YOLO COUNTY

ALCOHOL, DRUG & MENTAL HEALTH DEPARTMENT

CLINICAL GUIDE

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December 2009

For Questions, Email: ADMH-FAQ@yolocounty.org

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Introduction

This Clinical Survival Guide is a "Living Document". It is updated constantly as methods and practices evolve. "The Mental Health Plan (MHP) has the authority to administrate and authorize services according to program and organizational need." (Welfare and Institution Code 14680-14684). Changes in the guide are influenced by updates in the California Code of Regulations, Title 9, State and Federal regulations, and MHP contractual requirements, applicable MHP policies and procedures, and new policy and changes dictated by ADMH Executive Management, and discussion that occurs during regular meetings throughout the department, as well as bright ideas by staff.

In the spirit of ensuring the highest quality service to our consumers, the Yolo County Alcohol, Drug and Mental Health Department (ADMH) is committed to working towards completion of goals relating to service delivery, accessibility to ADMH services, quality services provided as measured by client satisfaction, and appropriately coordinating with other providers and professionals when necessary. We do this through incorporating Wellness and Recovery into all work with consumers.

We welcome your feedback, concerns and questions. FAQ's will be updated regularly on the ADMH Intranet. Please contact the Quality Management office with your input and questions at (**ADMH FAQ@yolocounty.org**).

Thank you.

The Quality Management staff

This guide is in compliance with the following Federal and California statutes:

- Federal Social Security Act XIX
- Code of Federal Regulations (CFR) – Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II)
- California Welfare & Institutions (W&I) Code
- California Code of Regulations (CCR), Title 9

This document is available in the Quality Management office and can also be referred to and downloaded at: **http://insideyolo/ADMH/Clinical Survival Guide.pdf**

All notes must use the following acronym guidelines:

PIRP

Presenting Problem — **I**nterventions — **R**esponse — **P**lan

P **Presenting Problem** and Place (Identify Location and City to justify travel time. This is necessary when great distances are travelled.) The staff must justify why the service is ***medically necessary*** (i.e., this writer provided an individual therapy session with a client complaining of angry feelings).

I **Interventions** the clinical staff provided to the client to either assess further or to address the treatment goals (e.g., this writer worked with the client on thinking before acting on impulsive responses such as fighting by utilizing cognitive behavioral interventions). Translation services and Transportation ***are not*** considered billable interventions.

R **Response** by the client or collateral contact support to the interventions utilized. Be specific and the response should be accurate (e.g., the client was apprehensive to count to 10 before acting on anger impulses).

P **Plan** for the client's future treatment. What is it that the client hopes to do in the future? When making plans for future sessions, indicate which treatment goals will be the focus. Be specific (i.e., the client's goal is to refrain from physical or verbal abuse of sibling. In order to continue working on the plan, we will revisit counting to ten and will also discuss anxieties that arise during conversation with sibling).

In addition to PIRP format, all notes must include the following at the start of the note

- **"Start Time":** This is the specific start time when staff begins working with a client, collateral or case management contact in person or via telephone. This must be documented to the minute. (For instance, an individual session time begins at 2:03 p.m. The Clinician would document 2:03 p.m. in the "start time"). This does not apply to notes that combine Case Management Brokerage or Plan Development services that occur in the same day for the same client regarding the same issue.
- **"Travel Time":** If traveling to provide services to a client, travel time can be billed. If traveling outside of the county, please document how much time was spent in travel. The time spent traveling from home to an appointment or from an appointment to home is not billable.
- **Total Time:** This includes the time it takes for providing the services, documenting the services and the travel time added together. You will note that throughout the guide, this is included in the example progress notes, however in AVATAR, this will be completed in the "Minutes billed" section (in a new note) or settled in the Post Staff Activity Log.

Some Interactive Verbs Useful in Writing Progress Notes		
acknowledged	discussed	offered feedback
analyzed	encouraged	reality tested
assisted	examined	re-framed
clarified	explained	reviewed
confronted	explored	role-modeled
consulted	helped	supported
demonstrated	interpreted	

SPECIALTY MENTAL HEALTH CARE

Any Progress Note written must include: PIRP format and documentation of a Client's Medical Necessity.

Specialty Mental Health Services are services that are deemed to be medically necessary.

Services may be brief, extended or long term. Specialty Mental Health Services include:

- Mental Health Services, Medication Support, and Targeted Case Management
- Day Treatment Intensive and Day Rehabilitation Services
- Crisis Intervention, Crisis Stabilization, Crisis Residential; and
- Adult Residential Treatment

Specialty Mental Health Services can be face-to-face or by telephone and may be provided anywhere in the community. Specialty Mental Health Services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning to achieve independent living and enhance self-sufficiency. When providing to seriously emotionally disturbed children and adolescents, Specialty Mental Health Services provide a range of services to assist the child/adolescent in gaining the social and functional skills necessary for appropriate developmental and social integration.

Medical Necessity:

Medical Necessity is the principal decision criteria used by the Mental Health Plan to determine authorization and reauthorization for covered services. Medical Necessity must exist in order to determine when mental health treatment is eligible for reimbursement under plan benefits. Medical Necessity refers to client's level of functioning that disrupts or interferes with community living to the extent that decompensation would result without service, resulting in significant functional impairments.

To meet medical necessity, a client:

- must have an "included in Title 9" Axis I diagnosis
- must meet functional impairment criteria (significant impairment in important area of life functioning or probability of significant impairment)
- will benefit from intervention by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning
- would not respond to physical healthcare

In addition to meeting the Title 9 definition of Medical Necessity, in order for clients to receive mental health treatment through YCADMH, s/he must also be considered "Seriously Emotionally Disturbed" (for children or adolescents) or "Seriously and Persistently Mentally Ill" (for Adults). Please see the Welfare & Institutions Code (attached) for more information.

For all clients the Medical Necessity tool must be completed. The diagnosis must be on Medi-Cal's included list of MH diagnoses. Medical Necessity must be documented throughout treatment in the Client Plan and in all Progress Notes. If at any point in time Medical Necessity does not exist, billable charges should not occur.

It is equally important to continue to document medical necessity later in treatment by:

- stating the residual symptoms that require continued treatment, or
- stating the level of intervention and support required to enable a safe transition to a lower level of service.
- stating the level of intervention needed to enable maintenance level treatment or service.

Other requirements to bill Medi-Cal

1. A current treatment plan must be in place. These are completed no less than annually. If the client is unable to sign, please document the reason.
2. There must be an active, accurate, and included diagnosis in AVATAR to bill any services.
3. A current assessment must be completed.

STATE DEPARTMENT OF MENTAL HEALTH MEDI-CAL MANAGED CARE PROGRAM SUBCOMMITTEE
SPECIALITY MENTAL HEALTH CONSOLIDATION PART II

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

A. Diagnoses

Must have one of the following DSM IV-TR 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, Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorder
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions that may be a Focus of Clinical Attention, except Medication Induced Movement Disorders, which are included.

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 *either* 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 client 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.

SERIOUSLY EMOTIONALLY DISTURBED/SERIOUS MENTAL DISORDER CRITERIA FROM THE WELFARE AND INSTITUTION CODE 5600.3

"Seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in a behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria.

A. As a result of the mental disorder the child has substantial impairment in at least two of the following areas:
   1. Self-care
   2. School functioning
   3. Family relationships, or
   4. Ability to function in the community; and

. and either of the following occurs
   a). The child is at risk of removal from home or has already been removed from the home; or
   b). The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or

B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or

C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

"Serious mental disorder" as it relates to adults means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. Members of this target population shall meet all of the following criteria.

A. The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

B. As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

C. For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

D. As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

Service Activity Codes

Note: Brief review of records prior to a session may be included in the appropriate billing code for that session.

Assessment

Initial Assessment Code: 1530

Assessment is defined as a service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. For Adults, full assessments are to be completed no more than 3 years apart. For Children, an assessment must be completed annually.

Assessment is a service activity that typically includes:

- gathering information regarding a client's presenting problems and symptoms
- a clinical analysis of the client's mental health history
- a current status of a client's mental, emotional or behavioral disorder
- a mental status determination
- an analysis of relevant cultural issues and history
- identification of client's strengths
- a five Axis diagnosis
- documentation of medical necessity

An initial assessment is completed when:

- a client is entering treatment for the first time
- an adult client has received services for 3 years
- a client is returning to treatment after the chart has been closed for more than 6 months
- Licensed/Registered/Waivered Staff completing Triage and Care Assessments

If necessary, assessments may be completed with the assistance of language interpreter or some other device to assist communication, such as play equipment, physical devices, or other mechanisms of communication for purposes of diagnostic assessment (i.e., use of language line). Assessment is also billed when completing psychological testing, for those individuals whose scope of practice includes psychological testing.

Note: Documentation of assessment must include that the clinical staff reviewed, explained, and had the client or guardian sign the following required paperwork**: HIPAA Privacy Practices, Problem Resolution and Advanced Directives (if applicable).** It also requires reviewing and explaining the Provider List, the Guide to Mental Health Services (Informing Materials), and evidence that Cultural and linguistic needs were discussed and offered (if applicable). The Acknowledgement of Receipt form must be completed and signed.

In addition, please note that any diagnosis of "Not Otherwise Specified (NOS)" must be changed within 6 months of the diagnosis.

Billable Activities:

- Meeting with a client in the office to complete intake paperwork and to gather information to complete assessment
- Completing the assessment and formulating the diagnosis.

Sample Notes:
Start Time: 3:02 PM
Total Time: 76 min.

P *– Client was seen for intake in Woodland office. Client presents with complaints of sleep disturbance, appetite disturbance, problems with family, inability to keep employment and mood cycles which result in over spending and inappropriate sexual behavior. Client appears depressed but denies any suicidal/homicidal ideation. Client denies drug use. Client is currently on unemployment, which will soon run out. Recently during an "upswing", client was arrested in another county for causing a disturbance at a store. Has a history of four psychiatric hospitalizations during the last two years, the first at age 23.*

Diagnosis:
Axis I: 296.4 Bipolar Disorder
Axis II: V71.09 No diagnosis
Axis III: 799.9 deferred
Axis IV: Primary, employment, legal, financial
Axis V: GAF = 50

I *– The psychosocial assessment is the intervention. In addition, the following information was reviewed, explained, and signed:* ***Informing Materials, HIPAA Privacy Practices, Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Provider List, Acknowledgement of Receipt form and Cultural/Linguistic*** *issues were also reviewed.*

R *– Client understands this session is an assessment and still needs approval for services. During intake, client answered questions with one word answers, and was fidgeting frequently in her chair. Approx. halfway through the assessment, client asked "how much longer is this thing going to take?" and rolled her eyes when this writer informed client that there were several questions still needing to be answered.*

P *– Will present to supervisor for disposition of services. Subsequent to authorization for ongoing outpatient mental health services, client will return to develop client plan.*

Start Time: 2:01 PM

Total Time: 93 Min.

P *– Met with client and mother in West Sacramento Clinic to complete intake paperwork. Client is a 9 year old Caucasian female, presenting with difficulty sleeping, weight loss (Approx. 10 pounds in the past month), and having great difficulty communicating with peers or family. Client answered a couple of questions with a "yes" or "no" answer, however client was mostly non verbal during the intake. She made little eye contact and hid her face behind her long hair. Mother reports that about three months ago, client began having a great deal of difficulty focusing in class, and client's grades have begun falling. Mother also reports frequent crying spells. Mother denies any trauma or abuse of client; client shook her head in response to the question. Mother reports that she and father are divorced; father lives out of state and has had little contact with client for several years.*

Diagnosis

Axis I: 311.0 Depressive Disorder, NOS
V61.20 Parent-Child Relational Problem
Axis II: V71.09 No diagnosis
Axis III: 799.9 deferred
Axis IV: Primary, Social, Educational
Axis V: GAF = 42

I** – This session was interactive because of the utilization of sand tray with client to assist client in being able to provide information. The psychosocial assessment is the intervention. In addition, the following information was reviewed, explained, and signed:* ***HIPAA Privacy Practices, Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Acknowledgement of Receipt form, Cultural/Linguistic needs and Provider List.

***R** – Client understands this session is an assessment and still needs approval for services. Client remained non verbal, but pointed to a monkey and then herself to indicate the monkey represented her, and then pointed to an elephant and to mother to indicate that elephant represented mother. Client then spent the majority of the time in the intake showing the monkey chasing the elephant around the sand tray.*

***P** – Will present to supervisor for disposition of services. Subsequent to authorization for ongoing outpatient mental health services, client and mother will return to develop client plan.*

Reassessment Code: 1532

Evidence of a reassessment is to be completed no more than 2 years from the most recent assessment or reassessment. Evidence of a reassessment can include completing the Reassessment Documents or completing a reassessment progress note with the appropriate information.

It is also appropriate to complete a reassessment when there has been a significant change in the client's life, or there a situation occurs which may have a clinical implication.

This code is used when completing the reassessment form. Other paperwork that must be completed at that time includes: **Acknowledgement of Receipt form (including reviewing the Informing Materials; HIPAA Privacy Practices; Provider List; Confidentiality and the Limits of Confidentiality; Linguistic, Cultural, and Ability issues, and Advance Directives (if applicable)); Release of Information; and Consent for Mental Health Treatment.** When documenting this service, there must be documentation that the aforementioned paperwork has been reviewed and signed by the client and/or parent/guardian.

Billable Activities:

- Meeting with a client in the office to complete reassessment paperwork and to gather information to complete reassessment form
- Completing the assessment and formulating the diagnosis

Sample Notes:
Start Time: 9:06 AM
Total Time: 68 min.
P *– Met with client in Davis Clinic to complete annual reassessment and other annual paperwork. Client has a hx of severe major depressive sx, and has been hospitalized three times in the past year for suicide attempts. Currently, Client reports hypersomnia, low appetite, difficulty concentrating, and poor memory, but reports no S/I or H/I. She is currently receiving medication services from YCADMH and reports taking her medication regularly.*

Diagnosis:
Axis I: 296.33 Major Depressive Disorder, Recurrent, Severe without Psychotic Features
Axis II: 799.9 Deferred
Axis III: 799.9 Deferred to MD
Axis IV: Problems with the social environment
Axis V: GAF = 50

I *– The psychosocial reassessment is the intervention. The following information was reviewed, explained and signed:* ***Informing Materials, HIPAA Privacy Practices, Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Acknowledgement of Receipt form Provider List and Cultural/Linguistic issues.***

R *– Client was teary eyed while answering questions, and appeared to have difficulty focusing on the questions, as evidenced by her frequent hesitation in answering questions, apologizing, and asking this writer to repeat the question. While discussing client's suicidal or homicidal thoughts, client denied any currently and verbally contracted for safety.*

P *– Will plan to meet with client next week to discuss and develop new treatment plan goals. Will plan to discuss case with supervisor.*

Start Time: 3:00 PM

Total Time: 93 min.

P *– Met with client and parent in home in Woodland to complete re-assessment and annual paperwork. Client has a hx of disruptive behaviors, including throwing things at other people, fighting with peers at school, and being physically aggressive with younger sister. Client has been receiving services through this agency and with this writer for the past year, and has made some small progress on goals. Client continues to be disruptive in class (e.g., throwing pencils at classmates while the teacher is lecturing, not completing homework, walking out of class) and continues to have difficulty getting along with younger sister. Client has been suspended from school once in the past 6 months, and this was due to starting a fight with another student.*

Diagnosis:
Axis I: 313.81 Oppositional Defiant Disorder
V61.8 Sibling Relational Problem
Axis II: 799.9 Deferred
Axis III: 799.9 Deferred to MD
Axis IV: Problems related to primary support group, Problems related to social environment, Educational Problems,
Axis V: GAF = 52

I *– The psychosocial reassessment is the intervention. The following information was reviewed, explained, and signed by parent and client: Informing Materials, HIPAA Privacy Practices, Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Provider List, and Cultural/Linguistic Issues.*

R *– Mother provided a great deal of information for the assessment because client was unwilling to speak during the assessment, except to indicate that he felt that the child he was in a fight with "deserved it." He refused to explain further about why he felt this way. Client sat next to his mother during the assessment with his arms crossed, refusing to make eye contact with this writer, but laughed when mother brought up the difficulties between client and sibling.*

P *– Will plan to meet with client and mother next week to complete new treatment plan and will plan to discuss case with supervisor.*

Plan Development

Plan Development Code: 1538

Plan Development is a Medi-Cal billable service, but is NOT a Chapter 26.5/AB 3632 allowable service. It is defined as a service activity that consists of development of a plan for the client with intervention(s) and monitoring and recording of a client's progress. The client does not have to be present for this service to be billed.

