Behavioral Health Department
Alameda County Health

SUPPLEMENTAL DOCUMENTATION GUIDE

SPECIALTY MENTAL HEALTH SERVICES

Alameda County Behavioral Health Department

Quality Assurance

Published November 2024

This document expands upon the information contained within CalMHSA's Clinical Documentation Guides. Where additional information exists, or clarification is needed, it will be captured in this document. If there is inconsistency between the CalMHSA and ACBHD guidance, ACBHD guidance should be followed.

Contents

Introduction to the Supplemental Documentation Guide

Alameda County Behavioral Health Department (ACBHD) has adopted California Mental Health Services Authority's (CalMHSA) Clinical Documentation Guides as a standard for the County. Specialty Mental Health Services (SMHS) providers should refer to that manual as their primary resource for documentation requirements. The purpose of this document is to supplement and expand upon the information contained within CalMHSA's Clinical Documentation Guides. Where additional information exists or clarification is needed, it will be captured in this document. If there is inconsistency between the CalMHSA and ACBHD guidance, ACBHD guidance should be followed.

Consents

Informing Materials

Medi-Cal beneficiaries receiving services funded, all or in part, by ACBHD must be provided with a copy of the *Informing Materials – Your Rights and Responsibilities* packet, on the Informing Materials page of the ACBHD Provider website. This document contains information about the beneficiary's rights and responsibilities and is available in all Alameda County threshold languages.

Staff with the required education, knowledge, training, and scope of practice should review the content with each beneficiary at intake, annually thereafter, and upon request. After satisfactory review of the packet, the *Acknowledgment of Receipt* signature page must be completed, signed, and retained in the beneficiary's medical record. By completing and signing the signature page, members acknowledge their consent to voluntarily receive services from that provider. Providers may supplement the Informing Materials packet but cannot alter, contradict, overrule, or remove any information.

Telehealth Consent

Per BHIN 23-018, Department of Health Care Services (DHCS) requires that providers do all of the following:

- Obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services prior to the initial delivery of covered services via telehealth (synchronous audio and video) or telephone (audio only).
- Explain specific information to beneficiaries regarding the use of telehealth.
- Document in the beneficiary's medical record their verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services.

See *Telehealth Consent Form* in section 7 of the QA Manual for specific details required when obtaining verbal consent and optional templates and forms that can be used for this purpose.

Medication Consent

Although a member/legal representative signature is not required, obtaining and documenting consent from members/their legal representatives when prescribing psychiatric medications is a clinical best practice and required by ACBHD. There are specific requirements for what must be documented when prescribing psychiatric medication. See *ACBH Medication Consent Form* in section 7 of the QA Manual on the Provider Website for detailed requirements and a suggested template.

Psychotropic Medication Consents for Wards of the Juvenile Court

The laws are different for Wards of the Juvenile Court, and JV court forms (e.g., JV 220) are required for informed consent to medication(s). More information on the requirements for this population can be found on the California Courts webpage.

Minor Consent to Treatment

Per Assembly Bill No. 665, effective July 1, 2024, a minor who is 12 years of age or older can consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services if the minor, in the opinion of the attending professional, is mature enough to participate intelligently in services. The minor consent to treatment excludes convulsive therapy, psychosurgery and psychotropic drugs.

The minor's mental health treatment or counseling must include involvement of the minor's parent or guardian unless the professional person treating or counseling the minor determines that their involvement would be inappropriate. This bill requires the professional person treating or counseling the minor to consult with the minor before determining whether involvement of the minor's parent or guardian would be inappropriate. This decision and any attempts to contact parents must be documented in the minor's record.

If the minor consents or could have consented to care, the provider may only share the minor's health information with their parents or guardian with the signed authorization of the minor. This is true even if in consultation with the minor, it is determined that the minor's parents can be informed and involved in treatment.

See Memo 2024-01 on the QA Manual page of the Provider website for more information.

Minor Consent Medi-Cal

Per Medi-Cal Eligibility Procedures Manual, section: 50147.1; 50163, persons under 21 years of age may apply for *Minor Consent Medi-Cal* coverage without their parents' consent or knowledge. Minor consent cases are confidential, and no contact or communication will be directed to the parents or guardian(s).

