐	☐
57. Plan signed/dated by legal rep., when appropriate.	☐	☐	☐
58. Plan indicates client was offered copy of Plan or client may obtain copy on request (may be in informing materials).	☐	☐	☐
59. Plan contains Tentative Discharge Plan	☐	☐	☐

Progress Notes:			
60. There is a progress note for every service contact.	☐	☐	☐
61. Correct service/code,	☐	☐	☐
62. Date of service	☐	☐	☐
63. Location	☐	☐	☐
64. Amount of time. *(Level 3 n/a - Location & Time)*	☐	☐	☐
65. Notes for Ct encounters incl. that day's eval/ behavioral presentation	☐	☐	☐
66. Notes for Ct. encounters incl.that day's Staff Intervention	☐	☐	☐
67. Notes for Ct. encounters incl. that day's Ct. response to Intervention.	☐	☐	☐
68. Notes for Ct. encounters incl. Ct &/or Staff f/u plan	☐	☐	☐
69. Group service notes include # clients served/on behalf.	☐	☐	☐
70. Services are related to Client Plan's goals/objectives.	☐	☐	☐
71. Unresolved issues from prior services addressed, if app.	☐	☐	☐
72. Signed/dated + title/degree/lic. (if lic., use designation).	☐	☐	☐
73. Completion line at signature (n/a for electronic notes).	☐	☐	☐
74. Service provided while Ct. was Not in lock-out setting, IMD, or Jail.	☐	☐	☐
75. Service provided was NOT SOLELY transportation, supervision, academic, vocational, or social group	☐	☐	☐
76. The activity was NOT SOLELY clerical, payee related, or voicemail	☐	☐	☐
77. Progress note was written within one working day of the date of service, and if needed, finalized within 5.	☐	☐	☐
78. Progress note documents the language that the service is provided in, as needed	☐	☐	☐
79. Progress note indicates interpreter services were used, and relationship to client is indicated, as needed	☐	☐	☐

Reviewer:	Date:

Alameda County Behavioral Health Care Services
CBO Procedure Code Table - Effective with January 2013 Dates of Service
REVISED 2-8-13

InSyst Proc Code	CPT Code Medicare/ Ins	HCPC CODE Medi-Cal		E/M	Face To Face	SFC	MD DO	Lic PhD	CNS NP PA	LCSW	MFT	Intern	RHB Coun	Unlic	Nurse
121		H2013	PHF Contract Day			20 - 29									
141		H0018	Crisis Residential Day			40 - 49									
165		H0019	Adult Residential Day			65 - 79									
221		S9484	Crisis Stabilization			20 - 24	X	X	X	X	X	X	X	X	X
281		H2012	Day Care Intens Half Day			81 - 84									
282		H2012	Day Care Intens AB3632 Half			81 - 84									
285		H2012	Day Care Intens Full Day			85 - 89									
286		H2012	Day Care Intens Full-AB3632			85 - 89									
291		H2012	Day Care Rehab Half Day			91									
292		H2012	Day Care Rehab Half-AB3632			91									
295		H2012	Day Care Rehab Full Day			95									
296		H2012	Day Care Rehab Full-AB3632			95									
571		T1017	Brokerage Services			01-08	X	X	X	X	X	X	X	X	X
581		H0032	Plan Development			30	X	X	X	X	X	X	X	X	X
323	90791	H2015	90791 Psychiatric Diag Eval (Init Assmnt)			30	X	X	X	X	X	X	X	X	X
565	90792	H2010	90792 Psych Diag Eval w/medical			60	X		X						
324	96151	H2015	96151 Behavioral Eval (CFE)			30	X	X	X	X	X	X	X	X	X
441	90832	H2015	90832 Psychotherapy 30 min		16-37	40	X	X	X	X	X	X	X	X	X
465	90833	H2010	90833 + PsyThpy with E/M 30 min	X	16-37	60	X		X						
442	90834	H2015	90834 Psychotherapy 45 min		38-52	40	X	X	X	X	X	X	X	X	X
467	90836	H2010	90836 + PsyThpy with E/M 45 min	X	38-52	60	X		X						
443	90837	H2015	90837 Psychotherapy 60 min		53 >	40	X	X	X	X	X	X	X	X	X
468	90838	H2010	90838 + PsyThpy with E/M 60 min	X	53 >	60	X		X						
545	99201*	H2010	99201 E/M NEW OFC SIMPLE 10 MIN	X	1-15	60	X		X						
546	99202*	H2010	99202 E/M NEW OFC EXP 20 MIN	X	16-25	60	X		X						
547	99203*	H2010	99203 E/M NEW OFC DETAIL 30 MIN	X	26-37	60	X		X						
548	99204*	H2010	99204 E/M NEW OFC COMPRE 45 MIN	X	38-52	60	X		X						
549	99205*	H2010	99205 E/M NEW OFC COMPLEX 60MIN	X	53 >	60	X		X						