It also includes the following:

- Monitoring and recording a client's progress with the client and/or the client's identified significant support person(s).
- Development of Client Plans with client participation.
- Adjusting or changing goals, when appropriate.

If cultural issues/considerations and/or linguistic considerations are present, these must be addressed in the treatment plan and documented. It also must be documented and addressed in the treatment plan if the client refuses to sign the treatment plan.

It is permissible to consolidate multiple Plan Development type services into one progress note if the services completed are the same service related to the same issue, completed on the same day.

Billable Activities

- Creating a Treatment Plan
- Creating a plan for a client, including interventions
- Reviewing progress completed on goals with a client with the focus of updating the treatment plan.
- Required annual treatment plan updates (Note: Treatment plan goals must differ from one authorization to the next.)
- Taking information from evaluations or assessments and developing a written plan when client is unable to participate due to severity of mental illness. Once client is able to participate in developing goals, a new plan must be created and signed with participation from the client. If a client is unable to sign the plan, there must be documentation as to why the client was unable to sign, and indicate what the plan is (i.e.-"will plan to attempt to gain client signature at next session.")
- Attending a System Review Meeting (or similar type of planning meeting), and as the attending practitioner or clinical person, presenting information, and working with others to develop a plan for the client.

Sample Notes:
Start Time: 3:46 PM
Total Time: 32 min.
P- Reviewed client's progress on goals and information gathered from school and social worker prior to meeting with foster parents. Met with foster parents in Woodland clinic to discuss future plans for client's treatment. Clt continues to show severe oppositional behaviors

in the home, such as hitting peers, stealing money and jewelry from the foster parents, refusal to follow directions, and breaking objects in the home.
I - Discussed the behaviors and the various interventions that have been previously attempted in the home, such as behavior charts, token system, and time outs. Discussed the possibility of TBS services, as client appears to not be benefiting from 1x a week services and possibly needs more intensive services.
R- Foster parents expressed concern over having TBS come into the home, due to the frequency of services, however agreed that there was a need for more intensive services to deal with these behaviors. Foster mother indicated that they have talked about giving notice on the client, but realize that the client has had several placements this year, and she is concerned that giving notice would cause the client harm. After discussing concerns, the foster parents agreed to try TBS.
P- Will plan to complete a referral for TBS services for client to continue with more intensive behavioral services. In the interim, this writer will plan to schedule an additional session with client to include foster parents per week to address the behaviors of hitting and stealing.

Start Time: 10:01 AM

Total Time: 46 min.

P – Met with client in West Sacramento clinic to formulate the Client Plan that was specific, medically necessary, measurable, observable, specified frequency and duration, and identified client strengths. Client identified frequent hospitalizations and maintaining sobriety as important issues.

***I** – Clinician and client were able to concur on the following as a focus of the treatment plan: reducing the number of hospitalizations, maintaining sobriety and finding a healthier support system. Goals that were identified and agreed upon by the client were identifying and increasing the use of appropriate coping skills and processing feelings of anger, sadness and frustration through constructive means in session.*

***R** – Client appeared pleased with the goals decided upon. Client expressed that he could honestly commit to maintaining medication compliance and sobriety with support from community, family and this agency. Client signed completed treatment plan.*

***P** – This clinician will be following this client to assist in achieving the above named goals; referrals have been made to AA. Will work closely with psychiatrist in monitoring medication compliance in order to reduce hospitalizations. Client will attend area churches to find a healthy supportive network.*

Start Time: 4:04 PM

Total Time: 63 min.

***P** – Met with Client and mother in home, in West Sacramento to complete treatment plan to address the behaviors of not getting along with siblings, fighting in school, and not complying with rules both at home and at school.*

I *– Discussed and formulated treatment plan goals that included reducing argumentative behaviors in home and in school from 7x a day to 3x per week and increasing appropriate expression of feelings (e.g., using "I" statements, using feeling words) from 0x a day to 3x a day.*

R *– Client participated some in developing the client plan, however continually asked why he had to participate in services. Mother was the primary participant in development of the treatment plan. Client verbally agreed to the client plan once it was complete.*

P *– Will plan to type client plan, and will review with mother and client for signatures at the next scheduled appointment. Will plan to review case with supervisor.*

Therapy

Individual Therapy Codes: 1534

Therapy includes the use of psychosocial methods within a professional relationship to assist the client to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential, and/or to modify internal and external conditions that affect individuals, groups or communities in respect to behavior, emotions and thinking. The purpose of therapy is to help and support the client, and may include more than only the client in session, such as a family member. A therapy session may also include services such as developing a client plan, if the development of a client plan was part of an individual therapy session.

Therapy is defined as a service activity that is:

- A therapeutic intervention
- Focused primarily on symptom reduction
- Utilized to improve functional impairments
- May also incorporate using play equipment, physical devices, language interpreter or other mechanism of non-verbal communication.

Billable activities (all with a focus of symptom reduction with the goal of improving functioning)

- Assisting client to process through thoughts and feelings regarding a certain event
- Assisting with a specific problem area
- Identifying obstacles
- Showing client how some obstacle might be overcome
- Helping strategize with client about what they can accomplish.
- Education regarding how symptoms/problem behaviors are interfering with his/her functioning
- Education about how symptoms/problem behaviors might be managed
- PCIT

Sample Notes:
Start Time: 1:59 p.m.
Total Time: 97 min.
P- *Met with client in the Woodland Clinic to address ongoing nightmares, flashbacks, and severe anxiety since client was raped by a former boyfriend. Client reported in this session that her former boyfriend also sexually abused her 4 year old daughter, and she was feeling guilty and depressed about this.*
I- *Discussed with client the need to report this information to Child Protective Services, and client was willing to make the report with this writer's assistance. This writer called CPS, and provided support, encouragement and guidance to client as she provided information to the CPS social worker. After the report was made, this writer processed the experience with client regarding making the report and attempted to reframe the experience in an empowering way.*

Also noted to the client that it was time to complete the treatment plan with goals for treatment for the client. This writer and client discussed the goals of increasing appropriate coping skills for anxiety (such as, writing, going for a walk, talking to a friend, or painting) and increasing assertive behaviors (such as speaking up for herself) to help client feel more empowered and to decrease overall anxiety.

R- *Client reported feeling intimidated and fearful at first regarding the report, however she agreed that it was empowering and that she was doing the right thing to protect her child and possibly other children in the future. Client took the lead on formulating her goals, and indicated that she very much wanted to "get better" and have less anxiety. She was tearful during most of the session, but appeared calm prior to leaving today.*
P- *Will plan to follow up with the verbal report with faxing the completed written report. Will also complete the client plan in AVATAR to plan to review with client for signature at next week's session. This writer provided client with the assignment of journaling her anxiety level on a daily basis, and will plan to review this with client at the next session, as well.*

Start Time: 2:06 p.m.

Total Time: 61 min.

P *– Client was seen in Davis office and she reports that she is having intrusive thoughts and nightmares related to a sexual assault she endured while homeless last year. She has not told anyone about this assault due to her self-blaming about the attack.*

I *– Utilized cognitive tactics to help client understand that she was the victim and did not cause the attack. In addition, this writer explained Post Traumatic Stress Disorder (PTSD) manifestation.*

R *– Client expressed that she felt some relief in discussing the attack, however she was not entirely trusting of clinician's statement that she did not provoke the attack. Client is fearful of going to sleep tonight and experiencing a nightmare.*

P *– Due to client's severe mental illness, this writer is not referring client to Sexual Assault and Domestic Violence Center (SADVC) where she reported she would feel out of place. Will plan to use cognitive techniques and will consult with psychiatrist regarding possible medication changes. Will plan to monitor client closely to ensure she has sufficient support to prevent decompensation.*

Start Time: 4:00 p.m.

Total Time: 58 min.

P *– Client was seen in Davis office to continue work on the goal of appropriately expressing feelings of sadness. Client expressed sadness about feeling rejected by others.*

I *– This session was interactive because of the utilization of sand tray techniques. Worked with client on alternatives to feelings of sadness.*

R *– During sand tray exercise, client placed a single donkey on a raised mound surrounding it as a moat with water. When asked the donkey's name, client sheepishly replied "Blue Donkey, you know, like Eeyore? He's always sad, just like me!" While working with client regarding alternatives to feelings of sadness, this writer attempted to assist client into thinking about who else could join the Blue Donkey on the island. Client placed a bridge across the moat and exclaimed "See, I done that!" Next she had a giraffe walk across the bridge to the donkey. When asked who the giraffe represented, client reported that it was her mother watching over*

her. Towards the end of the time, client reported that she felt better, and this writer observed client skipping out of the office to join her mother in the waiting area.

***P** – The plan for next session with client is to work with client in identifying what makes her feel isolated and sad, and how to bridge those feelings constructively.*

Group Therapy

Group therapy Code: 1536

Group therapy is provided in a group setting with the purpose of assisting clients in meeting goals.

Group therapy can include Psychotherapeutic Groups, which are groups with a focus of:

- Personal and group dynamics that are discussed and explored in a setting that allows for emotional catharsis, instruction and support
- Typically utilizes psychotherapeutic theories to assist clients in meeting goals
- Structured in terms of attendance policy, number of clients attending, and format of the group
- Utilizes a specific curriculum and interventions

This would also include psychotherapy administered in a group setting that involves working with clients who do not have the ability to interact by ordinary verbal communication; non-verbal communication skills or an interpreter may be used.

Please note that Prep time can be included in the total time, if it's completed on the same day as the group. This can include developing worksheets, setting up supplies, and other necessary activities to conduct group therapy. This is added into the Total Length of Time, and will be divided among the participants of the group.

Note: "Group Math" formula is:

__ (Minutes) x __ (Number of Staff) = __ (Total Minutes) ÷ __ (Number of Consumers) = __ (Adjusted Minutes) + __ (Documentation) = __ (Billable Minutes)

AVATAR will determine the math regarding group notes, and offers the opportunity to put in the total time and the number of individuals in the group. For additional information on how the time for groups is figured out, there are examples in the notes and more information can be located in Appendix I.

Billable Activities

- Groups with a focus on processing feelings
- Groups that have a focus on skill building to help cope
- Groups of siblings (i.e., conducting a session with 2 or more siblings, each who are clients to the benefit of all clients included in the group)

Sample Notes:
Start Time: 3:30 p.m.
Total Time:

_93_ (Minutes) x __1 (Number of Staff) = 93__ (Total Minutes)÷ _5_ (Number of Consumers) = 18.6__ (Adjusted Minutes)+ 6__ (Documentation) = _24.6_ (Billable Minutes)
(Note: 24.6 would round down to 24 min). *

***P** – Client participated in a dual diagnosis group therapy session today in the Woodland office. The topic of the group was "What are my triggers that lead me to use?" Client is participating in group due to history of severe depression and dependence on multiple substances.*

I *– Each client identified their own triggers, spent some time processing through feelings and thoughts associated with their triggers, and, utilizing cognitive behavioral techniques, began to create a plan to avoid triggering situations.*

R *– Client expressed a commitment to maintaining sobriety, however, client is discouraged by the continuation of voices despite his medication compliance. Client reported he was surprised by the amount of support he received from the group. Client quickly identified two triggers: boredom and phone calls from his mother.*

P *– Client agreed to utilize peer support, community resources, or to call this clinician if he feels his condition is deteriorating. Clinician and client will consult with psychiatrist regarding voices.*

Start Time: 2:30 p.m.
Total Time:

_122_ (Minutes) x _2_ (Number of Staff) = 244 (Total Minutes)÷ _5_ (Number of Consumers) = 48.8_ (Adjusted Minutes)+ _7_ (Documentation) = _55.8_ (Billable Minutes)
(Note: 55.8 would round down to 55 Min.)

P *– Client participated in a group therapy session today in the Woodland office, facilitated by this writer and Clinician John Doe. The topic of the group was "How to keep my focus at school." Client is attending group as part of client's treatment for Attention Deficit Hyperactivity Disorder (ADHD).*

I *– The goal of this activity is to provide participants a way to identify distractions and redirect appropriate self-redirection themselves without getting frustrated or giving up in different settings. The group utilized a structured card game that required participants to maintain focus and tracking. Worked with clients on identifying how they felt internally when frustrated by the structured task. Progressive relaxation techniques, and self-soothing exercises, and time outs were also introduced. These were utilized to assist clients in this focusing activity as well as the use of "time-outs" as warranted and needed. Activities were utilized to assist clients in sustaining his/her focus on activities.*

R *– Client was initially disruptive and intrusive; interrupting both presenters and violating other participants' space by taking away their cards and talking over her peers. This writer assisted client by initiating a time-out, then reintegrating client into the group by strategically helping client select a new seat where she could be more focused and less distracted. After the time-out and reintegration, client proceeded to engage successfully in the activity without further disruption.*

P *– The plan is to continue to work with client in choosing "seat placement" at the start of a group therapy activity that she has identified to be less distracting. Client will identify a "seat placement" that is less distracting.. Will also plan to consult the teacher to ensure that client is in a "seat placement" that is less distracting in the classroom, so that client may be focusing will focus more easily.*

****See Appendix I regarding billing for groups***

Non-billable Activities:

- Teaching a remedial English class

- Assisting with coursework or a study group
- Teaching job functions
- Teaching a group of youths publishing a newsletter
- Attending a group outing and watching a movie

Case Management/Brokerage

Case Management/Brokerage Code: 1501

The definition of "Case Management/Brokerage Services" are planned services that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Client does not necessarily have to be present to bill for Case Management/Brokerage.

Please note that including "start time" on each progress note is not necessary for Case Management/Brokerage Services.

This code is utilized when

- linking clients to necessary services
- consulting with other necessary professional entities (who are not identified as the client's support person/people) when linking client to other necessary services
- gathering information that will benefit client in receiving necessary services from sources (who are not identified as the client's support person/people) such as family members, medical providers, social workers and educators,
- making referrals to providers for needed services
- monitoring the activities for necessary follow up (i.e., ensuring that resources that client is accessing, to assist client in order to meeting treatment goals are assisting client in the most efficient and helpful way)
- Establishing contacts that are necessary to ensure the treatment plan is effectively implemented and that progress toward goals are being made.

Case Management is NOT skill development, assistance in daily living, or training a client to access services himself/herself. These activities may be billable under Rehabilitation.

Note: Must state in the note why the service is necessary for the client and why the client is unable to perform the action himself/herself.

Billable activities:

- Communication, coordination, and referral
- Monitoring to ensure a client's access to services
- Monitoring the client's progress
- Relaying information that is medically necessary from client, therapist, case manager, or psychiatrist to another person

Placement Services may include:

- Assessment regarding appropriateness of placement.
- Needs determination
- Locating and securing an appropriate living environment
- Pre-placement visit(s)
- Securing housing or placements
- Placement and placement follow-up
- Accessing services necessary to secure placement.

Note: Billing Case Management/Brokerage services is permissible any time during a crisis house stay, such as Safe Harbor Crisis House, as are Medication services.

Sample Notes:
Start Time: 9:02 AM
Total Time: 41 min.

P *– Client seen in Davis Clinic and is requesting assistance in dealing with his MD. He feels extremely anxious when going to the MD and cannot express himself during the appointment. Due to his anxiety, this writer was needed to assist client by providing necessary information to the doctor.*

I *– Release of Information obtained. This clinician was able to speak to MD that afternoon to discuss client's symptoms. This writer explained to MD of Peterson Clinic MD the client's physical symptoms and the need for special accommodations. MD agrees agreed to allot extra time to see this client.*

R *– Clinician contacts client at home; client appreciative of the intervention and reports a drop in anxiety level.*

P *– Will follow up with client to ensure that client felt understood during MD visit.*

Start Time: 9:31 AM
Total Time: 96 min.

P *– Met with client's teacher (Release of Information on file) in at his/her school in Davis to discuss client's behavior in class. Client has been suspended for the second time in the past month for fighting with another student. In addition, teacher reports that client is not completing the class work and seems easily distractible.*

I *–Spoke with teacher in at school regarding client's behavior to help in the treatment planning process and in the formulation of interventions for future sessions.*

R *– Teacher provided a great deal of information regarding client's behavior in class. Teacher reports that client was completing coursework regularly, turning it in on time, and was doing very well with the work. Teacher indicated that it is her belief that client is bored in class, and that is why he continually acts out in class. Teacher also reported that prior to a month ago, client was "getting along okay" with other students in the class, and this had been a "vast improvement" from a few months ago when client was fighting with everyone. Teacher reports that she "feel(s) like something happened that triggered this", but indicated she does not know what changed.*

P *– Will plan to discuss information with client's mother to determine if any changes have occurred in the home recently, will discuss client's suspension with mother and how mother can help alleviate client's maladaptive behaviors, and will attempt to discuss client's behaviors with client in next session.*

Non-billable Activities

- Any activity that is clerical in nature is not billable.
- Filling out SSI paperwork for a client who is not present is not billable; simply driving a client to an apartment complex is not billable. However, an intervention in which the clinician works with the client on the importance of stable housing to their mental health on their way to the apartment complex would be billable (This can be billed in accordance with the service activity that was provided and within a staff's scope of practice [e.g., a clinician might code this as individual therapy, whereas an MHRS may code this as rehabilitation]).
- Adult Protective Services (APS) and Child Welfare Services (CWS) are not billable unless the client is actively participating in the process.