Minor consent services are supported with State funds only. Services provided through Minor Consent

Medi-Cal are more limited than full-scope Medi-Cal and include the following:

- Under Age 12: Pregnancy and pregnancy related care, family planning services, sexual assault services
- Age 12 and older: sexually transmitted diseases treatment, drug and alcohol abuse treatment and counseling, mental health outpatient care, pregnancy and pregnancy related care, family planning services, sexual assault services

Minors must apply for minor consent services themselves. Parent(s) may not apply on behalf of their minor child. Additionally, parents are not required to contribute to the cost of minor consent services. However, they are required to pay for their share of any services they participate in (e.g. family counseling).

Minor Consent Medi-Cal benefits are administered through the Alameda County Social Services Agency. For more information, please review the Medi-Cal Eligibility Procedures Manual.

Protected Health Information (PHI)

Federal regulations create the baseline for data privacy and security provisions for safeguarding protected health information. Summaries of the HIPAA Privacy Rule and HIPAA Security Rule can be found on the HHS website. When another federal or state regulation or rule applies (ex. 42 CFR Part 2, W&IC 5328), the stricter rule must be followed.

Providers are required to follow all privacy regulations to ensure the safety of member records and to fully comply with the following policy and procedures on the ACBHD Policy and Procedures webpage:

- *350-3-1 Privacy, Security and Confidentiality Statement of Client Services, Records and Information*
- *1702-1 Record and Data Retention and Destruction of Protected Health Information*
- *1704-1-1 Privacy and Security Incident Reporting*

Provider Notification Requirements

There are several ACBHD and DHCS notification requirements. Additional requirements may be specified in regulations, licensing standards, provider contracts, etc. Whenever a contracted provider is required to notify DHCS, they must also notify ACBHD. Below is a list of some of these requirements. Note that the list is not exhaustive:

- Providers must notify ACBHD Information Systems (IS) immediately using the Web Portal/E-Form if any of their staff with access to protected health information (PHI) or personally identifiable information (PII) through ACBHD's applications (e.g., Clinician's Gateway, SmartCare, Yellowfin) separate from the organization or change functions and no longer need this access so that

ACBHD can terminate/revoke access.

- Providers must notify ACBHD Operational Lead and Fiscal Contract Manager of changes to key personnel within five (5) business days of the change by submitting a Provider/Program Change Notification Form.
- Providers must notify ACBHD of changes in employees, volunteers, board members, agents (clinical and non-clinical) providing and/or supporting Federally-funded services and/or goods under their ACBHD contract using the Web Portal/ E-Form.
- Providers must submit *Unusual Occurrence Notifications* per ACBHD policy. See section 6 of the QA Manual for policy and notification form.
- Providers must issue Notices of Adverse Benefit Determinations per ACBHD policy. See the following resources for more information:
    - Policy titled *Notices of Adverse Benefit Determinations for Medi-Cal Beneficiaries* in section 300-1-2 of the ACBHD Policy and Procedures page
    - Section titled *Notice of Adverse Beneficiary Decisions* on the QA Manual/Grievance Systems webpage

Medi-Cal Eligibility Check

All providers are required to check Medi-Cal eligibility at intake and ongoing during the first week of each month that services are being claimed to Medi-Cal. This activity must be documented in the clinical record. If a beneficiary loses Medi-Cal eligibility, the provider must assist the beneficiary in regaining Medi-Cal.

For questions, or to determine funding sources in complicated cases, e.g. Medi-Cal-Medicare dual eligible individuals, contact *ACBH Billing & Benefits Support Unit - Outpatient Health Information Technician (HIT)* at (888) 346-0605.

General Documentation Requirements

Whether using the ACBHD Electronic Health Record (EHR) system, an agency specific EHR or keeping paper records, the following documentation requirements must be followed:

- Records are organized and divided into sections according to a consistent standard, allowing for ease of location and referencing.
- Records are sequential, and date ordered.
- Paper records are fastened or stapled together to avoid loss or being misplaced. There are no loose papers or sticky notes in the chart.
- All entries, including signatures, are legible.
- Only black or blue ink is used to document services across all chart entries.
- Progress Notes are filed in clinical records.
- Every page includes two forms of member identification (name, identification number, date of

birth, etc.). [1]

- Names of other members are not used in the record. In cases where reference to another member is needed, initials or other methods are used to safeguard the other individual's identity.
- Each Progress Note is distinct and reflects the member's response on the day of service. The same content is not copied/pasted across multiple notes.
- Notes, once finalized, are not deleted or removed from a chart.
- Note corrections for paper records are made by drawing a single line through the error, indicating the word "error", including the initials of the person making the corrections and the date. Correction tape/fluid is not used and there are no scribbles over the incorrect note.
- Only original authors of the entry make alterations. Reviewers or supervisors do not edit an entry by the original author but may supply an addendum with dated signature.
- Only universal and County-approved acronyms and abbreviations are used. See document titled *Standard Abbreviations* in section 7 of the QA Manual.
- All entries are dated based on the time and date they are documented. Late entries are noted as "late entry" and correct date of service indicated in the note.