Alameda County Behavioral Health Care Services
CBO Procedure Code Table - Effective with January 2013 Dates of Service
REVISED 2-8-13

InSyst Proc Code	CPT Code Medicare/ Ins	HCPC CODE Medi-Cal		E/M	Face To Face	SFC	MD DO	Lic PhD	CNS NP PA	LCSW	MFT	Intern	RHB Coun	Unlic	Nurse
641	99211	H2010	99211 E/M EST OP SIMPLE 5MIN	X	1-7	60	X		X						
643	99212	H2010	99212 E/M EST OP PROBFOCUS 10MIN	X	8-12	60	X		X						
644	99213	H2010	99213 E/M EST OP EXPANDED 15MIN	X	13-20	60	X		X						
645	99214	H2010	99214 E/M EST OP MOD COMPL 25M	X	21-32	60	X		X						
646	99215	H2010	99215 E/M EST OP HIGHCOMPL 40M	X	33 >	60	X		X						
381	H2017**	H2017	Individual Rehabilitation			40	X	X	X	X	X	X	X	X	X
391	H2017**	H2017	Group Rehabilitation			50	X	X	X	X	X	X	X	X	X
377	90839**	H2011	90839 Crisis Thpy 60 min		30-75	70	X	X	X	X	X	X			
378	90840**	H2011	90840 + Crisis Thpy ADD 30 min		16-45	70	X	X	X	X	X	X			
311		H2015	Collateral			10	X	X	X	X	X	X	X	X	X
413	90846	H2015	90846 FAMILY PSYCH WO PATIENT			10	X	X	X	X	X	X			
449	90847	H2015	90847 FAMILY PSYCH W PATIENT			40	X	X	X	X	X	X			
455	90849	H2015	90849 MULTI FAMILY GRP PSYCH			50	X	X	X	X	X	X			
456	90853	H2015	90853 GROUP PSYCHOTHERAPY			50	X	X	X	X	X	X			
367	H0034**	H0034	Medication Training & Support (non face/face)			60	X		X						
369	H2010**	H2010	Meds Mgmt by RN LVN Only			60									X
491	90785	H2015	90785 + INTERACTIVE COMPLEXITY			30	X	X	X	X	X	X			
415	96101	H2015	96101 PSYCH TESTING			30	X	X	X	X	X	X			
535	96111	H2015	96111 EXT DEV TEST INTERP RPT			30	X	X	X						
417	96118	H2015	96118 NEUROPSYCH TESTING			30	X	X	X						
498		H2019	Therapeutic Behavioral Svcs			58	X	X	X	X	X	X	X	X	X

BOLD = NEW JANUARY 2013

*restricted to 1 every 3yrs
** not billable to Medicare
+ Add-On Code may not be used alone
Revised 2-8-13

www.psychiatry.org

Interactive Complexity

Revised 11/3/12

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Definition

A new concept in 2013, interactive complexity refers to 4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure. Report with CPT add-on code **90785**.

Code Type

Add-on codes may be reported in conjunction with specified "primary procedure" codes. Add-on codes may never be reported alone.

Replaces

Codes for interactive diagnostic interview examination, interactive individual psychotherapy, and interactive group psychotherapy are deleted.

Use in Conjunction With

The following psychiatric "primary procedures":

- Psychiatric diagnostic evaluation, 90791, 90792
- Psychotherapy, 90832, 90834, 90837
- Psychotherapy add-on codes, 90833, 90836, 90838, when reported with E/M
- Group psychotherapy, 90853

When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work *intensity* of the psychotherapy service, and does not change the *time* for the psychotherapy service.