A Note regarding placement and billing: Mental Health Services, such as assessment, collateral, psychotherapy or rehabilitation can only be billed on day of admit to a crisis house stay, such as Safe Harbor Crisis House.

For Fee-For Service Hospitals, such as Woodland Memorial, Case Management/Brokerage cannot be billed except for day of admission and discharge planning 30 days prior to scheduled discharge. Medication services and mental health services can continue to be billed.

For Short Doyle/Medi-Cal hospitals, such as Sierra Vista Hospital, Heritage Oaks Hospital and Sutter Center for Psychiatry, Case Management/Brokerage cannot be billed except for day of admission and discharge planning 30 days prior to scheduled discharge. Medication services and mental health services can only be billed on day of admission.

For more information, refer to the Discharge Planning code and/or the Title 9 Lockout Crosswalk.

Discharge Planning Code: 1502

Discharge planning is a **Case Management billable service** provided when a client is currently in placement. The following chart shows the common situations that are faced regarding discharge and the guidelines to use to determine whether discharge services are billable. For further information, refer to the Title 9 Lockout Crosswalk, located in Appendix D.

Type of Facilities	Name of Facility	When is discharge planning billable?
Acute Facilities Fee-For-Service	Woodland Memorial Hospital	Discharge Planning 30 days prior to scheduled discharge
Short-Doyle/Medi-Cal Facilities	Heritage Oaks Hospital	Discharge Planning 30 days prior to scheduled discharge
	Sierra Vista Hospital	
	Sutter Center for Psychiatry	
	St. Helena Center for Behavioral Health	
Psychiatric Health Facility (PHF)	North Valley Behavioral Health	Discharge Planning 30 days prior to scheduled discharge
Crisis Residential	Safe Harbor Crisis House	Discharge Planning services are okay to bill for the duration of the stay.
Institutes of Mental Disease (IMD)	Some Crestwood Facilities	Discharge Planning 30 days immediately prior to discharge
Adult Residential Treatment Facilities	Farmhouse	Case Management and Medication Support Services are OK to be billed; Other Mental Health services are a lockout if Adult Residential Services are being billed at the same time.
Board and Care Facilities	Willow Glen American River	Case Management, Medication Support, and Mental Health Services OK to be billed
State Hospitals	Napa State Hospital	Discharge Planning 30 days immediately prior to discharge
	Metropolitan State Hospital	
Other	Juvenile Hall	Discharge Planning after court disposition for release but prior to actual discharge

Rehabilitation/ADL

Rehabilitation Code: 1540

Rehabilitation is a Medi-Cal billable service, but is NOT a Chapter 26.5/AB 3632 allowable service. It is defined as a service that includes assistance in improving, maintaining or restoring a client's:

- functional skills
- daily living skills
- social and leisure skills
- grooming and personal hygiene skills

Rehabilitation can also include:

- obtaining support resources from other Medi-Cal supports
- providing or obtaining medication education
- Linkage and brokerage to Medi-Cal services (i.e.-doctor's appointment)
- Counseling (i.e.-Peer Counseling)

Billable Activities:

- Assisting with a specific problem area related to such activities as Activities of Daily Living (ADLs)
- Showing client how some obstacle might be overcome (i.e., how to obtain a bus pass when client has difficulty making decisions)
- Identifying obstacles (i.e., client wishes to attend Junior College but has difficulty getting up in the morning, does not know how to use public transportation, and has not gotten necessary hearing aids)
- Helping strategize with client about what they can accomplish. (i.e., prioritizing household chores)
- Education regarding how problem behaviors are getting in the way of meeting goals
- Education about how symptoms/problem behaviors might be managed (i.e., diet changes, medication)
- Accompanying a client in public to model and help client practice appropriate behavior in public (i.e., accompanying a client to the grocery store to assist client in practicing appropriate behavior in the grocery store)

Sample Notes:
Start Time: 3:00 p.m.
Total Time: 109 min.

P – Met with client in home today to work on her active listening skills with a focus on skill-building tasks. The goal that is being focused on today relates to decreasing client's impulsivity.

I – Identified distractions in the room, and role played with client on how to decrease distractions such as turning off background noises.

R – Client was able to independently identify two additional distractions in the room without guidance, and client was able to identify ways to decrease distractions in order to increase her ability to stay focused. She was able to focus for 5 out of 10 minutes on the task at hand, and client expressed that she was very pleased with her improvement.

***P** – Follow up appointment set in one week. The plan is to work on how to identify and decrease distractions at school.*

Start Time: 12:46 p.m.
Total Time: 94 min.

***P** – Met with client at school in Winters to assist client in meeting goals of being able to successfully sit through class with no behavioral difficulties.*

***I** – Sat with client in class and modeled appropriate behavior and assisted client in learning and using appropriate behaviors in class.*

***R** – Client attempted to interrupt the teacher on several occasions while the lecture was going on, however client responded well to this writer's redirection, and was able to sit through the last third of the class with no outbursts.*

***P** – Will meet with client individually to discuss client's feelings regarding today' s activities and review skills that client has learned. Will plan to continue work on a plan for client to have in place when client feels the need to be impulsive. Will also plan to sit with client in class again next week.*

Non-billable Activities

- Assisting a client with coursework or learning job functions
- Going to the store to buy the client's groceries for them while the client is at home.
- Skill building services/Rehabilitation is not billable under Ch. 26.5/AB3632

Group Rehabilitation/ADL Code: 1542

Rehabilitation is a Medi-Cal billable service, but is NOT a Chapter 26.5/AB 3632 allowable service. It is defined as a service that includes assistance in improving, maintaining or restoring a client's:

- functional skills
- daily living skills
- social and leisure skills
- grooming and personal hygiene skills

Rehabilitation can also include:

- obtaining support resources
- obtaining medication education

When providing these services to a group of clients (2 or more), the Group Rehabilitation/ADL code is utilized.

Sample Notes

Start Time: 1:34 PM

131_(Minutes) x_2 (Number of Staff) = 162 (Total Minutes) ÷ 4_ (Number of Consumers) = 40_ (Adjusted Minutes)+ _9 (Documentation) = 49 (Billable Minutes)

P- Facilitated group in the Wellness Center with ADMH Specialist Jane Smith regarding building skills of appropriate expression of anger. The client has a history of being explosive and verbally assaultive with staff and peers, and while there has been improvements on impulse control, client continues to be demanding of staff time and attention. Client recently had an argument with a peer at his housing facility, and staff at the facility was able to redirect both individuals before the altercation became physical. However, this pattern is placing client's housing at risk currently.

I- Led the group through the anger management curriculum and discussed the difference between assertiveness and aggressiveness.

R- Client was able to participate in the discussion and provided several good examples of assertive behavior and provided examples from his past behavior as examples for aggressive behavior. Client also participated fully in a conversation with clients and both facilitators as to how those examples of aggressive behavior could have been handled differently, and client was open to this discussion.

P- Client will continue to participate in these weekly meetings, and has also agreed to working on identifying times when his behavior might be aggressive and/or assertive in the next week. Next week's topic of group will be "Identifying Anger Triggers".

Collateral

Collateral Code: 1510

Collateral is defined as contact with one or more significant support persons in the life of the client with the intent of improving or maintaining the mental health status of the client. Collateral services include, but are not limited to:

- helping significant support persons to understand and accept the client's condition
- involving identified significant support person/people in planning of and implementation of client plan(s)
- Sessions with client's family (if they are identified as significant support person/people) on behalf of client with the intent of benefiting client
- Family sessions with the focus on benefiting the client, with the client present, are also included in Collateral.

Note: Sessions must always relate to client plan. Client may or may not be present.

A significant support person means person(s) in the opinion of the client who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of the client (who is a minor), the legal representative of the client, a person living in the same household as the client, and relatives of the client. Contact with these individuals may necessitate client signed releases. **Document identified significant support people in client plan under "Client's/Family's Desired Results from Mental Health Services" section of the client treatment plan, and in the corresponding progress note.**

Note: Collateral can only be billed for working on issues pertaining to the client only, not issues of the collateral support person being worked with.

Billable Activities:

- Obtaining information from an important person in clients life
- Discussing (with Release of Information) with an important person in client's life how to collaborate and help client to overcome obstacles, or how they might support (and not hinder) some area of improvement in functioning.

Sample Notes:
Start Time: 1:30 PM
Total Time: 22 Min.

***P** – Received phone call from Client's Sister who indicated that she was very concerned about client due to an a recent increase in client's symptoms recently. Sister reports that client is not sleeping well, is becoming increasingly manic and appears to be hearing voices and having visual hallucinations again.*

***I** – Gathered information from sister, and asked if she knew if client was continuing to be compliant on his medications. Sister reported that she did not know. Discussed whether or not client would be willing to come in to speak with writer today, and sister reported that client*

"took off" this morning, and has not been back. Provided contact information for crisis services, and instructed sister to call this writer when if client returned.

***R** – Sister reported she would contact this writer, and she indicated she planned to contact friends of client, and places that client liked to "hang out at."*

***P** – Will discuss information with client's psychiatrist, crisis team, and supervisor, and will plan to follow up with sister later regarding whether or not client has been located.*

Start Time: 10:03 AM
Total Time: 29 min.

***P** – Placed phone call to mother today regarding client's progress on client's star chart. Mother reported that client experienced a set-back this past week when client "blew out" in school, resulting in a one day suspension. According to mother, client was being redirected to her seat following an outside activity at school, but was having difficulty in following the teacher's instructions resulting in client being frustrated and "throwing a chair at the teacher."*

***I** – Worked with mother in identifying the events that led up to client's "blow out", including a recently failed visit with her father the night before the incident. Encouraged mother to continue to use the positive reinforcers to assist in redirecting client when client is frustrated.*

***R** – Mother agreed to continue to use the positive reinforcers with client. Mother expressed frustration over how slow progress seems to be occurring.*

***P** – Will report this incident to client's therapist for her next follow up at session. Will also plan to contact mother at the end of the week to check in regarding client's behavior in school.*

Non-billable Services

- Coordinating/linking with *other* providers (But this may be billed as Case Management/Brokerage).
- Billing for time spent focusing on individuals other than the client

Crisis Intervention

Crisis Intervention Code: 1570

Crisis Intervention is an *unplanned* need for immediate service. It is a Medi-Cal billable service, but is NOT a Chapter 26.5/AB 3632 allowable service. It is to address criteria of:

- Danger to Self
- Danger to Others
- Grave Disability Secondary to a mental health disorder.

Note: The maximum amount billable for crisis intervention in a 24-hour period is 8 hours. Services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community (Title 9, 1840.336). While a client might state that they are in crisis, it is the responsibility of the practitioner to determine if the situation is a crisis. If the practitioner determines that the client is not in crisis, the appropriate code must be billed for the that service.

Billable Activities

The service activities that fall within the scope of crisis intervention may include but are not limited to:

- Assessment (must document crisis: threats to self/others, risk behaviors, or severe symptoms)
- Collateral (speaking to others about the individual in crisis)
- Therapy

Sample Notes:
Start Time: 3:21 PM
Total Time: 54 Min.

***P** – Client was seen at Woodland Memorial Emergency Department, and appeared disheveled, confused, and responding to internal stimuli. Client was brought to the Woodland Clinic by his brother, who reported he found client sleeping in a pile of garbage in client's living room. Brother reports that he usually checks on client daily by phone, but had not heard from client in two days, and went to check on him. Brother was able to successfully transport client to WMH where client was medically cleared then evaluated by crisis staff and placed in a 5150 hold as gravely disabled. Client was unable to successfully complete most elements of a MSE, and could not answer questions regarding his safety, the safety of others, or the ability to care for himself. Client has a hx of Schizophrenia, and it was noted in client's chart that there has been a recent change in medication.*

***I** – Client was medically cleared. Completed crisis assessment to determine Danger to Self, Danger to Others, or level of grave disability. Client was determined to be gravely disabled, and a 5150 was completed on client. Client was placed on a 5150 hold.*

***R** – Client did not show any indication or response that he understood what was going on.*

***P** – Will contact ADMH on-call psychiatrist to review case and ask for approval to place client at an acute inpatient psychiatric facility. Will contact hospitals to determine placement for client and will contact the police for transport.*

Start Time: 11:04 AM
Total Time: 160 min.

***P** – Received a telephone call from school principal requesting immediate response due to client "throwing a chair at her teacher" and destroying school property at school. This writer arrived at the school site to find client in a quiet room yelling obscenities, threatening to kill her peers if she got out. Upon seeing this writer, client angrily yelled and cursed at me accusing her peers of "setting her up."*

***I** – Client calmed down after about 15 minutes and agreed to speak with this writer about the incident. Assessed client for risk to herself and to others.*

***R** – After calming down, client was assessed to be at low risk for hurting herself or others. Client was willing to discuss the incident, and reported that she was outside playing with her peers when she was told to "hide" and they would come get her when recess was over. Her peers did not follow through resulting in her teacher advising client that she will receive a demerit for being late to class. At this point, client admitted accusing the teacher of being "unfair" and throwing a chair at him.*

***P** – Was informed that mother had been called and that client would be going home today. Client has been suspended for 2 days for this incident. Will plan to continue to work with client on better anger management techniques and impulsivity control.*

Note: While Crisis Staff only respond to the Emergency Departments and the jail, other clinic staff who might be assigned to a school-based site or field location could respond at a location where the client is seen, and bill crisis. All non-"crisis" staff are to use this code only when assessing a client's risk of Danger to Self, Danger to Others, or Grave Disability. It is not necessary to bill this code only under the Crisis Site Code. In addition, for those staff who primarily work crisis, it may not always be necessary to bill Crisis Intervention, and the appropriate code for the service provided should be used.

Therapeutic Behavioral Services

Therapeutic Behavioral Services Code: 1558

Only use this code if TBS has been pre-approved.

Therapeutic Behavioral Services (TBS) are Medi-Cal services only, provided to eligible clients who are under the age of 21. TBS is a

- one-to-one therapeutic contacts between a mental health provider and a client
- completed within a specified short-term period of time
- designed to maintain the child/youth's residential placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals

A contact is considered therapeutic if intended to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that is the barrier to achieving residence in the lowest appropriate level.

Two important components of delivering TBS include the following:

- Making collateral contacts with family members, caregivers, and other significant support persons in the client's life
- Developing a TBS plan that clearly identifies specific target behaviors and interventions

Therapeutic Behavioral Services (TBS) must be provided face-to-face with the client and may be provided anywhere in the community. Services can be provided to clients up until their 21st Birthday.

Day Treatment Codes

Day Treatment Intensive	Codes
Day TX Intensive ½ day:	**1081**
Day TX Intensive full day	**1085**

Day Treatment Intensive service provides an organized and structured multidisciplinary treatment program that may be an alternative to hospitalization; the purpose is to avoid placement in a more restrictive setting or maintain the client in a community setting. These services are provided to a distinct group of individuals and occur in a therapeutic, organized and structured setting.

For seriously emotionally disturbed children and adolescents, Day Treatment Intensive provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration. Interventions are intended to prevent hospitalization, placement in a more restrictive facility, or out of home placement. This service may be integrated with an education program. A key component of this service is contact with the families/caregivers of these clients.

Medication Support Services are billed separately from Day Treatment Intensive.

Note: Please see DMH Letter 03-03 for more detailed information.

Day Rehabilitation	Codes
Day Rehabilitation ½ day:	**1091**
Day Rehabilitation full day:	**1095**

Day Rehabilitation provides rehabilitation and therapy to improve, maintain or restore personal independence and functioning consistent with requirements for learning and development. This structured program provides services to a distinct group of clients.

For seriously emotionally disturbed children and adolescents, Day Rehabilitation focuses on maintaining individuals in their community and school setting; consistent with their requirements for learning, development and enhanced self-sufficiency. Services emphasize delayed personal growth and development and may be integrated with an education program. A key component of this service is contact with the families of these clients.