Electronic Signatures

California approved the use of electronic signatures in electronically signed records as equivalent to a manual signature affixed by hand for financial, program, and audit purposes. ACBHD requires that electronic signatures meet the following standards[2]:

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

Assessments

Sharing Assessments Between Providers

If a current assessment, completed by another ACBHD affiliated entity (CBO or County clinic), is shared with a new treating provider, the assessment may be used to streamline the documentation process if:

- The assessment meets SMHS assessment requirements.

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[1] Joint Commission National Safety Goals
[2] California Civil Code - CIV § 1633.2

- The assessment is reviewed with the member to ensure accuracy, and this activity is documented in a Progress Note.
- Needed updates to the assessment are documented in an Assessment Addendum or Progress Note.
- A copy of the assessment received from the separate provider is kept in both charts.

Compliance with assessment requirements is the responsibility of the treating provider.

Risk Assessment and Safety Planning

All clinical records should include a complete risk assessment, including information related to personal and family history of risk of harm to self or others.

When risk is identified, within the last 90 days, a formal written safety plan should be created in partnership with the member and included in the clinical record. When appropriate, a copy of the safety plan should be provided to the member. As safety screening and risk assessment are ongoing processes, Progress Notes, Problem Lists, Care Plans and other pertinent notes should be updated to indicate changes to a member's level of risk and steps taken to ensure safety, including updates to the Safety Plan, as needed.

There are multiple online resources available to assist with risk screening and safety planning. The following are links to helpful resources available on national websites:

- General information: NIMH » Suicide Prevention (nih.gov)
- Suicide Risk Screening tools: NIMH » Ask Suicide-Screening Questions (ASQ) Toolkit (nih.gov)
- Suicide Assessment Five Step Evaluation and Triage: SAFE-T

Required Assessment of ICC, IHBS, and TFC

Per BHIN 21-058, mental health plans are required to provide Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) to all children and youth under the age of 21 eligible for full scope Medi-Cal and who meet medical necessity criteria for these services. Membership in the Katie A class or sub-class is not a requirement for this assessment to occur and services to be provided. These services are protected as part of the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) when necessary to correct or ameliorate defects and mental illnesses or conditions for beneficiaries under age 21 eligible for full scope Medi-Cal (42 U.S.C. § 1396a (a)(43) and 42 U.S.C. § 1396d (r)).

Providers are required to complete individualized screening for these services and document this activity in the Assessment. If the beneficiary can benefit from these services a referral must be provided promptly.

The ACBHD assessment form includes a section for this assessment. Providers are encouraged to build a

similar template in their own Electronic Health Record systems.

See training titled *Intensive Care Coordination, Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC)* on the QA Training page for more information.

Assessment Tools: CANS and PSC-35

The following assessment tools are required for children and adult beneficiaries:

- Child and Adolescent Needs and Strengths (CANS) is a standardized tool, used for ages 0-24, to quantify and document outcomes and levels of functioning in common life domains.

- The Pediatric Symptom Checklist (PSC-35) is a parent-report questionnaire designed to identify children with difficulties in psychosocial functioning. A positive result on the overall scale indicates that the child would benefit from further evaluation. PSC-35 is to be completed by the parent/caregiver for members ages 3- 17 years old.

For more information regarding these assessment tools, see the following resources on the ACBHD Provider website:

- Manuals, Rating Sheets, Policies, Frequently Asked Questions: CANS/ANSA
- Policy titled *1601-1-1 CANS, ANSA, and PSC-35 Implementation:* Policy and Procedure.

Note: Completion of the Adult Needs and Strengths Assessment (ANSA) is no longer required by ACBHD.

Timeliness and Administration of CANS and PSC-35

The CANS and PSC-35 are completed at the time of admission, every six months thereafter, and at closing.