May Not Report With

- Psychotherapy for crisis (90839, 90840)
- E/M *alone*, i.e., E/M service *not* reported in conjunction with a psychotherapy add-on service
- Family psychotherapy (90846, 990847, 90849)

Typical Patients

Interactive complexity is often present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.

Report 90785

When at least one of the following communication factors is present during the visit:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, ~~interpreter or translator~~ to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.

Complicating Communication Factor Must Be Present *During* the Visit

The following examples are ***NOT*** interactive complexity:

- Multiple participants in the visit with straightforward communication
- Patient attends visit individually with no sentinel event or language barriers
- Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
GUIDELINES FOR SCOPE OF PRACTICE

February 2013

SERVICE ACTIVITY	**LICENSED LPHA:** *Clinical Psychologist (PHD/PSYD), LCSW, LMFT,*	**Medication Prescribers:** MD, DO, NP, CNS, PA	**Registered Nurses**	**UNLICENSED LPHA:** **(Intern**)** Waivered Psychologist, MFT-I, ASW,	**GRADUATE STUDENT / TRAINEE:** **(Intern**)** *Students in MH programs: MSW, MA, MS, PHD/PSYD*	**MHRS** **(RHB Counselor**)** *AA + 6 yrs., BA + 4 yrs., or MA/MS/PHD/ PSYD—in MH or related field but not waivered or registered. Co-sig's recommended.*	**ADJUNCT STAFF** **(Unlic worker**)** *Program documents qualifications, requires supervision and staff works within scope. Co-sig's recommended.*
Assessment	Yes	Yes	No	Yes ^	Yes # *	No = +	No = +
Evaluation (CFE related only)	Yes	Yes	Yes	Yes	Yes # *	Yes = ~	Yes = ~
Plan Development	Yes	Yes	Yes	Yes	Yes *	Yes = *	Yes = *
Individual Rehab	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~
Therapy (Ind / Family)	Yes	Yes	No	Yes	Yes *	No	No
Group Therapy	Yes	Yes	No	Yes	Yes *	No	No
Group Rehab	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~
Collateral	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~
Medication Services E/M	No	Yes	No	No	No	No	No
Psychological Testing	Yes =	Yes =	No	Yes =	Yes=*	No	No
Crisis Therapy (Crisis Svcs)	Yes	Yes	Yes=	Yes =	Yes=*	Yes = ~	Yes = ~
Case Management Brokerage/Linkage	Yes	Yes	Yes	Yes	Yes*	Yes = ~	Yes = ~
Medication Services RN Only	No	No	Yes	No	No	No	No

* Requires co-signature by licensed LPHA.
# Cannot provide Dx—report source (including if referral source).
^ Diagnosis may be made but must be co-signed by licensed LPHA.
+ May bill for Assessment—but can only gather and provide assess info.
~ Licensed co-signatures not required—but recommended.
= If within scope of practice and with appropriate training & experience.
**Designation indicates the category on the Staff Master.

B.I.R.P. Progress Note Checklist

B Behavior **Counselor observation, client statements**	**Check if addressed**
1. Subjective data about the client—what are the clients observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
I Intervention **Counselor's methods used to address goals and objectives, observations, client statements**	
1. What goals and objectives were addressed this session?	
2. Was homework reviewed?	
R Response **Client's response to the intervention, progress made toward Tx Plan goals and objectives**	
1. What is the client's current response to the clinician's intervention in the session?	
2. Client's progress attending to goals and objectives outside of the session?	
P Plan **Document what is going to happen next**	
1. What in the Tx Plan needs revision?	
2. What is the clinician going to do next?	
3. What is the next session date?	

General Checklist	**Check if addressed**
1. Does the note connect to the client's individualized treatment plan?	
2. Are client strengths/limitations in achieving goals noted and considered?	
3. Is the note dated, signed and legible?	
4. Is the client name and/or identifier included on each page?	
5. Has referral and collateral information been documented?	
6. Does the note reflect changes in client status (eg. GAF, measures of functioning)?	
7. Are all abbreviations standardized and consistent?	
8. Did counselor/supervisor sign note?	
9. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
10. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	

Progress Note Exercise:

Objectives:

1. Participants will be able to understand how to link the Medi-Cal Included Diagnosis, the Client Plan Goals & Objectives, and Interventions in Progress Notes.