Non-Billable Activities
Two half-day programs may not be provided to the same client on the same day.

Note: Please see DMH Letter 03-03 for more detailed information.

Adult Residential Treatment Services

Adult Residential Treatment Services (Transitional and Long Term) Code: 565

Adult Residential Treatment Services are provided in a therapeutic community setting and provide a range of activities and services for clients at risk of hospitalization or other institutional placement. The service is available twenty-four hours per day, seven day per week.

Medication Support Services will be billed separately from Adult Residential Treatment Services.

Adult Residential Treatment Services will have a clearly established certified site for services, although all services need not be delivered at that site. Services will be claimable unless there is face-to-face contact on the day of service and the client has been admitted to the program.

Programs providing Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the Department of Mental Health as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program.

In addition to a Social Rehabilitation Program certification, programs providing Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the Department of Social Services, or authorized to operate as a Mental Health Rehabilitation Center by the Department of Mental Health.

Medication Management Codes

Medication Support-MD/DO/NP/PA **Code: 1560**
Medication Support-RN **Code: 1561**
Medication Support-LVN/LPT **Code: 1562**

Services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education, and plan development related to the delivery of the service and/or assessment of the beneficiary. Allowable costs may include drugs and laboratory tests related to the delivery of this service.

Services may be either face-to-face or by telephone with the client and/or significant support persons and may be provided anywhere in the community. In the unusual circumstance where the client and/or support person is not present, plan development activities are reimbursable without face-to-face or phone contact.

Plan Development-No Show MD/DO/NP/PA **Code: 1565A**

Chapter 26.5/AB-3632 Codes

These codes are used for those clients who qualify for Chapter 26.5 of the California Government Code services. AB 3632 and AB 2726 implements this Code. Please note, a client who receives these services must have a Mental Health Client Plan in addition to an Individual Education Plan (IEP) to receive services through YCADMH. In order to bill services using the Ch. 26.5 codes, the services must be included in the IEP. Please view the descriptions in the guide for further information relating to use of these codes.

Please also remember that the Chapter 26.5 Codes can only be used in the 26.5 Episode on AVATAR. Clients who are Ch. 26.5/AB-3632 must have both a 26.5 Episode and a Mental Health Episode on AVATAR open.

The "Lockout" codes included in this section are for services billable to Ch. 26.5 guarantors, but are "locked out" to billing Medi-Cal. A chart in the next section highlights when this might occur.

Initial Assessment-Chap 26.5 (Clinician) 1531
This code is used for completing assessments for Chap 26.5 Clients. For Chap 26.5 clients, this code is also utilized for review of records in formulation of assessment, diagnosis, and treatment.

Initial Assessment-Chap 26.5 (Clinician) LOCKOUT 1531X

Reassessment-Chap 26.5 (Clinician Only) 1533
This code is used for completing annual reassessments for Chap 26.5 Clients.

Reassessment-Chap 26.5 (Clinician) LOCKOUT 1533X

Case Management/Brokerage-Chap 26.5 1503

This code is used in providing Case Management/Brokerage services to or on behalf of Chap 26.5 clients.

Case Management/Brokerage-Chap 26.5 LOCKOUT 1503X

Case Management (MH)-Chap 26.5 1544

Case Management (MH)-Chap 26.5 LOCKOUT 1544X

Collateral-Chap 26.5 1511
This code is used when providing collateral services to AB-3632 Clients.

Collateral-Chap 26.5 LOCKOUT 1511X

Individual Therapy-Chap 26.5 1535

This code is used for completing therapeutic treatment for Chap 26.5 Clients.

Individual Therapy-Chap 26.5 LOCKOUT 1535X

Group Therapy-Chap 26.5 1537
This code is used for groups that include Chap 26.5 clients. When documenting groups, this code would only be used for those clients who qualify for Chap 26.5 services.

Group Therapy-Chap 26.5 LOCKOUT 1537X

Psychological Testing-Chap 26.5	**1548**
Psychological Testing-Chap 26.5-LOCKOUT	**1548X**
Medication Support-Chap 26.5	**1563**
Medication Support (MD/DO/NP/PA)-Chap 26.5 LOCKOUT	**1563X**
Initial Assessment-Physician-Chap 26.5	**1563A**
Plan Development-MD/DO/NP/PA-Chap 26.5	**1566**
Plan Development-No Show-MD/DO/NP/PA-Chap 26.5	**1566A**

	Client has both 26.5 & Medi-Cal: When and What do We Bill to Who?	
Location	**Billable to Medi-Cal**	**Billable to IDEA/SB90/DMH**
Juvenile Hall * Pre Disposition	No	Yes
Hospital (Other than Discharge Planning)*	No	No
* These are examples of when services could be provided under Ch. 26.5, but "locked out" to Medi-Cal. In these instances, services provided would be billed using the Ch. 26.5 Lockout code set.		

Please note: If a service is not listed on an IEP, use the Medi-Cal Mental Health Service Codes.

Examples:

Situation	Use MH Codes	Use 26.5 Codes	Notes
A Client has both Medi-Cal and qualifies as Ch. 26.5. He receives individual therapy services in the community, and the service is listed in his IEP.	No	Yes	
A Client has both Medi-Cal and qualifies as Ch. 26.5. He receives individual therapy services in juvenile hall, and the service is listed in his IEP.	No	Yes	In this situation, the "26.5 Lockout" code of 1535X would be used.

A Client has both Medi-Cal and qualifies as Ch. 26.5. He receives rehabilitation services in the community.	Yes	No	Rehabilitation, Plan Development, and Crisis services are not covered under 26.5.
A Client has private insurance and qualifies as Ch. 26.5. He receives collateral services.	No	Yes	
A Client who has both Medi-Cal and qualifies as Ch. 26.5. He is hospitalized. Are any MHS services billable?	No	No	

Prop 63 (MHSA) Codes

These codes are utilized for clients in Prop 63 (MHSA) programs, and can only be billed by those staff approved to provide Outreach and Engagement Services.

Prop 63 Outreach & Engagement Enrolled **Code: Y9927**

This direct code is used by MHSA programs to document outreach and engagement with registered clients.

Prop 63 Outreach & Engagement Pre-enrolled **Code: Y9928**

This direct code is used by MHSA programs to document outreach and engagement time to individuals who are not registered clients. Generally, by the third service, the client should be registered into the AVATAR system as an active client.

CalWorks Codes

Alcohol and Drug Codes

CalWorks Initial Assessment **Code: 2005**

CalWorks Reassessment **Code: 2006**

CalWorks Individual Counseling (Alcohol) **Code: 2080A**

CalWorks Individual Counseling (Drug) **Code: 2080D**

CalWorks Group Counseling (Alcohol) **Code: 2085A**

CalWorks Group Counseling (Drug) **Code: 2085D**

Mental Health Codes

Case Management/Brokerage (CALWORKS) **Code: 1701**

Collateral (CALWORKS) **Code: 1710**

Initial Assessment-Clinician (CALWORKS) **Code: 1730**

Reassessment-Clinician (CALWORKS) **Code: 1732**

Individual Therapy (CALWORKS) **Code: 1734**

Group Therapy (CALWORKS) **Code: 1736**

Plan Development (CALWORKS)	**Code: 1738**
Rehab/ADL (CALWORKS)	**Code: 1740**
Group Rehab/ADL (CALWORKS)	**Code: 1741**
Medication Support-MD/DO/NP/PA (CALWORKS)	**Code: 1760**
Medication Support-RN (CALWORKS)	**Code: 1761**
Medication Support-LVN/LPT (CALWORKS)	**Code: 1762**
Clozapine (CALWORKS)	**Code: 1764**
Plan Development No Show – MD/DO/NP/PA (CALWORKS)	**Code: 1765A**
Crisis Intervention (CALWORKS)	**Code: 1770**
Adult Crisis Residential (CALWORKS)	**Code: 540CW**

CHAT Grant

Case Management/Brokerage (CHAT)	**Code: 1401**
Collateral (CHAT)	**Code: 1410**
Initial Assessment (CHAT)	**Code: 1430**
Reassessment (CHAT)	**Code: 1432**
Individual Therapy (CHAT)	**Code: 1434**
Group Therapy (CHAT)	**Code: 1436**
Plan Development (CHAT)	**Code: 1438**
Rehab/ADL (CHAT)	**Code: 1440**

Group Rehab/ADL (CHAT) **Code: 1441**

CONREP Codes

These codes are used for clients participating in the CONREP Program, and is to be billed by CONREP/Forensics staff only.

Case Management/Brokerage (CONREP) **Code: 1801**

Collateral (CONREP) **Code: 1810**

Initial Assessment-Clinician (CONREP) **Code: 1830**

Reassessment-Clinician (CONREP) **Code: 1832**

Individual Therapy (CONREP) **Code: 1834**

Group Therapy (CONREP) **Code: 1836**

Plan Development (CONREP) **Code: 1838**

Rehab/ADL (CONREP) **Code: 1840**

Group Rehab/ADL (CONREP) **Code: 1841**

Medication Support-MD/DO/NP/PA (CONREP) **Code: 1860**

Medication Support-RN (CONREP) **Code: 1861**

Medication Support-LVN/LPT (CONREP) **Code: 1862**

Clozapine (CONREP) **Code: 1864**

Plan Development No Show-MD/DO/NP/PA (CONREP) **Code: 1865A**

Adult Crisis Residential (CONREP) **Code: 540CR**

CONREP Annual Review **Code: Y9923**
This direct code is used for documenting the CONREP annual review.

CONREP Quarterly Review **Code: Y9924**
This direct code is used for documenting the CONREP quarterly review.

CONREP Hospital Liaison Services **Code: Y9925**
This direct code is used for documenting CONREP hospital liaison services.

CONREP Home Visit **Code: Y9926**
This direct code is used for documenting CONREP home visits.

Drug & Alcohol Program Codes

These codes are used for clients participating in Drug & Alcohol Programs.

AOD Assessment **Code: 2002**

Individual Counseling (Alcohol) **Code: 2026A**
Utilizing therapeutic interventions to assist clients in meeting treatment goals.

Individual Counseling (Drug) **Code: 2026D**
Utilizing therapeutic interventions to assist clients in meeting treatment goals.

Group Counseling (Alcohol) **Code: 2028A**
Utilizing therapeutic interventions in a group setting to assist clients in meeting treatment goals.

Group Counseling (Drug) **Code: 2028D**
Utilizing therapeutic interventions in a group setting to assist clients in meeting treatment goals.

Lockout Codes

(See Lockout Crosswalk, Appendix D):

Lockout **Code: Y9934**
This direct code is used to document services other than Assessments and Discharge Planning for a client that is in a program which prohibits ADMH from billing Medi-Cal. Examples of this would include services provided in an IMD setting (other than allowable discharge planning services), services provided in Jail, or certain services (e.g.-Day Treatment, TBS) that are performed concurrently.

Y-Codes

Y-Codes and A-Codes are the codes to indicate non-billable circumstances. Y-Codes are utilized for Mental Health services, and A-Codes are utilized for Alcohol and Drug services.

No Show/Cancellation **Code: Y9929**

This code is to be used when a no show or a cancellation of an appointment occurs.

Group Scheduling **Code: Y9944**

This non-billable code is used to schedule/book group appointments.

Jail Group **Code: Y9913**

This direct code is used for time spent conducting educational groups at the jail.

QM/UR Case Review **Code: Y9905**

This code is used to account for time spent doing utilization review. This can be Peer Review or Supervisors UR or chart reviews utilizing the UR tool.

Translation **Code: Y9948**

Admin Time **Code: Y9946**

Break Time **Code: Y9907**

Time Off **Code: Y9945**

This non-billable code is used to account for time off (vacation, sick, XTO, etc).

Helpful Hints & Tips

- The body of every note must contain the start time
- Interpreter assistance must be documented in the note associated with the Client Plan and that the client plan was reviewed in the presence of the client in the client's native language.
- Please include in your Progress Notes each time if you are using an interpreter, and what the language is; also if you are speaking in the client's native language (i.e. Spanish, Russian) without the assistance of an interpreter include a comment in your documentation each time that you meet that you are able to perform this service.

- **Transportation (non-billable) vs. Travel Time (billable)**
  Transportation: Physically taking clients from one place to another when no services were being provided.
  Travel Time: The time spent traveling to/from a service site where a mental health service was provided. (It is also billable if services are provided during travel to someplace with the client. Bill the appropriate code for the service provided, however be mindful that the time is not double billed (e.g., time billed for the service provided while traveling with the client and billing the travel time).)
- **Administrative Activities (non-billable)**
  - Filing
  - Faxing
  - Making an appointment
  - Leaving/retrieving a message
  - Reserving and setting up a room or audio-visual equipment for a session
  - Studying/researching a topic
  - writing letters
- **Other Non-Billables**
  - Billing for second staff only <u>when the roles appear to be duplicative, non-essential or inappropriate for the individual service or group</u>.
  - Appointment reminders or rescheduling without any discussion of treatment
  - Excessive billing for reviewing the chart with no documented product (i.e. updated plan, concrete documented outcome that results from the review).
  - Providing mental health counseling or services for someone else's issues other than the beneficiary's.
  - When clinical staff provide interpretation services.
  - Non-Mental Health Services
  - Some services provided during Lock-Out situations
  - Supervision time
  - Completing and submitting APS, CPS and SSI documentation with no participation of the client.

Appendix A

Staff Education and Experience Requirements (per Yolo County HR)

Physician
A Physician shall be an individual who has graduated from an accredited medical school with a degree in medicine and is licensed by the Medical Board of California to practice medicine in the State of California.

Psychologist
A psychologist shall be an individual who has graduated from an accredited graduate school with a doctoral degree in Psychology and is licensed by the Board of Psychology of California to practice psychology in the State of California, or has a waiver granted by the State Department of Mental Health.

Clinician II
A Clinician II shall be an individual who has a Masters Degree from an accredited college/university in Social Work, Counseling, Psychology, and/or Marriage and Family Counseling. In addition, the individual must possess be licensed by the California Board of Behavioral Sciences as a Licensed Clinical Social Worker (LCSW); Marriage, Family Therapist (MFT); or Licensed Clinical Psychologist (LCP).

Clinician I
A Clinician I shall be an individual who has a Masters Degree from an accredited college/university in Social Work, Counseling, Psychology, and/or Marriage and Family Therapy. In addition, the individual must be registered with the California Board of Behavioral Sciences and completing hours toward licensure or in the examination cycle. (During the time in the examination cycle, the individual must remain registered with the Board of Behavioral Sciences).

Nurse Practitioner
A Nurse Practitioner shall be an individual who has graduated from an accredited program and is licensed by the Board of Registered Nursing to practice as a nurse in the State of California, who has completed additional training and supervision requirements in pharmacology and who as been issued a registration number by the Board of Pharmacy. Nurse Practitioners may order and furnish medications under physician supervision.

Registered Nurse
A Registered Nurse shall be an individual who has graduated from an accredited program and is licensed by the Board of Registered Nursing to practice as a nurse in the State of California.

Licensed Vocational Nurse/Licensed Psychiatric Technician
A Licensed Vocational Nurse or a Licensed Psychiatric Technician shall be an individual who has graduated from an accredited program and is licensed by the Board of Vocational Nurses and Psychiatric Technician Examiners to practice in his/her respective field in the State of California.

Mental Health Rehabilitation Specialist (MHRS)

A Mental Health Rehabilitation Specialist shall be an individual who has a bachelor's 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. An individual can qualify for MHRS status if they have:

- **Masters Degree** or PhD ***AND*** two years of full-time/equivalent (FTE) direct care experience in a mental health setting.

OR

- **Bachelors Degree *AND*** four years of full-time/equivalent (FTE) direct care experience in a mental health setting.

OR

- **Associate Arts Degree *AND*** six years full-time/equivalent (FTE) direct care experience in a mental health setting. *At least two of the six years must be post AA degree experience in a mental health setting.*

Social Worker

A social worker shall be an individual who has a bachelor's degree in Social Work, Social Welfare, Sociology, Psychology, or other Social/Human Services, and/or a combination of education and commensurate experience in the Social/Human Service field.

Alcohol and Drug/Mental Health Specialist II

An Alcohol and Drug/Mental Health (ADMH) Specialist II shall be an individual who has graduated from high school or is in possession of a valid G.E.D. certificate and training and experience equivalent to two years working in a community setting or social rehabilitation program in a position which involved supportive client interaction, community outreach, and a familiarity with substance abuse and/or mental illness; OR two years experience performing duties comparable to an Alcohol and Drug/Mental Health Specialist I.