The CANS may only be administered by those who are CANS certified and have the training, experience, and ability to do so. The clinical staff completing the CANS must have a comprehensive understanding of the beneficiary's clinical history to accurately report on each CANS domain. The appropriate CANS version must be used based on the member's age group.

Care Plans

The terms care plan, client plan and treatment plan are generally interchangeable. For most Specialty Mental Health Services, prospectively completed, standalone care plans are not required. However, care planning remains an important component of providing quality services and should be an ongoing and interactive process that is documented in the clinical notes.

Although for most Specialty Mental Health Services, standalone care plans are not required, there are

some services that continue to have specific standards for care planning under state and federal law. Some of these include Enhanced Care Management, Mental Health Services Act Full-Service Partnership (FSP), Individual Services and Supports Plan (ISSP), Peer Support Services, Short-Term Residential Therapeutic Programs (STRTPs), Social Rehabilitation Programs (including Short-Term Crisis Residential Treatment, Transitional Residential Treatment and Long-Term Residential Treatment), Targeted Case Management (TCM) and Therapeutic Behavioral Services (TBS). For a complete list and requirements, see Enclosure 1a of BHIN 23-068.

For services, programs, or facilities for which care plan requirements remain in effect:

1. Providers must adhere to all relevant care planning requirements in state or federal law.
2. Providers should document the required elements of the care plan within the member record. For example, required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an Electronic Health Record.
3. To support delivery of coordinated care, providers should be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws.

Medi-Cal behavioral health delivery systems shall not enforce requirements for the location, format, or other specifications for documentation of the care plan.

Progress Notes

Progress notes have multiple important functions, including documentation of the individual's condition, treatment interventions, and intended next steps, and serve as a communication tool to alert other practitioners (or the person in care) of the status of treatment.

The information provided in this section is in addition to the general daily note requirements as described in the CalMHSA CalAIM Documentation Guides. In general, Progress Notes must include the following elements:

- The type of service rendered
- The date that the service was provided to the member
- Duration of direct patient care for the service
- Location/place of service
- A typed or legibly printed name, signature of the service provider, and date of signature
- A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors)
- A brief summary of next steps

In order to submit a service claim for reimbursement, there must be a complete and signed progress

note for that service within the required timeframe. Once a progress note has been signed, the clinical content of the service may not be changed. Clinician's Gateway (CG) allows for a clarifying addendum, with the original text remaining unchanged, after a note has been signed. Providers not using CG may use a similar addendum feature in their Electronic Health Records.

Language and Interpretation Needs

Members must be provided with services in their preferred language. Each time an intervention is provided to a member that is not in English, the corresponding progress note should include the method used for language assistance and the language used to provide the services.[3] Examples: "Alameda County's language interpreter line was used by phone to translate Farsi." "Client's mother participated in treatment today and since she primarily speaks Spanish, our agency's Spanish interpreter attended session to help with translation."

Family members or friends present in a session may not act as interpreters. The exception would be in a crisis while attempts to get an interpreter are being made and have not been obtained yet. A provider that has some language proficiency but is not fluent enough to discuss complex treatment needs in the preferred language may not act as an interpreter. Interpreters used should convey to the member or to the provider as accurately as possible exactly what is said. Interpreters should not engage in assessment or interventions unless they themselves are the provider.

See policy titled *24/7 Language Assistance to Beneficiaries*, in section 100-2 of the ACBHD Policy and Procedures webpage.

Group Services

When a group service is rendered, a list of participants must be documented and maintained by the provider, outside the clinical record. Every participant must have a progress note in their clinical record noting their attendance in the group. In addition to the required elements of a Progress Note mentioned above, the note should include a brief description of the member's response to the service.

Notes for services involving one or more providers should also include: a) Total number of providers and their specific involvement in delivering the service, b) Time involved in delivering the service for each provider.

When more than one provider renders a service, either to a single member or to a group, at least one Progress Note per member must be completed. The note must be signed by at least one of those service providers. The Progress Note must clearly document the specific involvement and duration of direct

[3] W&IC § 14029.91

patient care for each provider of the service.

Daily Notes

Daily notes are required for documentation of some residential services, day treatment, and other similar settings that use a daily rate for billing. Daily notes contain the same elements required for Progress Notes.

Services for Children and Youth

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. See *EPSDT Chart Documentation Manual* in the *Specialty Services* section of the QA Manual for more information.

ICC, IHBS and TFC

Per BHIN 21-058, mental health plans are required to provide Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) to all children and youth under the age of 21 eligible for full scope Medi-Cal and who meet medical necessity criteria for these services.