2. Participants will be able to successfully write Client Plan Objectives which are observable and/or measureable with baselines and timeframes.

3. Participants will be able to successfully write a progress note which meets Medi-Cal documentation standards linking the Included Diagnosis, Client Plan Objectives, and Interventions.

- 30 minutes
    - Break out in to smaller groups
    - Each group will collectively identify 2 mental health objectives based upon the client's goal stated in the vignette.
    - Each group will write a progress note for a psychotherapy session based upon client's presentation in the current session using the BIRP model. (Participants will think of an intervention, client response, and plan that is pertinent to the content of the vignette).
    - Review and revise notes with group

Vignette 1

You have been seeing John for 4 months and have developed a solid working rapport. He attends sessions as scheduled. He is a 22 year old, single, African-American, identified gay male, who lives with roommates in Berkeley, employed as a waiter, and is a Landscape Architecture major attending UC Berkeley. He began therapy to address feeling sad, lonely, and depressed for the past year, but maybe longer. His primary diagnosis is Dysthymic disorder. He has reported a decrease in his marijuana use during the past 6 months and is improving in his academics. His main goal is to be able to be in a steady relationship, complete school in the next 9 months, and then secure a position.

Today he presents with sad affect and discussed feeling disappointed with himself because he drank a lot the other night, overslept, and missed one of his classes. He also stated that he feels uncertain that he will ever meet guys that are “easy going and have a good head on their shoulders.”

Vignette 2

You have just met with Donovan for the 3 initial assessment sessions. He is a 42 year old Mexican-American, Bilingual, and is employed as an electrician in his cousin's company. He is originally from Oaxaca, Mexico, has been in the US off and on since he was 14 years old, is an undocumented person, living in San Leandro with his wife and their 3 children. He reported occasional use of alcohol and denied all drug use or experimentation. He denied a history of mental health issues/treatment. He was directed by his PCP to seek out counseling for intense panic attacks. He is not clear what counseling is about, but is willing to give it a try. He reported that he does not want to take medications and would rather find another way to stop what is happening. He reported his sleep is "rocky", has intermittent nightmares that he cannot remember, and wakes up in a pool of sweat. You were able to identify with him that his main concerns are to stop the sudden panic attacks.

Vignette 3

Yolanda is a 15 year old, African American female. She has been in counseling with you for approximately 2 months. She was brought in for counseling by her parents who were concerned about her abrupt change in mood after a break-up with her boyfriend. For the past 3 months, she has been feeling predominantly sad, anxious, her sleep has been disrupted, and she reports having difficulty concentrating. She denies any self-harm behaviors or thoughts, has no history of mental health issues/treatment, and denies all substance use. In general, she is bright, has a long-history enjoying school, and has several close friends. She described her relationship to her family as very good. Her main goals are to stop feeling sad and be able to feel good about herself. Her primary diagnosis is Adjustment Disorder with mixed Anxiety and Depressed Mood. Today she is reporting she has not spent time with her friends in a long time, feeling lonely, her affect is sad and she discussed feeling anxious about the upcoming summer break. She discussed feelings of rejection and unworthiness since her boyfriend broke up with her. She reported she is mostly listening to music and studying on her own after school and in the past week has become suddenly angry with her younger sister when she came into her room.

Progress Note

Client Name: _____ MRN: _____

Service Date: _____ Service Code: _____ Service Location: _____

Included Diagnosis: _____

Objective #:_____

B (Today's Behavioral Observation/Assessment):

_____
_____
_____
_____

I: (Clinician's Intervention)

_____
_____
_____
_____

R: (Client's Response)

_____
_____
_____
_____

P: (Today's Plan: Follow up, Homework, Focus of Next Session, etc.)