Alcohol and Drug/Mental Health Specialist I

An Alcohol and Drug/Mental Health (ADMH) Specialist I shall be an individual who has graduated from high school or is in possession of a valid G.E.D. certificate and training and six months experience working in a community setting requiring extensive public contact.

Occupational Therapist

An Occupational Therapist shall be an individual who has graduated from an approved school of occupational therapy and is licensed as an Occupational Therapist with the American Occupational Therapy Association.

Appendix B

Scope of Practice

Psychiatrist
May diagnose and treat persons with mental disorders; prescribe, administer, and dispense medications; provide psychotherapy to patients; may provide testimony as an expert witness in forensic matters; admit and treat within psychiatric inpatient units; and approve treatment plans of non-Medical mental health providers.

Clinical Psychologist
May diagnose and treat mental disorders; administer psychological tests; treat patients within inpatient psychiatric facilities; provide court testimony as an expert witness in forensic matters.

Clinician I/II
May assess and diagnose mental health disorders; provide individual and group counseling and therapy; assist in brokerage of services; provides consultation; participates in treatment planning for services; and evaluates clients for 5150 holds.

Registered Nurse
May observe signs and symptoms of illness, reaction to treatment, general behavior or general physical conditions, and determine whether these conditions exhibit normal characteristics. May also implement appropriate nursing interventions, report findings to another health professional, refer client to another health professional and/or initiate necessary emergency procedures; implement a disease prevention rehabilitative regime ordered by a licensed physician, including the administration of medication. Under written protocols, Registered Nurses may also assess and diagnose mental health disorders and provide counseling and monitoring of client responses to medication.

Nurse Practitioner
In addition to performing all functions of a Registered Nurse, the Nurse Practitioner may order and furnish medications and devices under written protocols and the supervision of a physician.

Psychiatric Technician and Licensed Vocational Nurse
All of the following duties must be performed under the supervision of a Registered Nurse or licensed physician: received, transcribe, and document an order from a licensed physician; administer medication that has been ordered by a physician; observe the signs and symptoms of mental illness, reactions to treatment, general behavior, and determining whether these conditions exhibit normal characteristics. Following such an assessment, report findings to another health profession and/or initiate necessary emergency procedures.

Mental Health Rehabilitation Specialist
Under supervision, the Mental Health Rehabilitation Specialist provides a variety of paraprofessional services to clients. These include evaluating a client's functioning, identifying and facilitating appropriate referrals, assisting a client in accessing necessary care and services, assisting clients in securing benefits, maintaining community liaisons, working with persons who are collateral to the client's life, ensuring adequate services are made available to the client, monitoring the client's condition and progress, facilitating a variety of rehabilitation groups, and implementing aspects of the treatment plan developed by the treatment team, which are

appropriate to the duties of the Mental Health Rehabilitation Specialist. In addition, the Mental Health Rehabilitation Specialist may provide services as part of a structured multi-disciplinary

day treatment program and day rehabilitation program that includes evaluation, rehabilitation and therapy to maintain or restore personal independence and functioning consistent with requirements for learning and development.

Social Worker

Under supervision, the Social Worker may provide a variety of professional services to clients. These include interviewing clients or applicants in a variety of settings to assess their need for services; interpreting rules, regulations, and policy to applicants, clients, and the community; responding to requests and making referrals to utilize appropriate community and other resources; coordinating service plans with supervisor and appropriate resources; gathering, maintaining, and disseminating current information and community resources to clients, applicants, and departmental staff; preparing case records, documents, and reports in a timely manner; participates in staff development programs; formulating case plans with clients to resolve individual or family dysfunction; identifying and presenting alternatives to client problems; collaborating with other agencies for appropriate client care; and other appropriate tasks as necessary.

Alcohol and Drug/Mental Health Specialist II

May perform the following duties: Interviews the client and/or family to obtain medical, psychological, social, legal, and financial history; talks, listens to, and observes clients in individual and group settings to obtain information necessary for diagnosing, treating, and evaluating clients' progress; discusses these observations with professional staff as input to treatment review; engages in supportive interaction with clients; collaborates with professional staff to provide individual and group rehabilitation services; and participates in multidisciplinary treatment team meetings. May also assist in the training of Alcohol and Drug/Mental Health Specialists I.

Alcohol and Drug/Mental Health Specialist I

Under supervision, participates in training programs for counseling, group counseling, case management, and other related subjects; learns to work with Clinicians in group therapy sessions and multidisciplinary treatment team meetings; learns to counsel clients with a variety of substance abuse and/or emotional or mental disturbances; learns community resources available for referral of clients with specialized difficulties; and assists in liaison work with community agencies.

Occupational Therapy

Assess, assist and counsel clients in their psychosocial adaptation to their illness and physical and social environment.

Graduate Students (Masters Level) in Disciplines of Social Work or Marriage Family Therapist

Same duties as a Clinician I, however requires:

1. The student is enrolled and practice is part of a course of study of a qualified educational program;
2. and is directly supervised by a Clinician who is licensed or registered as an ASW or MFTI in good standing with the BBS, and is able to engage in the practice in which the student is engaged;
3. and all clinical documentation of the student is reviewed and countersigned by the field supervisor;
4. and the student identifies himself/herself as such to the client(s) and in all clinical documentation and communications.

Service Functions

Only providers that are listed under each classification are authorized to deliver those services. All organizational providers shall meet the education, training and experience requirements noted above.

Medication Support Services

Physician
Nurse Practitioner
Physician Assistant
Registered Nurse
Licensed Vocational Nurse
Licensed Psychiatric Technician

Clozapine

Physician
Nurse Practitioner
Physician Assistant
Registered Nurse
Licensed Vocational Nurse
Licensed Psychiatric Technician

Mental Health Services

Assessment/Reassessment

Clinician I/II
Clinical Psychologist (PhD, PsyD)
PhD, PsyD Waivered by DMH
Graduate Student[1]

Plan Development

Clinical Psychologist (PhD, PsyD)
Clinician I/II
Mental Health Rehabilitation Specialist[2]
PhD, PsyD Waivered by DMH
ADMH Specialist[2]
Graduate Student (Masters Level)[1,2]

Individual Therapy/Group Therapy

Clinician I/II
Clinical Psychologist (PhD, PsyD)
Graduate Student (Masters Level) [1]
PhD, PsyD Waivered by DMH

Notes:

[1] All clinical documentation must be countersigned by Supervisor
[2] Client Plans must be co-signed by a Physician, Psychologist, Registered Nurse or Mental Health Clinician

Rehabilitation

Licensed Vocational Nurse
Licensed Psychiatric Technician
Clinician I/II
Clinical Psychologist (PhD, PsyD)
PhD, PsyD Waivered by DMH
Mental Health Rehabilitation Specialist
ADMH Specialist I/II
Graduate Student (Masters Level)[1]

Case Management/Brokerage

Licensed Vocational Nurse
Licensed Psychiatric Technician
Clinical Psychologist (PhD, PsyD)
PhD, PsyD Waivered by DMH
Clinician I/II
Mental Health Rehabilitation Specialist
ADMH Specialist I/II
Graduate Student (Masters Level)[1]

Collateral

Licensed Vocational Nurse
Clinician I/II
Mental Health Rehabilitation Specialist
PhD, PsyD Waivered by DMH
Licensed Psychiatric Technician
Clinical Psychologist (PhD, PsyD)
ADMH Specialist I/II
Graduate Student (Masters Level)[1]

Crisis Intervention Services

Ph.D., Psy.D. Waivered by DMH
Clinical Psychologist (PhD, PsyD)
Clinician I/II
ADMH Specialist[2]
Graduate Student (any level)[1]
Licensed Vocational Nurse [1]
Licensed Psychiatric Technician[1]
Mental Health Rehabilitation Speciliast[2]

Notes:
[1] All clinical documentation must be countersigned by Supervisor
[2] Client Plans must be co-signed by a Physician, Psychologist, Registered Nurse or Mental Health Clinician

Appendix C

Co-signing Requirements

	PROGRESS NOTES	ASSESSMENTS	CLIENT PLANS	MEDICAL NECESSITY
ADMH Specialist	Yes	N/A	Yes	Yes
AOD Counselor Intern	Yes	Yes	Yes	Yes
ASW	No	No*	No*	No*
Certified AOD Counselor	No	Yes	Yes	Yes
D.O	No	No	No	No
Graduate Student	Yes	Yes	Yes	Yes
LCSW	No	No	No	No
LPT	No	N/A	Yes	Yes
LVN	No	N/A	Yes	Yes
M.D.	No	No	No	No
MFT	No	No	No	No
MFT Intern (MFTi)	No	No*	No*	No*
MFT Trainee	Yes	Yes	Yes	Yes
MHRS	No	N/A	Yes	Yes
MHSA Intern/Trainee	Yes	N/A	Yes	Yes
NP	No	No	No	No
Ph.D.	No	No	No	No
Ph.D. Candidate	Yes	Yes	Yes	Yes
Ph.D. Intern	No	No	No	No
Psy.D.	No	No	No	No
Psy.D. Intern (Psy.Di)	No	No	No	No
Psy.D. Trainee	Yes	Yes	Yes	Yes
RN	No	No	No	No
Undergraduate Student	Yes	N/A	Yes	Yes

* At the discretion of the MHP, all unlicensed clinical staff (ASW, MFTi, Psy.Di, etc.) working for provider agencies must have their client plants, assessments and medical necessity forms co-signed by their licensed supervisor.

** Please refer to Appendix C for Scope of Practice.

Appendix D
Lockouts

YOLO COUNTY ALCOHOL, DRUG MENTAL HEALTH DEPARTMENT

TITLE 9 LOCKOUTS FOR SPECIALTY MENTAL HEALTH SERVICES

	MH/TBS Service (5)	Med Support (1)	CM/ Brokerage (4)	DT Intensive Full Day	DT Intensive Half Day	Day Rehab Full Day	Day Rehab Half Day	Adult Residntl Tx	Adult Crisis Residntl Tx	Crisis Intvntn (2)	Crisis Stabilizn ER & UC (3)	Hospital Inpatient	Hospital Inpatient Admin Day (6)	PHF	Jail/ Juvenile Hall	IMD
Mode of Service:	12, 18	12, 18	12, 18	12, 18	12, 18	12, 18	12, 18	05	05	12, 18	12, 18	07-09	07-09	05		
Service Function:	10-19,30-59	60-69	01-09	85-89	81-84	95-99	91-94	65-79	40-49	70-79	20-29	10-18	19	20-29		
MH/TBS Service (5)	5	OK	OK	T	T	T	T	T	A	OK	T	A	L	A	J	L
Med Support (1)	OK	1	OK	OK	OK	OK	OK	OK	OK	OK	T	A	L	A	J	L
CM/Brokerage (4)	OK	OK	4	OK	OK	OK	OK	OK	OK	OK	OK	D	D	D	J	L
DT Intensive Full Day	T	OK	OK	L	L	L	L	OK	A	OK	T	A	L	A	J	L
DT Intensive Half Day	T	OK	OK	L	L	L	L	OK	A	OK	T	A	L	A	J	L
Day Rehab Full Day	T	OK	OK	L	L	L	L	OK	A	OK	T	A	L	A	J	L
Day Rehab Half Day	T	OK	OK	L	L	L	L	OK	A	OK	T	A	L	A	J	L
Adult Residntl Tx	T	OK	OK	OK	OK	OK	OK	L	A	OK	T	A	L	A	L	L
Adult Crisis Residntl Tx	A	OK	OK	A	A	A	A	A	L	A	A	A	L	A	L	L
Crisis Intvntn (2)	OK	OK	OK	OK	OK	OK	OK	OK	A	2	T	A	L	A	L	L
Crisis Stabilizn ER & UC (3)	T	T	OK	T	T	T	T	T	A	T	T	A	L	A	L	L
Hospital Inpatient	B	B	D	A	A	A	A	A	A	A	A	L	L	A	L	L
Hospital Inpatient Admin Day (6)	L	L	D	L	L	L	L	L	L	L	L	L	L	L	L	L
PHF	A	A	D	A	A	A	A	A	A	A	A	A	L	L	L	L
Jail/Juvenile Hall	J	J	J	J	J	J	J	L	L	J	L	L	L	L	L	L
IMD	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L

A — Lockout except for day of admission.
B — Lockout except for day of admission for Short Doyle/Medi-Cal hospital. OK for Fee For Services hospital.
C — If coming from Crisis Stabil. to Crisis Resid., lockout except for day of admission. If coming from Crisis Resid. to Crisis Stabil., lockout during actual time service is provided at Crisis Resid.
D — Lockout except for day of admission and lockout except for discharge planning 30 days prior to scheduled discharge (up to 3 non-consecutive periods per continuous stay).
J — Lockout except for day of discharge. Juvenile Hall can be billed for D/C planning after court disposition for release but prior to actual discharge.
L — Lockout
S — OK, but same staff time may not be allocated under two cost centers for the same time period.
T — Lockout during actual time service is provided.

(1) Maximum of 4 hours (240 Minutes) per day
(2) Maximum of 8 hours (480 Minutes) per day
(3) Maximum of 20 hours per 24 hour period
(4) Maximum of 24 hours (1,440 Minutes) per day
(5) Maximum of 2,878 Minutes per day
(6) An Administrative Day may not be billed on the day of admission

Revised 05/18/2009

Lockouts(7-30-09).xls

Appendix F — Lockouts

Appendix E
Components of an Assessment

Assessments are comprehensive and are utilized to create appropriate treatment plans for clients. The forms for the adult and child assessment differ, however the information that both the adult assessment and child assessment require is very similar and include many of the same requirements. Where there are differences, those are noted in this guide.

Comprehensive assessments contain many components. This guide generally covers what information should be included in every assessment, but it is always important to include any pertinent information about the client in the assessment.

Presenting Problem

This includes:

- Symptoms as reported by client, caregiver, or other involved party (i.e., a teacher reporting hyperactivity in the classroom)
- Behaviors as reported by client, caregiver, or other involved party
- Frequency of symptoms and behaviors (Be as specific as possible. This may help you when writing the Client Plan goals.)
- Precipitating events/stress
- History of Trauma or Abuse (physical, sexual, emotional). Witnessing Domestic Violence would also be pertinent information.
- Other relevant history (i.e., familial relationship issues)
- Relevant conditions affecting mental health (i.e., physical stressors, relationship factors, living conditions, job/employment/educational stressors, etc)
- Medical conditions that could be affecting mental health
- History of presenting problem (i.e., when did the symptoms begin?)
- If completing a child's assessment, also document the response of the caregivers to the symptoms and/or behaviors.

Psychosocial History

This includes:

- Current living situation
- Current employment situation/employment history
- Marital Status
- Social Support Network (for a child assessment, document caregivers).
- Relevant family history (abuse, neglect, substance abuse history, mental health history, chronic illness)
- For children, document school functioning. The assessment form requires that information regarding grade and school, academic ability, achievements, any special education participation, and vocational goals must be documented.

Psychiatric History

This includes information regarding:

- Previous mental health providers (include location, provider, date, and duration of care, if at all possible)
- Past hospitalizations (include location, provider, date, and duration of care, if at all possible)
- Why were the previous services received?
- Under what circumstances did the client receive services?

Medical History/Medications

This includes information regarding:

- Current medication (prescribed or over-the-counter) For medication, document dosage and frequency.
- Relevant Prior Medications
- Medical Issues
- Allergies (to medication, food, seasonal, etc.)
- Hospitalizations
- Surgeries
- Illnesses
- For children, document developmental history, including prenatal and perinatal events

Substance Use/Abuse Issues

This includes information including:

- Present use of illicit substances, alcohol, tobacco, caffeine, and abuse of prescription drugs
- Past use of illicit substance, alcohol, tobacco, caffeine, and abuse of prescription drugs
- If there is any current use of tobacco or caffeine, frequency of use must be documented.
- With regards to past use, date of last use must be documented.

Suicide/Assault Risk Assessment

This includes information regarding:

- History of suicidal ideations, gestures and/or attempts (If there is a history of ideations, gestures, and/or attempts, this information must be documented).
- Current assessment of suicidal ideations, gestures, and/or attempts and documentation as to what information that assessment has yielded.
- History of assaultive or abusive behavior (If there is a history of this behavior, the information must be documented.)
- Current assessment of assault risk and documentation as to what information that assessment has yielded.