Detailed information regarding these services is posted in the *Specialty Services* section of the QA Manual.

Therapeutic Behavioral Services (TBS)

TBS services are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED) and are experiencing a stressful transition or life crisis that necessitates additional short-term, specific support services.

TBS is never a primary therapeutic intervention and is always used in conjunction with a primary specialty mental health service. TBS is designed to support clients to be successful in their current environment or to transition to a lower level of care.

Detailed information regarding TBS can be found on the QA Manual page of the provider website.

Staff Qualifications for Service Delivery and Documentation

Providers should ensure, on an ongoing basis, that all staff credentials are up-to-date and maintain documentation of all staff persons' qualifications and their supervision schedule to support their level of service provision.

Individuals providing SMHS may only perform activities within their scope of practice that they have the education, training, and experience to competently provide. Any given discipline's scope of practice is established through legislative statutes[4] and rules adopted by relevant credentialing entities.[5] The CA State Plan, Section 3, Supplement 3 to Attachment 3.1-A (SPA 12-025), CA Business and Professions Code Div. 2 Healing Arts, and Cal. Code Regs, tit. 9, 1840.314 provide additional clarification regarding scope of practice requirements.

The ACBHD QA team has created reference documents to assist with ensuring that services are provided in compliance with the scope of practice requirements. These documents can be found in section 12 of QA Manual and include *MH and SUD Provider Definitions and Qualifications*, and *ACBHD Guidelines for Scope of Practice (MH).*

Oversight of Service Delivery

All services provided to members must be "under the direction of" a Licensed Mental Health Professional (LMHP), who assumes ultimate responsibility for the services provided.

"Under the Direction" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery. An individual directing a service is not required to be physically present at the service site to exercise direction.

A Licensed Mental Health Professional (LMHP) includes any of the following providers:

- Licensed Physicians
- Licensed Psychologists (includes waivered psychologists)
- Licensed Clinical Social Workers (includes waivered or registered)
- Licensed Professional Clinical Counselors (includes waivered or registered)
- Licensed Marriage and Family Therapists (includes waivered or registered)
- Registered Nurses (includes certified nurse specialists and nurse practitioners)
- Licensed Vocational Nurses
- Licensed Psychiatric Technicians
- Licensed Occupational Therapists

[4] E.g., CA Business and Professions Code Div. 2 Healing Arts
[5] E.g., CA Board of Behavioral Sciences, CA Board of Psychology, Medical Board of CA, CA Board of Registered Nursing

Supervision Requirements

All clinical services provided by non-licensed practitioners must meet oversight and supervision requirements per the applicable licensing board, accreditation, or credentialing entity.

The document titled *ACBHD Guidelines for Scope of Practice (MH),* in section 12 of QA Manual provides detailed information regarding the scope of practice, oversight and co-signature requirements for different staff disciplines. **Where there is a difference between this document and the Scope of Practice grid in the CalMHSA Clinical Documentation Guide, the *ACBHD Guidelines for Scope of Practice (MH)* should be followed.**

For additional information regarding supervision requirements, please contact the applicable board or credentialing entity:

Medical Board of California
Osteopathic Medical Board of California
California Board of Registered Nursing
Board of Behavioral Sciences
California Board of Occupational Therapy
California Board of Psychology
California Board of Vocational Nursing and Psychiatric Technicians
California Physician Assistants Board
California State Board of Pharmacy

Peer Specialists and Medical Assistants do not have a state credentialing board, please refer to the following resources for more information: Certified Peer Specialists, Medical Assistants.

Credentialing/Recredentialing Requirements

All new and existing ACBHD providers are required to submit information and any applicable updates necessary to complete credentialing or re-credentialing verification, as stated in the policy *1603-3-2-Credentialing and Re-Credentialing Verification for ACBH Mental Health and Substance Use Service Providers* on the Policy and Procedure webpage. Providers are required to create, maintain, and attest every 120 days to the accuracy of their electronic provider profile application. Attestation and disclosure occur during onboarding of a new provider, and a new attestation is required at every credentialing or re-credentialing event thereafter. Please review the policy for more details.