_____
_____
_____
_____

Clinician Name: _____

Clinician Signature: _____ **Date:** _____

Objective Formulation Exercise:

Axis I Diagnosis: _____

Client's Stated Goal:

_____
_____
_____

Objective 1 (Observable & Measureable, With Baseline & Timeframes):

_____
_____
_____

Objective 2 (Observable & Measureable, With Baseline & Timeframes):

_____
_____
_____

Medi-Cal/Medicare Documentation Training Development Exercise

Audience (circle): Adjunct Staff: Consumer Worker, Family Partner, etc. / MHRS / Non-licensed LPHA: Registered Interns, Waivered Interns, Student Trainees / Licensed LPHA / Medication Prescriber
Other(s): _____

Trainer (circle): Staffs' Supervisor / Clinical Supervisor / QA Coordinator
Other(s): _____

Length of training: _____ hrs. _____ min's

Focus of training (circle): Medical Necessity / Assessments / Informing Materials / Client Plans / Progress Notes / Scope of Practice and MH Services / Billing & Procedure Codes
Other(s): _____

Resources Provided:

Handouts (circle): Assessment Plan & Due Dates / Informing Materials Signature Page / Lock-outs Information Sheet / ACHBCS Medi-Medi- Procedure Code List / Medi-Medi Procedure Codes Descriptions / Medical Necessity Handout / BIRP Progress Note Checklist / Medicare Resources / ACBHCS Medi-Cal Benefits Help Desk Flyer / List of Included Dx / ACHBCS Standard Abbreviations / Regulatory—Compliance Checklist
Other(s): _____

Agency or ACBHCS Forms: Assessment / Client Plan / Progress Note / Release of Information / Consents
Other(s): _____

Manuals (circle): ACBHCS Clinical Record Documentation Manual / CIMH EPSDT Chart Documentation Manual / Part B CMS MH Services Billing Guide
Other(s): _____

Books (circle): _____Treatment Planning Manual
Other(s): _____

Power Point Slides (Medi/Medi Direct Lines Staff Documentation Training) & **Exercises** attached. Indicate which will be used and modify as needed in the notes section.

Notes:

Introducing the BHCS Finance Provider Relations Medi-Cal Benefits Help Desk

Start Date: April 19, 2010

Alameda County Behavioral Health Care Services will provide a call center staffed with knowledgeable Patient Service Technicians ready to assist Providers with basic Medi-Cal benefit questions, including:

- Interpreting Medi-Cal Eligibility Response System
- Medi-Cal with Other Health Insurance
- Managed Care Insurance and Private Insurance
- Medi-Cal Share of Cost
- Out of County Medi-Cal Clients

1-(888) 346-0605

Help Desk Hours:
Monday through Friday
9 a.m. to 12:00 noon
1 p.m. to 4 p.m.

* Voicemails will be responded to within 24 hours or the next business day.

* The Help Desk is <u>not</u> a Medi-Cal Eligibility Verification line and does not replace your monthly verification process.

CPT and PROCEDURE CODE TRAINING for NON-MEDICAL STAFF

ADDITIONAL DATES ANNOUCEMENT

APRIL 10, 2013- 1 - 3p

OR

MAY 13. 2013- 10a - 12p

OPEN TO CLINICAL MANAGEMENT, AND QA STAFF OF MENTAL HEALTH PROGRAMS IN ALAMEDA COUNTY BHCS CBO (Master Contract) NETWORK

NOTE: This is a clinical training for QA, Training, or Clinical Supervisory Staff- NO LINE STAFF- THIS IS NOT A BILLING TRAINING

*If you have recently attended but would like a refresher, you may register for the added dates but only if you fit the training criteria

Presenters:

- Kyree Klimist, MFT
- Michael DeVito, MFT, MPH
- Anthony Sanders, PhD

Training will be held on the ACBHCS Administration Campus:
2000 Embarcadero Cove, Oakland
5th Floor, Gail Steele Room

Learning Objectives:

1. Understand the newly implemented CPT codes and the eliminated CPT codes
2. Distill your clinical care into appropriate documentation best captured by specific CPT codes
3. Update your clinical practice to successfully use and deploy CPT codes

Pre-registration is required

Please click or go to: https://www.surveymonkey.com/s/CPT2013

Check-in, on the day of training, will begin 30 minutes prior to start time.

For further questions, please contact QAOffice@acbhcs.org

This is a free training presented by ACBHCS QA Office

Alameda County Behavioral Health Care Services

Updated CPT and Procedure Handouts are available at the Provider's website(click below link):
http://www.acbhcs.org/providers/QA/docs/2013/CPT_Code_Training_Handouts.pdf