Legal History

This includes information regarding:

- Current legal involvement with law enforcement, probation, or parole
- Arrest History (when and what)
- Past legal involvement with law enforcement, probation, or parole
- Past or current involvement with Child Welfare Services (CWS)
- Involvement with Public Guardian/Administrator's office

Mental Status Exam

While the Mental Status Exam (MSE) is largely constructed by the assessor's impressions and observations of the client, some parts of the MSE need to be completed by asking direct questions of the client. The components of a mental status exam include:

- Appearance (i.e., older than stated age, younger than stated age, disheveled, clean, neat, odd appearance, etc)
- Behavior (i.e., overactive, under active, fidgety, distant, childlike (for an adult), friendly, impulsive, etc.)
- Attitude (i.e., cooperative, uncooperative, evasive, etc.)
- Mannerisms (i.e., gestures, tics, grimacing, etc.)

- Posture (i.e., slumped, relaxed, stooped, etc.)
- Speech (i.e., soft, coherent, incoherent, rambling, pressured, etc.)
- Affect (i.e., appropriate, rich, flat, restricted, blunted, etc.)
- Mood (i.e., euthymic, depressed, elevated, etc.)
- Characteristics of thoughts (i.e., illusions, paranoia, grandiosity, hallucinations, delusions, etc.)
- Orientation (i.e., person, place, time)
- Memory (i.e., remote, recent, immediate, etc.)
- Intellectual functioning
- Eye Contact
- Awareness of illness
- Appetite
- Sleep (i.e., nightmares, waking frequently, difficulty falling asleep, sleeping too little, sleeping a great deal)

Five Axis Diagnosis

This is to be formulated with the information in the assessment. The diagnosis must accurately reflect information gathered in the assessment, and information gathered in the assessment must accurately reflect the diagnosis. For help in appropriate Five Axis Diagnosis formulation, please see the DSM IV TR for more information.

Disposition/Recommendation/Referrals to other services

This section is used to explain the next step for client. This includes information as to how the clinical staff will be proceeding with regards to treatment. This includes, but is not limited to:

- Individual therapy
- Group therapy
- Rehabilitation
- Support Services
- Referrals to other providers based on the level of services needed
- Medication referrals

Other information about Assessment

For clients undergoing their initial assessment, the practitioner can bill assessment one (1) time for adults and up to three (3) times for children for completing the full and complete initial assessment. Annually, the practitioner can bill one (1) time for adults and up to three (3) times for children. The following are examples of other situations that are common, and how those assessments would be handled:

A. For an on-going client with uninterrupted treatment, the client would have the initial assessment (1) and a yearly re-assessment (2).
B. If the client had an initial assessment (1), left treatment, was discharged, then returned after 6 months, the clinician would have to complete another assessment (2).
C. If the client had an initial assessment (1), left treatment, was discharged, then returned prior to 6 months but had significant changes in their life, a complete assessment would be required (2).
D. If the client had an initial assessment (1), left treatment, was discharged, then returned prior to 6 months but did not have significant changes in their life, a re-assessment (2) would be required.

Appendix F
Components of a Re-assessment

Re-assessments are completed when an annual client plan is being completed, unless a full assessment is being completed. There is a Re-assessment form, available on the intranet, however Re-assessments can also be completed in progress note format with the following information included.

Re-assessments include much of the same information as assessments, however this information is used as an update to the most recent assessment, so there is not as much information needed as there is in a full assessment.

Information included in the re-assessment is:

- Presenting problem, including the current symptoms and relevant conditions affecting mental health
- Psychiatric symptoms and any change of symptoms in the last year
- Any change in family composition
- Medical History
- Current Five Axis Diagnosis
- Current Mental Status Exam
- Current Recommendations for treatment

Other paperwork to be completed annually:

- Releases
- Authorization Form
- Medical Necessity
- Consents
- Client Plan
- Financial, including Medi-Cal eligibility (if changes occur)

Appendix G
Components of a Client Plan

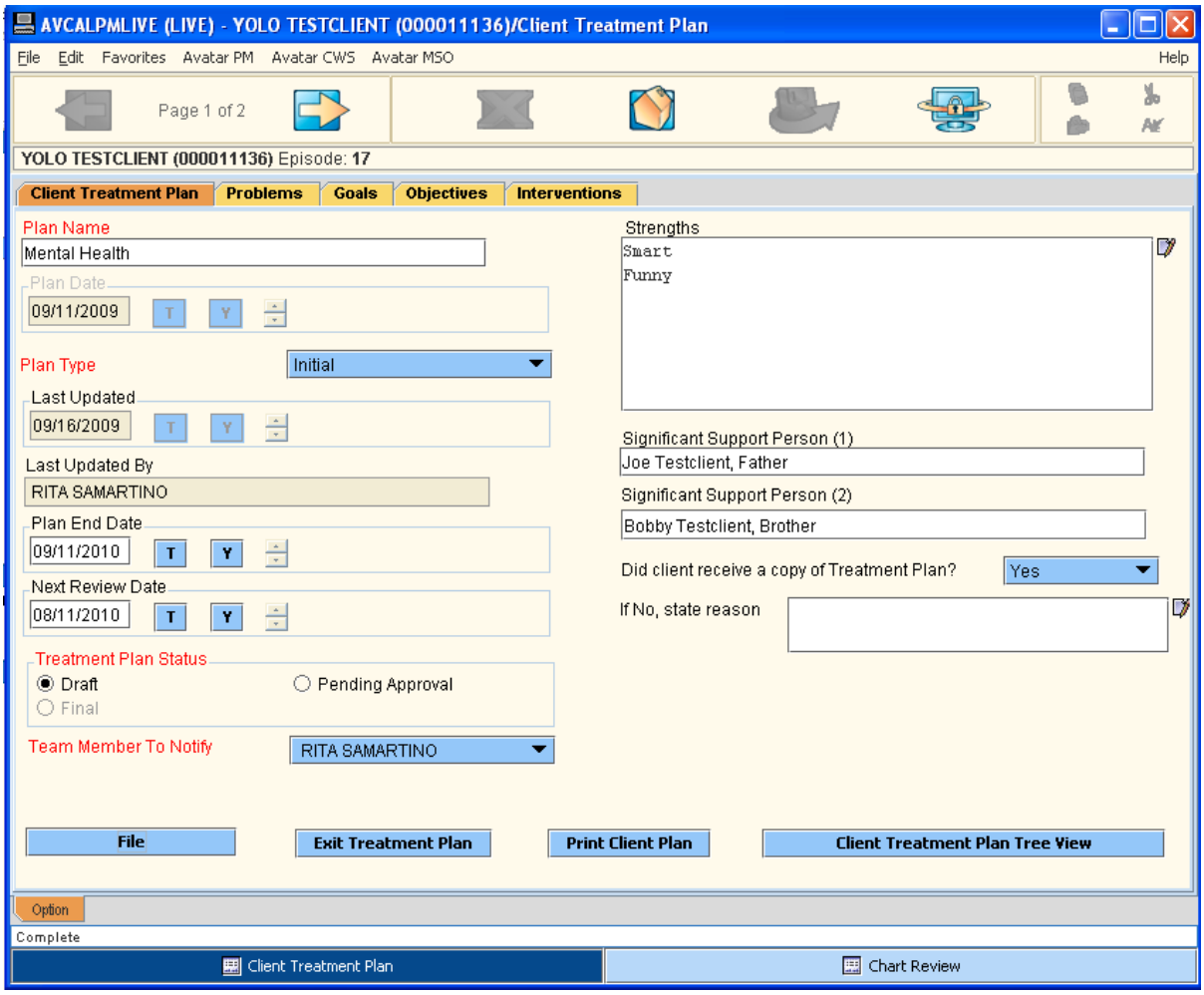
Client Plans are formulated as a *joint effort* between Clinician/Specialist and client (and parent/guardian/conservator as necessary).

The Client Plan needs specific, observable and measurable behavioral, emotional or cognitive targets that assist the client in achieving their needs from mental health services. Quotations from the client can be helpful in articulating the expectations the client and/of family has in accessing services. Strengths of the client that will assist client in meeting goals must also be documented. Goals should be reflective of the diagnosis. It might also be helpful to follow the acronym SMART when formulating goals and objectives: **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, **T**ime Limited

Remember to include the significant support persons, as defined in collateral, in the "desired result from mental health services." Collaborating with these individuals on behalf or for the benefit of the client will be billed as collateral.

The following are screen shots from the AVATAR Treatment Planner to help the explanation of treatment planning. Remember to file after completing each section.

Client Treatment Planning Screen

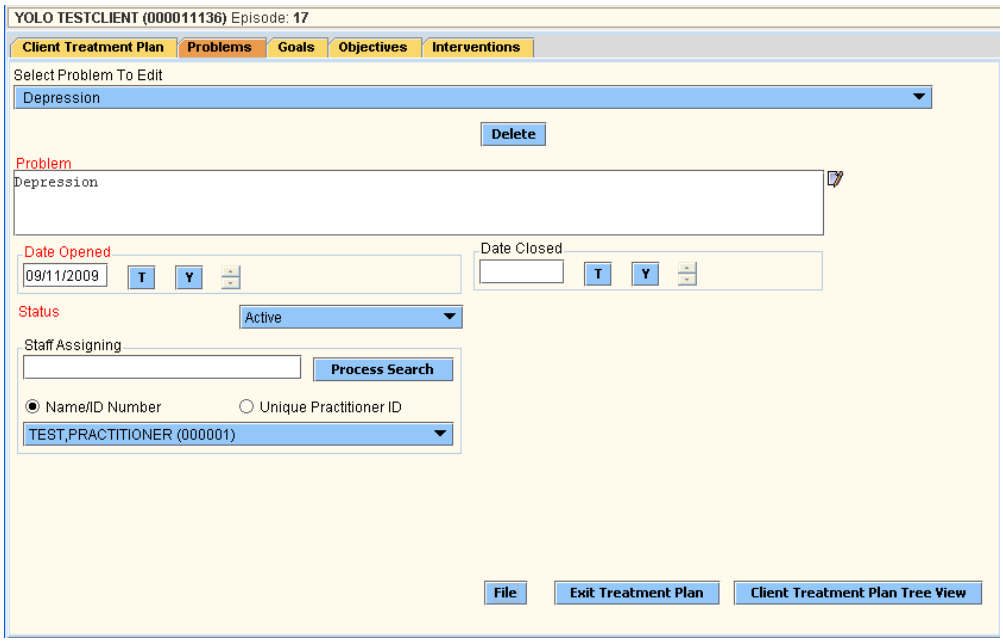


Please remember to include strengths, significant support persons, and whether or not the client received a copy of the client plan.

Examples of strengths could include the client is motivated for therapy, client has the cognitive ability to learn new coping skills and gain new insights, client has a sense of humor, client has many interest, etc.

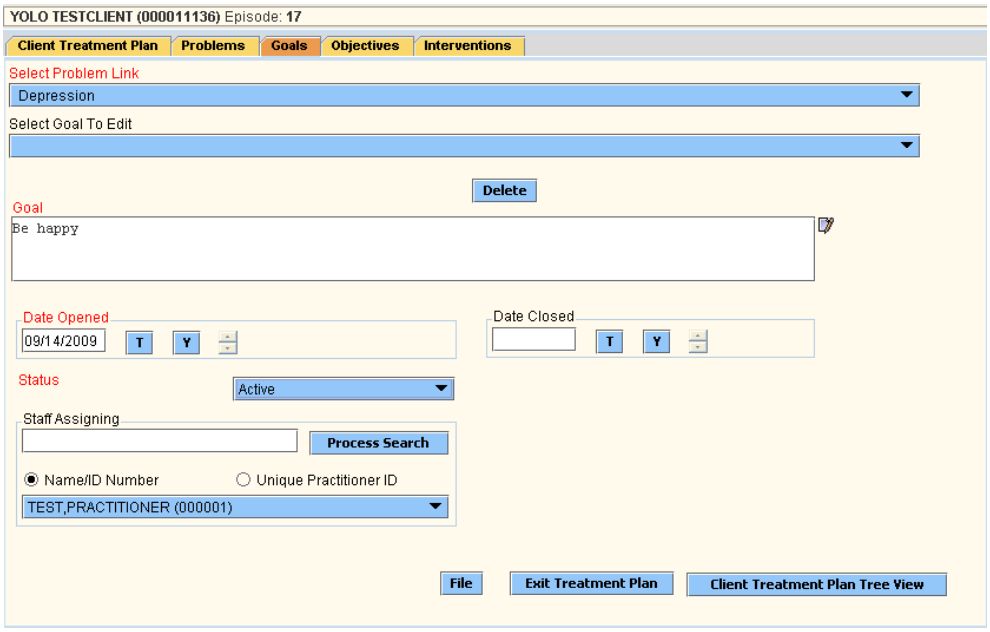
When indicating the significant support persons, identify the person by name and the role the person plays in the client's life. And example of this would be "John Doe, Father". If you need further space for more people, there are more spaces available on the second page of the "Client Treatment Plan" screen.

Problems



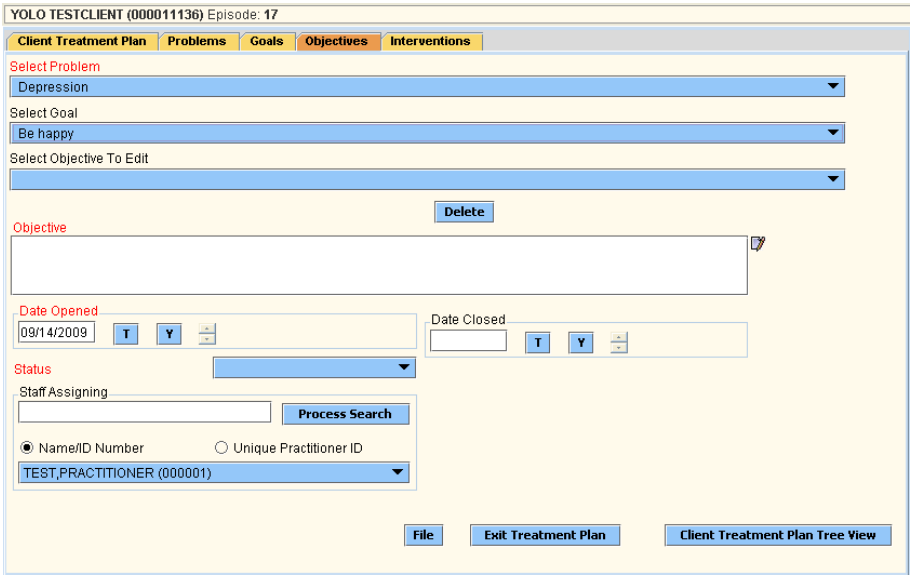
This section addresses the presenting problems that the client plan will be addressing. This could include the symptoms (i.e.-depression, anxiety), behaviors (i.e.-aggression, cutting), or life impairments (i.e.- lack of skills sets, inappropriate interaction with others).

Goals



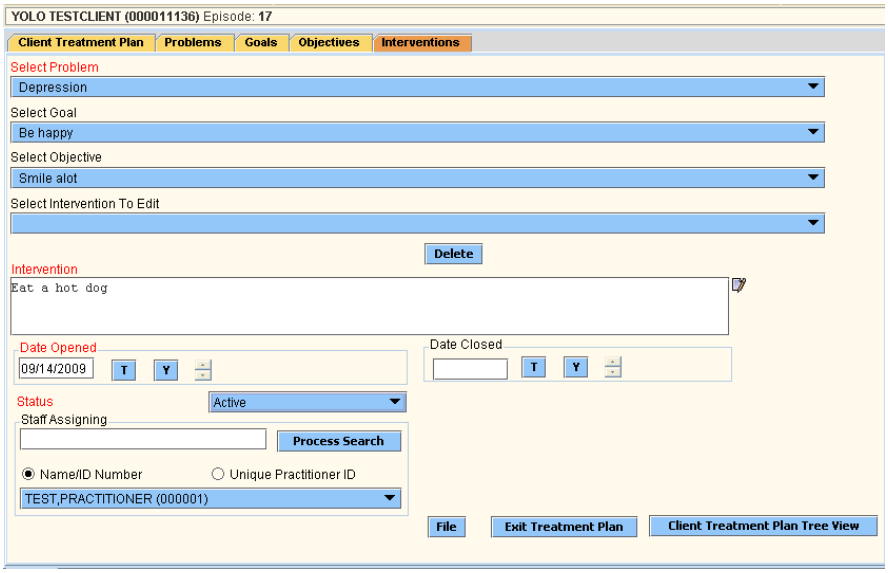
Choose which problem the goal will be addressing. Goals are general statements, whereas objectives are the more specific routes to the goals (and objectives will be addressed in the next screen). Goals could include "Decrease depressive/anxious symptoms", "Increase appropriate social interaction", etc.