Professional Licensing Waivers

To provide Medi-Cal SMHS, DHCS requires professional licensing waivers for the following individuals:

- Psychologists who are gaining the “experience required for licensure”
- Psychologists, clinical social workers, marriage and family therapists, or professional clinical

counselors who have been recruited for employment from outside California and whose experience is sufficient to gain admission to a licensing examination

See the following resources for detailed information about this requirement:

- Policy 1603-3-1 Professional Licensing Waiver on Policy and Procedure webpage
- Section 3 of the QA Manual

Service Descriptions and Billing

Medi-Cal SMHS includes a variety of treatment services provided to individuals, groups and/or families. The reference document titled *Service Descriptions MH and SUD*, posted in section 12 of the QA Manual provides detailed information about Medi-Cal covered services and their descriptions.

Procedure Codes

On July 1, 2023, California behavioral health Medi-Cal adopted a new Healthcare Common Procedure Coding System (HCPCS) code set. This new code set consists of a combination of HCPCS Level I (Current Procedural Terminology - CPT) and HCPCS Level II codes.

Below are helpful resources related to procedure codes:

- DHCS Short Doyle Medi-Cal Manuals and Service Tables published on DHCS MedCCC
- American Medical Association's (AMA) CPT codebooks
- ACBHD QA Manual
    - Section 13- Service and Billing Resources
    - Section 19-6 – HCPC/CPT Code FAQs
- ACBHD QA Training
    - Current Procedural Terminology Training
- CalMHSA Training Modules
    - Registration is required to gain access to the modules

Evaluation and Management (E/M) CPT codes have distinct chart documentation requirements that must be met when using these codes. E/M coding resources may be found below:

- AMA E/M Coding Guide 2023
- CMS MLN906764_Evaluation_and_Management_Services_Guide_2023-08 (cms.gov)

Medi-Medi Billable Services (Medicare and Medi-Cal)

Individuals who are Medicare/Medi-Cal dual-eligible are commonly referred to as Medi-Medi beneficiaries. As a general rule of medical billing, services must be provided and documented to standards specified by the entity that ultimately pays for the service. For Medi-Medi beneficiaries, it is

typically unknown at the time of the service/documentation how the claim will be paid. For most programs, the simplest solution is to document services to the higher standard between Medicare and Medi-Cal.

Per the DHCS SMHS Billing Manual, Medi-Cal is the payer of last resort. This means that providers must submit claims to Medicare for Medi-Cal eligible services, performed by Medicare-certified providers in a Medicare certified facility, before submitting a claim to Medi-Cal. The claim submitted to Medi-Cal must include Other Health Coverage (OHC) information. Medi-Cal will reimburse the county the difference between the amount it would normally pay and the amount that Medicare already paid.

Specific Medicare documentation and billing standards are beyond the scope of this document, however for more information about Medicare requirements in California, please refer to guidance provided by Noridian Healthcare Solutions, the provider of administrative services for Medicare in Jurisdiction E, Part B. Additional information about Medicare billing requirements can be found in DHCS' SMHS Billing Manual on the DHCS MedCCC Library.

Progress notes must contain the minimum Medi-Cal service information requirements, per CalMHSA's Clinical Documentation Guide, as well as the following to be billable to Medicare:

- ACBHD SmartCare Code AND Medicare CPT Code of the service provided
- Face-to-face time and total time to provide the service
- ICD-10-CM Diagnosis
- Exam findings and prior test results, if applicable
- Member's progress: Response to treatment and changes in treatment, member's level of compliance, revision of diagnosis.
- Plan of care: Treatments, medication, member/family education, follow up instructions and discharge plan.

The above is not an exhaustive list. All providers who claim to Medicare are responsible for meeting Medicare clinical documentation standards.

Documenting Lockouts

The California Code of Regulations prohibits some mental health services from being provided to a member on the same day or states that those outpatient services are part of the bundled residential or 24-hour service. Sometimes lockouts can be overridden with an appropriate modifier.

The DHCS Services Tables on the MedCCC library identify the combination of procedure codes that cannot be billed for the same beneficiary on the same day, as well as modifiers, when available. Lockout codes that do not have a modifier will be denied when locked out services are provided to the same beneficiary by the same provider on the same day.

When a mental health service is provided to a member in a lockout situation, a Progress Note for that

service should still be written and noted as "non-billable".

One example of a lockout situation, ineligible for Medi-Cal billing, is services provided to a member in juvenile hall. However, according to CCR, title 22, section 50273(c)(5), a dependent minor in a juvenile detention center is eligible for Medi-Cal after adjudication for release into community, meaning that the juvenile is only in the facility, awaiting placement into a Short Term Residential Therapeutic Program (STRTP) or another setting.

In these situations, to minimize the risk of disallowance, evidence of a placement order should 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 such documents are not available prior to providing necessary services, the provider may use a Progress Note to document a member's adjudication status as reported by a reliable source that is identified in the note, while continuing to make efforts to obtain paper evidence.

Additional details regarding Lockout situations can be found in the document titled *MH Lockout Grid* in section 13 of the QA Manual**.**

Network Adequacy Reporting Requirements

DHCS requires Mental Health Plans (MHP) to track and report data demonstrating timely access to services for all beneficiaries. To meet this requirement, providers are required to participate in Client Service Information (CSI) Assessment Timeliness Data Reporting for all new members (Medi-Cal and Medi-Cal eligible) who are new to the MHP, and all New Returning members that have not received outpatient services in the past 12 months in the MHP system. See training titled *Client Service Information (CSI) Data Documentation for Specialty Mental Health and Substance Use Disorder Providers* and corresponding documents on the QA Training page for detailed information.

Clinical Quality Review Team (CQRT)

The contract between Alameda County Behavioral Health Department (ACBHD) and the Department of Health Care Services (DHCS) requires ACBHD to certify that claims made to Medi-Cal meet Federal and State requirements for medical necessity and documentation. The CQRT process was created to perform this required function and involves review of clinical documentation by service providers during specific review cycles to certify that it meets Medi-Cal requirements.

The CQRT process is initially performed by the ACBHD Quality Assurance team and gradually transitioned to providers to be completed independently on a monthly basis. All contracted agencies are required to participate in the CQRT process. CQRT Checklists must be retained for a period of 10 years. Agencies are required to provide the County with their completed CQRT Checklists and CQRT Tracking Tools when requested. This can occur at the time of a scheduled chart audit or more informally as determined by the County.

For more information regarding this process and relevant resources, please see Section 8 of QA Manual.

Audits and Recoupment Risk

Providers offering SMHS are subject to periodic audits of their clinical records by DHCS and ACBHD. The purpose of these audits is to ensure that services that are provided are consistent with clinical best practices and follow the Medi-Cal requirements. Recoupment of claims will focus on issues of overbilling, fraud, waste, and abuse.

Non-Reimbursable Activities

The following are common activities provided by SMHS providers that are not billable to ACBHD or DHCS:

- Services provided while the beneficiary's Medi-Cal is "locked out." E.g., Jail without adjudication, IMD exclusion, etc.
- Services that are fraudulent, redundant, excessive, wasteful, or not medically necessary.
- Any service after the beneficiary is deceased, including services to collateral supports of the deceased.
- Preparing documents for court testimony for the purpose of fulfilling a requirement. When the preparation of documents is directly related and reflects how the intervention impacts the beneficiary's behavioral health treatment and/or progress in treatment, then the service may be billable.
- Completing reports for mandated reporting such as to Child Protective Services or Adult Protective Services.
- Texting or emailing a member.
- When a service is not provided. These include billing for:
    - The missed appointment
    - Documenting a missed appointment
    - Time spent waiting for a "no show"
    - Traveling to a site when no service is provided due to a "no show"
    - Leaving a note on the door of a beneficiary or leaving a message on an answering machine or with another individual about the missed session
- Personal care services provided to individuals such as grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals.
- Purely clerical activities such as faxing, copying, calling to reschedule/schedule an appointment, calling to check on results of a tox screen.
- Recreation or general play.
- Socialization that consists of generalized groups that do not provide systematic individualized feedback to the specific targeted behavior.
- Childcare/babysitting.

- Academic/Educational services. For example, teaching an academic subject such as math or reading.
- Vocational services that have work or work training as their actual purpose
- Supervision of clinical staff or trainees.
- Utilization management, peer review, or other quality improvement activities.
- Money Management services and Payee related activities, such as cashing checks, bringing money, buying clothes for the beneficiary.
- Transportation, meaning the time it takes a provider to transport a member from one location to another. However, if a clinical activity takes place while transporting a member, the time can be reported as the clinical activity provided. Also, time spent connecting a beneficiary to transportation services (such as paratransit) is claimable as care coordination.

Frequently Asked Questions (FAQs)

The QA Manual includes a section that contains FAQs on various topics. Providers are encouraged to check that section for additional information on documentation and other relevant topics.