Objectives



Objectives are more specific, and will be the measurable piece to attain the goals. For instance, for the goal of "Decrease depressive symptoms", an objective may be "Increase positive self talk from 0 times a day to 3 times a day as reported by client".

Interventions



The intervention is the means by which you plan to attain the goal. If we continue with the example of "Decreasing depressive symptoms", and intervention could be "Brief Solution Focused therapy focused on issues of depression and sleep difficulties. Will teach stress management skills."

In addition,

1. A Client Plan is required from each service providing on-going treatment, including Adult, Children, and Older Adult Mental Health Services; Adult and Children's Intensive Day Treatment and Day Rehabilitation; Crisis Residential and Adult Residential; Medication Services when a client is receiving medications only; and contract providers

2. Dated signature(s) with professional degree, license or job title for:

   - Primary service clinician, or person representing a team or program, and/or

   At least one of the following:
   - Licensed Physician
   - Licensed Psychologist
   - Licensed Clinical Social Worker
   - Licensed Marriage, Family Therapy
   - Registered Nurse
   - Mental Health Rehabilitation Specialist (MHRS) if Head of Service

3. Dated signature(s) is required for
   - Clients 12 or older, unless client refuses or is unavailable
   - Parent/guardian of minors under 12 and, preferably, when 12 or older as well

4. Time Frame:
   - Completed no later than the second visit following assessment
   - Crisis residential within 72 hours of admission
   - Updated at appropriate intervals
   - Updated prior to Plan's expiration
   - Starts on date on-going services first provided

5. Document the level of involvement from the client, parent/guardian, and/or conservatorship's office in development of the treatment plan.

6. If client and/or the parent, guardian or conservator refuses to sign the client plan, you must state why, both on the plan and in an accompanying progress note.

Appendix H
Client Plan Library

CLIENT PLAN GUIDE

The purpose of the Client Plan is to address the goals for the client. These goals must directly relate back to the specific Specialty Mental Health Service(s) the client is receiving, must be related to the client's diagnosis and must be measurable AND observable. For example, if the client is receiving case management, the client plan goals and interventions need to directly pertain to those services.

A goal can be very worthy and beneficial to the client, such as "increase community social contact", but not be acceptable because the goal is not linked directly back to the specific Specialty Mental Health Service (Day Rehabilitation, Mental Health Services, Case Management, Medication Support).

Additionally, attending groups/treatment or participating in groups/treatment cannot be in itself a goal. Medi-Cal assumes that the client will attend and participate.

Unacceptable **Client goals:**

- Increase community contacts
- Attend groups regularly
- Do chores without prompting
- Attend school or work
- Reduce paranoid episodes
- Reduce manic episodes
- Take medication without prompting
- Get along better with staff, peers, or board and care operator
- Maintain sobriety
- Attend 12-step groups

Acceptable **Client goals for Day Rehabilitation:**

- Twice a week in Socialization Group and as reported by staff, the client will verbalize effective coping skills for managing auditory hallucinations for the next six months.
- Three times a week in Symptom Reduction group and as observed by staff, the client will identify barriers to participating in group for the next six months.
- Once a week in Community group and as observed by staff, the client will identify barriers to completing daily/weekly chores for the next six months.
- Once a week in Life Skills group and as observed by staff, the client will process and explore school/work options for the next six months.
- Twice a week in Symptom Reduction group and as observed by staff, the client will identify triggers of paranoid ideation or hypomanic episodes for the next six months.
- Weekly in Life Skills group and as observed by staff, the client will identify internal barriers to taking medication unprompted by staff for the next six months.
- Three times a week in Life Skills group and as observed by staff, the client will identify socially inappropriate behaviors and express acceptable behaviors/verbalizations for the next six months.

***Acceptable* Client Plan goals for Case Management and Mental Health Services:**

SOCIAL ANXIETY/ANXIETY

- Client will reduce social anxiety by initiating 3 social interactions per week as observed by staff for the next 6 months.
- Client will reduce social anxiety related to his persistent mental illness by identifying emotional triggers and communicating related feelings 2 times per week as observed by staff for the next 6 months.
- Client will effectively manage social anxiety by verbalizing at least 3 symptoms of anxiety at least once a week as observed by staff for the next 6 months.
- Client will effectively manage anxiety related to h/her persistent mental illness by sharing h/her symptoms of anxiety and appropriate coping techniques 3 times a week for the next 6 months.
- Client will reduce feelings of anxiety around not being understood by verbalizing thoughts __x/week every week for six months as observed by staff.
- Client will reduce feelings of anxiety about housing by verbalizing thoughts related to housing __x/week every week for six months as observed by staff.

SOCIAL/RELATIONSHIP SKILLS /WITHDRAWAL

- As part of improving social skills, Client will improve self-awareness by reporting to staff 1 negative and 1 positive social interaction 2 times a week for the next 6 months.
- Client will improve social skills by identifying and verbalizing one difficulty related to his social interactions twice a week for the next 6 months as observed by staff.
- To improve relationship skills, Client will identify and communicate triggers of anger and irritability that surface during interactions at least 2 times a week, as observed by staff, for the next 6 mos.
- Client will reduce social withdrawal by actively participating in available treatments/social resources at least 3 times a week as observed by staff for the next 6 months.
- Client will reduce social withdrawal by identifying and verbalizing three triggers of isolation as observed by staff __x/week every week for six months.
- Client will increase relationship skills by identifying two social interactions and communicating these feelings __x/week during process groups as observed by staff for six months.

FOCUS & CONCENTRATION

- At least twice a week for the next 6 months (during case management meetings; plan development; individual, group, client), Client will identify and verbalize barriers to focusing and concentrating as observed by staff.
- Client will increase her ability to concentrate and focus on a daily basis by demonstrating the ability to complete her projects during Creative Arts groups 2 times per week for the next 6 months, as observed by staff.

ACTIVITIES OF DAILY LIVING

- Client will understand the need for good hygiene by reporting and practicing 3 healthy personal hygiene skills as observed by staff for the next 6 months.
- Client will implement healthy personal hygiene practices by attending community and peer functions/meetings appropriately groomed (showered, clean clothing, teeth brushed, deodorant) __x/week every week for six months as observed by staff.
- To learn basic hygiene and grooming skills, Client will produce and commit to a daily hygiene routine as reported by Client/observed by staff.

- To learn basic hygiene and grooming skills, Client will purchase/obtain at least 2 grooming supplies every month as reported by client observed by staff.
- To learn basic hygiene and grooming skills, Client will self-initiate attending 3 independent living skills groups each week as reported by client observed by staff.
- Client will independently demonstrate self-care needs by showering with soap and shampoo without prompting from staff at least _x's week every week for 6 months as reported by client observed by staff.
- Client will demonstrate to staff _x's a week the ability to prepare well rounded and balanced meals as observed by staff.
- Client will demonstrate effective independent living skills by laundering clothes at least _x's a month as reported by Client/ as observed by staff.
- Client will demonstrate an understanding of Board and Care rules by complying with the rules 80% of the time during the first month, 85% of the time the next month…, as reported by Client/ as observed by staff.

SYMPTOM MANAGEMENT

- Client will effectively manage symptoms related to schizophrenia, e.g., responding to internal stimuli, by verbalizing 3 coping skills 3 times a week as observed by staff for the next 6 months.
- Client will effectively manage symptoms of depression, e.g., feelings of hopelessness, worthlessness, and low self-esteem, by verbalizing feelings related to his/her mental illness __x/week every week for six months as observed by staff.
- Client will recognize, manage, and cope with symptoms of depression, e.g., low self-esteem and feelings of hopelessness, by verbalizing how he/she is feeling (during Community
- Meeting, case management sessions, Client) __x/week every week for six months as observed by staff.
- Client will decrease irrational internal stimuli that contribute to feeling anxious by weekly identifying 1 anxiety provoking trigger for the next 6 months as reported by client observed by staff.

RELAPSE PREVENTION

- Client will develop a healthy support system by obtaining and utilizing at least 1 telephone number of a clean and sober person as reported by Client weekly.
- Client will develop a healthy support system by making weekly contact with 2 sober support people as reported by Client
- Client will develop a healthy support system by attending at least 3 12-step meetings a week as reported by client and with proof of a completed sign-in sheet.
- Weekly, Client will reduce risk of relapse by identifying in writing at least 10 triggers, e.g., people, places and things, as reported by Client/observed by staff.
- Weekly, Client will verbalize at least 2 statements of acceptance regarding his/her addiction as observed by staff.

OTHER STUFF

- Client will effectively manage impulsive behavior during group by raising his hand before speaking out loud 3 times a week as observed by staff for the next 6 mos.
- Client will reduce the need to gain approval from staff by identifying and verbalizing at least one new coping skill for increasing emotional independence each week for the next 6 months as observed by staff.

- Client will self-regulate emotions and/or behaviors by requesting to speak out loud in group _x times a week as observed by staff for the next 6 mos.
- Client will increase stress management skills to reduce irritability by respectfully verbalizing angry feelings during group __x/week every week for six months as observed by staff.

Strengths:
Strengths are those qualities that the client possesses that will make attainment of that particular goal likely. This can include spiritual beliefs, family support, motivation, intelligence and good connections with staff, etc.

Interventions:
These are the activities of the staff that will assist the client in achieving the client's goals. Some examples include: Symptom Reduction group; Living Skills group; and providing feedback from staff in Community group, Case Management, Medication Support, etc.

Duration and Frequency:
How often will the identified services take place during a day/week/month (frequency) for the next 6 months (duration).

Appendix I
Billing for Time Spent in Groups
(Group Therapy or Rehabilitation Groups)

Note: If not using AVATAR Groups Notes, the math to figure out the billing time for each client must be shown in the body of the note.

Group in Office

__ (Minutes) x __ (Number of Staff) = (Total Minutes) ÷ __ (Number of Consumers) = _ (Adjusted Minutes) + _7_ (Documentation) = __ (Billable Minutes)

Example: A skill building group with 6 clients in the office lasted for 96 minutes. The Specialist is completing the notes the same day the group occurred. It takes 8 minutes for the Specialist to write the note for one client. The formula would be:

96_ (Minutes) x _1_ (Number of Staff) = 96 (Total Minutes) ÷ _6_ (Number of Consumers) = 16_ (Adjusted Minutes) + 8_ (Documentation) = 24_ (Billable Minutes)

Therefore, the time that is billed for that client is 24 minutes.

Groups Requiring Travel

__ (Minutes) x __ (Number of Staff) = (Total Minutes)÷ _ (Number of Consumers) = _ (Adjusted Minutes)+ __ (Documentation) = __ (Billable Minutes)

Please note that we do not require the travel time to be split out from the total number of minutes unless traveling outside of the county. In this scenario, the "minutes" includes the face time and travel time.

Example: A Clinician drove to another office site to complete a psychotherapy group. It took him/her 25 minutes to travel there. There were 8 people in the group, and the group lasted for 128 minutes. The Clinician then returned to his/her office to complete the documentation. The return trip took 23 minutes. The Clinician spent 9 minutes on a note for one of the clients. The formula would be:

_176_ (Minutes) x _1_ (Number of Staff) = 176 (Total Minutes)÷ 8_ (Number of Consumers) = _22 (Adjusted Minutes)+ _9_ (Documentation) = _31_ (Billable Minutes)

Therefore, the time that is billed for that client is 31 minutes.

Groups with Two Facilitators

In conducting groups with two facilitators, the time of both facilitators is taken into consideration when billing for the note. Only one note has to be written for each client who participated in group.

Therefore, the equation is as follows:

__ (Minutes) x __ (Number of Staff) = (Total Minutes)÷ _ (Number of Consumers) = _ (Adjusted Minutes)+ __ (Documentation) = __ (Billable Minutes)

Please note that prep time is allowable on the same day as the service is provided. This time is included into the total time. Please see the example below for more clarification.

Example: Two Clinicians complete a psychotherapy group. Preparation for the group took 41 minutes. The group lasted 90 minutes, and there were 9 people in the group. In addition, the Clinician spent 11 minutes on the note for the client. The formula would be:

_131_ (Minutes) x _2_ (Number of Staff) = 262 (Total Minutes)÷ 9_ (Number of Consumers) = 29.1_ (Adjusted Minutes)+ 11__ (Documentation) = _40.1_ (Billable Minutes)

Therefore, the time that is billed for that client is 40 minutes.

***Note**: When the amount of time figured out for each client happens to end in a decimal (i.e., 16.3), round down to the nearest full number (e.g., 16.3 would become 16).*

Co-Staffing During Services

Co-staffing is when two professions are billing the same service code for the same client, where the time is the same. When this occurs, only 1 progress note needs to be completed. Examples of this would be if two staff are facilitating a collateral group or two staff go out in the field to see a client where safety may be a concern.

How to Bill for Two Staff Providing Service

In a situation where two staff are providing the service and they are of a different discipline (i.e.-a physician and a clinician; a clinician and a specialist; a physician and a specialist), the staff are providing two different services (i.e.-a physician provides medication support while a clinician provides emotional support to the client), or there is a different amount of time each staff provided their respective services, each staff is responsible for completing a progress note.

Appendix J
Transfer Cases

What to do when transferring an existing case:

- Discuss with Supervisor, and obtain Supervisor's approval to transfer.
- If the transfer is to take place within the same site, the Supervisor will assign the case to another Clinician.
- If the transfer is to take place between sites, the Supervisor will contact the transfer site's supervisor to discuss and obtain permission to transfer to a different site.
- Discuss case with new/receiving Clinician, if possible
- Write summary progress note, including reason for transfer. This would be billed as Plan Development, unless direct service with the client was provided. If the client was present, the note would be billed as whichever service was provided (i.e.- individual therapy, rehabilitation, etc.)

What to do when receiving a transfer case:

- Prior to receiving a transfer case, the Clinician who is accepting the transfer case must utilize the UR tool and review the chart to ensure the completeness of the chart. When reviewing a chart with the UR tool, use the code Y9905 to account for the time.
- Note any corrections that need to be made and contact the Clinician who is transferring the case prior to the transfer, if possible to have the Clinician make necessary corrections.
- If returning a chart for corrections, include the UR tool.
- Update the MIS packet and submit to either support staff or billing staff

What to do when acquiring a transfer case from a Clinician who is no longer with the agency:

- Utilize UR tool and review the chart. Utilize code Y9905 to account for the time.
- If there are correctable issues within the chart, work with the supervisor to make those corrections.

Appendix K
Acknowledgement of Receipt Script

With the requirement of offering and explaining certain materials to Medi-Cal beneficiaries also comes the requirement to explain. Each section of this script corresponds to a section on the Acknowledgement of Receipt Form.

"These materials are located in (explain where materials are located in the office/offer materials if in community). Feel free to take a copy if you're interested, or if you would like a copy of them."

Medi-Cal Mental Health Guide to Service (also known as the Informing Materials)
"This is a booklet that explains the mental health services you can access through our agency. It also includes information about the problem resolution process and rights as a client receiving mental health services through the agency."

Problem Resolution Information
"Information regarding the problem resolution process is located within the Medi-Cal Mental Health Guide To Services/ Informing Materials. There is also a grievance form attached to an envelope out in the (location where client can find all these materials). If you have a problem or a concern, you can fill out the form, drop it into the attached envelope, drop it in the mail, and it goes to our Quality Management Department."

(Note: The grievance forms are available in all threshold languages.)

Advance Directive Brochure
"There is information about Advance Directives also available to you if you're interested. Are you familiar with what an Advance Directive is?"

An explanation of Advance Directives: "An advance directive is a legal document that states what you would want to have happen in case you were unable to make decisions for yourself due to a medical or mental health emergency."

Interpreter Services
"Do you need any sort of interpretation services?"

Yolo County Mental Health Plan Provider List (also known as the Provider List)
"This is a list of all the providers in the community Yolo County contracts with to provide mental health services. It's currently in the process of being updated, so if you are trying to find a particular provider, and need assistance, we'd be happy to help you locate them."

Notice of Privacy Practices
"This is the document that was provided to you when you were filling out paperwork for the intake. It includes information about how we keep your information highly private and confidential. We may ask you to sign a release of information if there are other entities that we feel speaking to would benefit your treatment, however it is your decision on whether or not you sign the release. If you choose not to sign a release of information, it may impact the level of service we are able to provide to you." (This is due to not being able to gather necessary information from other sources that the client is involved with. For instance, if client denies access to speaking with their doctor, one of our doctors completing a medication evaluation may not have necessary medical information.)

"Along with confidentiality, I also like to explain to people the limits of confidentiality (based on state law). These include:

- If you tell me you are going to hurt yourself or someone else, I have to take the necessary precautions.
- If you tell me you are going to damage someone's property, I have to take the necessary precautions.
- If you report child or elder abuse to me, I have to make a report.
- I also like to let clients know that there is the chance that we may or our charts may be subpoenaed into court. It does not happen very often, but it can happen."

"Any questions?"

Appendix L
References

Regulation or Law	Title	Code Section (§)	Regulation Area/Topic
CCR	9	§1810.204	Assessment
CCR	9	§1810.205	Beneficiary
CCR	9	§1810.206	Collateral
CCR	9	§1810.209	Crisis Intervention
CCR	9	§1810.210	Crisis Stabilization
CCR	9	§1810.211	Cultural Competence
CCR	9	§1810.212	Day Rehabilitation
CCR	9	§1810.213	Day Treatment Intensive
CCR	9	§1810.215	EPSDT Supplemental Specialty Mental Health Services (i.e., Therapeutic Behavioral Services - TBS)
CFR	9	§625	(Licensed Clinical) Social Worker (LCSW)
CFR	42	N/A	(Licensed Practitioner of the Healing Arts) [LPHA] Diagnostic, screening, preventative and rehabilitative services
CCR	9	§626	Marriage and Family Therapist (formerly *Marriage, Family and Child Counselor*) [MFT]
CCR	9	§1830.205	Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services
CCR	9	§1830.210	Medical Necessity Criteria for MHP Reimbursement of Specialty MHS for Eligible Beneficiaries Under 21 Years of Age
H & S	N/A	§123105(b)	Medical Record
CCR	9	§1810.225	Medication Support Services
CCR	9	§1810.226	Mental Health Plan
CCR	9	§1810.227	Mental Health Services
CCR	9	§630	Mental Health Rehabilitation Specialist
CCR	9	§1840.312	Non-Reimbursable Services
CCR	9	§1810.231	Organizational Provider
CCR	9	§1810.232	Plan Development
CCR	9	§623	Psychiatrist
CCR	9	§624	Psychologist
CCR	9	§782.44	Registered Nurse
CCR	9	§1810.247	Specialty Mental Health Services
CCR	9	§1810.246.1	Significant Support Person
CCR	9	§1810.380 and §1810.385	State Oversight and Civil Penalties
CCR	9	§1810.249	Targeted Case Management
CCR	9	§1810.250	Therapy
CCR	9	§1810.254	Waivered/Registered Professional (LPHA)

CCR = California Code of Regulations (www.oal.ca.gov); H & S = California Health and Safety Code (www.leginfo.ca.gov); CFR = Code of Federal Regulations(www.gpoaccess.gov/cfr/index.html)

Appendix M
Frequently Asked Questions

1. **What code should the doctors and other prescribers use when completing an assessment like session with a patient?**

   ***Answer**: Anytime an MD, DO, NP, or PA completes an initial assessment, they would bill the Medication Support Code of 1560 or if completing a reassessment, the code would be 1560B.*

2. **I noticed that the assessment requires paperwork be given to the client, such as the HIPAA Privacy Practices, Problem Resolution, Advanced Directives, and the Provider List. Does this paperwork have to be provided every time this code is utilized?**

   ***Answer:** The necessary paperwork such as the HIPAA Privacy Practices, Problem Resolution Information, Advanced Directive and the provider list need to be provided/offered to the client on an annual basis. So, if the client has seen a Clinician to complete the intake, and has been provided with that paperwork, this paperwork does not need to be mentioned in the documentation for a year, even if the assessment or reassessment code is used. (Of course, if the client requests it again, it must be made available to the client). If more than a year has passed, and the client has yet to be seen for a re-assessment by a Clinician, an appointment should be scheduled for an intake to occur as quickly as possible, and the necessary paperwork will be covered in that appointment.*

3. **Is there a list of Included Diagnoses posted somewhere?**

   ***Answer**: Yes. The list of included diagnoses can be found in the ADMH Mental Health Program forms on the Intranet, and is listed under the Medical Necessity bullet as Addendum. This information is also included in the Clinical Survival Guide.*

4. **Can we bill for reviewing a case that has been transferred to us?**

   ***Answer**: We recommend completing a UR tool on any case that is transferred, and this time is billed as Y9905 in AVATAR..*

5. **If I am speaking with another Clinician or another Doctor about a client, can we both bill that time?**

   ***Answer**: Yes. AVATAR allows another staff's time to be included in a service note.*

6. **Can I bill for time in supervision?**

   ***Answer**: No. The time spent in supervision is documented using Y9946.*

7. **Can I bill for a no-show?**

   ***Answer**: No. At one point, we were allowing people to bill 5 minutes in AVATAR for no shows and cancellations, however that is no longer the case. The Y-code for No Show /Cancellation is Y9929.*

8. **Is documentation time billable?**

   ***Answer**: Yes.*

9. **I received a phone call from a provider who wants to transfer a client's services to ADMH. I understand that I am the assigned practitioner for this client. Can I call this provider back to discuss the client?**

   ***Answer**: Yes, you can always return a phone call, however depending on whether or not the client has signed a release for you to be able to speak with the previous provider limits the amount of information you can provide. If you are able to speak with this provider, this conversation may be billed 2 different ways depending on how the client defines the provider. If the provider is defined by the client as a "significant support person", the conversation could be billed as collateral. If the provider is not defined by the client as a "significant support person", then the conversation would be billed as case management/brokerage If you do not know how the client defines the provider, bill on the side of caution and go with targeted case management.*

10. **I have an AB-3632 client with a current IEP. Do I still have to complete a Mental Health Treatment Plan?**

    ***Answer**: Yes. A Mental Health Treatment Plan must be completed with the client and/or parent/guardian.*

11. **How do I bill for the time spent in an IEP meeting regarding an AB-3632 Client?**

    ***Answer**: Attendance at IEP meetings are billable for Chapter 26.5 clients. During the time of assessment and at annual IEP meetings, the intervention being provided is determining ongoing eligibility, and is billed as assessment or reassessment, appropriately. If the Case Manager determines that there is a need for a change in residential placement or change in mental health services, such as Day Treatment, this would be billable as plan development. Attendance at an IEP for a non-Chapter 26.5 client is not billable as a meeting.*

    Documentation must always include the mental health intervention that was provided, and the reason the professional providing the service was the one to provide the service. In order for participation at an IEP to be billable, an intervention must be provided, not just advocacy.

12. **If I am at a treatment planning meeting, and have discussed a current patient, can I bill?**

    ***Answer**: Billing time spent in meetings discussing a client is always a slippery slope, due to the lack of direct service being provided to the client. If, while at a meeting, information is being provided and gathered that will directly impact treatment planning, and this is documented to such, a reasonable amount of time can be billed under Case Management/Brokerage .*

13. **Can I bill for dictation time and review of dictation?**

    ***Answer**: Dictation time is considered documentation time, and the same rules apply. Review of dictation is not considered billable time by Medi-Cal standards.*

14. **When completing a child assessment, should I bill the time spent with the parent/guardian separately as collateral, or should I bill the whole time as assessment?**

***Answer**: The whole time can be billed as assessment, but as a separate assessment session. Generally, it is permissible to bill for 3 assessment sessions for children/youth/adolescents and 1 for adults.*

15. If I share a client with another practitioner, can we bill the same code on the same day for that client?

***Answer**. It really depends on the code. For instance, it may be completely appropriate to have two different people billing Rehabilitation, Case Management/Brokerage), or Collateral on the same day. Keep in mind there might be time limits on codes (i.e.- medication support can only be billed for a total of 4 hours in a day; crisis intervention can only be billed for 8 hours in a day).*

16. How does an On-Call doctor bill for the calls they receive while on call?

***Answer**: Currently, this is not a practice we engage in, due to not having off site access.*

17. Would you please clarify if we are able to bill for services on a day that a client is released from the hospital or Safe Harbor, etc?

***Answer**: Assuming SHCH is also billing on the day the client was discharged, only medication support and case management can also be billed on day of discharge. Remember that medication support and case management can be billed at any time during the SHCH stay.*

At a fee-for-service hospital (e.g., Woodland Memorial 3B North), mental health services and medication support can be billed any time during the hospitalization and case management can be billed on the day of discharge. However, this answer is different regarding Short-Doyle/Medi-Cal hospitalization like Sierra Vista or Heritage Oaks. See Title 9 Lockout Document for further information.

18. Can a Clinician bill for providing interpretation services as a third party interpreter?

***Answer**: No. Interpretation and translation services are not billable to Medi-Cal or Medicare.*

19. Is completing the Authorization Paperwork billable?

***Answer**: On its own, no, it's not billable. However, if you complete the authorization paperwork while doing the rest of the assessment paperwork, a reasonable amount of time can be claimed.*

20. How many people are needed in a group activity (such as a skill building group) before I have to do the math on the note?

***Answer**: A group is 2 or more clients.*

21. Do Clinicians need to complete DTs for direct services?

***Answer**: "DTs" are no completed in AVATAR through the Post Staff Activity Log. All minutes that are worked in a day must be accounted for in AVATAR.*

22. How many times can we bill assessment in a year for one client?

***Answer**: Generally, we allow 1 assessment session to be billed for adults in an appropriate time frame and 3 assessment sessions for children. There are times when it will be appropriate to have more, and documentation of these circumstances is necessary. Some examples of this are:*

A. For example, for an on-going client with uninterrupted treatment, the client would have the initial assessment (1), and a yearly re-assessment (2).

B. If the client had an initial assessment (1), left treatment, was discharged, then returned after 6 months, the clinician would have to complete another assessment (2).

C. If the client had an initial assessment (1), left treatment, was discharge, then returned prior to 6 months but had significant changes of functioning, a complete assessment would be required (2).

D. If the client had an initial assessment (1), left treatment, was discharge, then returned prior to 6 months but did not have significant changes in their life, a re-assessment (2) would be required.

23. How do I bill for that unexpected and unplanned "downtime"?

The following are scenarios that Clinicians and Specialists can frequently find themselves dealing with, and ideas to help make the time billable.

A. A Client no showed for our session in the office today. How can I recoup that time?

- *First, attempt to contact the client by phone. If you're able to reach them on the phone, attempt to have your session with them. Bill for the appropriate code of the service provided.*
- *If you are not able to reach the client and have a release to speak with collateral contacts, try to contact them. Gathering information about a client can help with treatment planning. Plus, the collateral contact may know where the client is, and may be able to provide you the information to contact the client.*
- *If there are other professional supports for the client, you could also attempt to reach them to discuss your shared client's treatment, if there is a release on file.*
- *If all else fails, this gives you an opportunity to tackle those other phone calls and pressing matters with other clients. Just don't forget to bill! Those brief phone calls can really add up, and you want to give yourself credit for the work you're already doing.*

B. I arrived for a client appointment in the field, but the client wasn't there. Is there something I can do to make this travel time billable?

- *First, is there anyone at the residence who would be considered a collateral or case management contact with whom you have a release to speak with? If so, spend some time speaking with that person or people about how the client is doing. It's possible they know where the client is, and you can locate the client. Just be cautious in trying to find the client; always be aware of the potential violations of the client's confidentiality when encountering them in a public place.*
- *If you are able to, and the client has a cell phone, try calling to find out where they are. From there, you can located and client and proceed from there.*

C. It's 1:55 p.m. and my 2 o'clock appointment just called and cancelled. What do I do now?

- *Did you spend time talking to the client about how they're doing, why they're cancelling, etc? That time would be billable, particularly if you're working on something like importance of maintaining scheduled appointments for treatment or working on treatment planning for future sessions.*
- *Is it possible to move a later client into an earlier spot and possibly reschedule this client for later in the week? That will help increase your billing as well.*
- *If you still have time leftover, try to contact collateral or case management supports on behalf of the client.*

The following answers are for Prescribers:

I've reviewed the chart in preparation for my appointment only to have the patient no show/cancel? Can I bill?

- *Yes. You have still spent time reviewing the chart and creating a plan. This would fall under "Plan Development No Show-MD/DO/NP/PA".*

Like the Clinicians and Specialists, there is also the option of contacting the client to determine why there was a cancellation or no show and/or speak with collateral or case management supports. For prescribers, since this information is used to guide treatment planning with regard to medication, these services would be billed as Medication Support.

24. If a client/patient is in a Psychiatric Health Facility (PHF) for longer than 30 days, should the initial Discharge Planning notes be disallowed or changed if they were completed when the client/patient was admitted?

Answer: *Technically speaking, yes they would have to be, however this should be such a rare instance that if this arises, the case manager on the case should be supervising with their supervisor and/or manager, and this will be addressed on a case-by-case basis.*

25. If a psychiatrist is completing an affidavit on a Willow Glen client in the Woodland Office, can they bill for their time since Willow Glen is an IMD?

Answer: *First of all, Willow Glen is a Board & Care, not an IMD. Therefore, all services would be billable.*

26. Crisis receives a call from someone YCADMH has never seen and the crisis worker spends 40 minutes on the phone with them. The client later ends up in the ER and is seen by day crisis and a crisis assessment is completed. Can we bill for the original phone call?

Answer: *If the services all occurred within the same day, yes. However, the case should have been opened during the initial phone contact.*

27. Crisis receives a call from a client who has mismanaged their medications and is distraught and hysterical. An RN handles the call. Should this be billed as Crisis Services or Medication Support?

Answer: *Medication Support. The Medical Staff (MD, DO, PA, NP, RN, LVN) bill medication support for all the services they provide.*

28. Can a Supervising Clinician bill any time for consultation on a case, or should consultation time be included in the Clinician's time? What code should be used?

Answer: *It really depends on the circumstances. If the Supervising Clinician was speaking with a Supervisee during supervision, and this is indicated in the note, that time is considered supervision and is not billable. If the Supervising Clinician is speaking with a Clinician about a case and plan development is taking place, then plan development can be billed. Because the Supervising Clinician and a Clinician are both in the same professional line, the Co-Staffing feature on AVATAR can be utilized, and only one note must be written while the time for both staff can be counted.*

29. Can Y9905 (Utilization Review Code) be used when a supervisor is reviewing a staff's progress notes?

Answer: *Yes, however Y9905 is currently lumped in with "Admin Time" and would not increase a supervisor's productivity.*

30. If I'm reviewing a chart of a new referral for services, what code do I use?

Answer: *Remember that in order to bill, an intervention must be provided. If you are reviewing a chart prior to seeing a client, and the client shows for the appointment on the same day, you can include the review in the total time of the direct service.*

Appendix N
Progress Note Quick Notation (PIRP) and Progress Note Language

(This Tool contains the Required Information for any Medi-Cal Progress Note)

Progress Note Quick Notation – PIRP

After each visit, and before leaving for your next appointments take a few minutes in your car to write the answers to the questions below, be brief. Use this sheet to write your progress note when you return to the office. *In order to maintain HIPAA compliance, do not put any identifying information on these sheets.*

Child Indicator: *(initial, number, symbol)*
Date:
Time of Intervention: *(Minutes/Hours)*
Location:
Those Present:

Presenting Problem

1. What safety issues were present?

2. Are there any safety issues that need to be monitored?

3. Medical Necessity: What are the mental health or community functions that are still not resolved?

Intervention

4. Client Intervention: What did you attempt to accomplish with the individual?

5. If you modified the intervention; how did you modify it as appropriate?

Response

6. How did the individual react to the intervention?

Plan

7. What are the plans for continuing to work with this client?

8. How do you see the client moving or not moving toward the goal? If very little or no progress, explain why.

9. What is the next step you are planning to carry out?

DMH Approved Language for California Wraparound-Medi-Cal Progress Notes

Intervention Starters (depends on service activity)

- Acknowledged child
- Assisted child with
- Assisted child to
- Briefed child/parents, etc. about
- Brainstormed possible solutions/ways to
- Built rapport by
- Commended child
- Consulted with (case mgmt)
- Coordinated with (case mgmt)
- Cued child
- Developed
- Directed child/child's attention
- Discussed
- Discussed consequences of
- Employed positive reinforcements to
- Encouraged child to
- Engaged child in positive social interaction
- Explored ideas about
- Facilitated…for an extended period
- Gave cues/prompts to
- Generated
- Identified
- Implemented
- Informed
- Intervened when
- Intervened with
- Located
- Maintained
- Monitored (case mgmt)
- Monitored maintenance of appropriate boundaries (case mgmt)
- Monitored child's behavior/interactions with peers (case mgmt)
- Observed
- Offered supportive assistance
- Offered to
- Practiced active listening
- Praised
- Prompted child to comply with expectations
- Problem solved
- Prompted child to respect others' boundaries
- Provided frequent behavioral prompts
- Redirected
- Reframed
- Reminded
- Reviewed child's successes/progress
- Role modeled
- Set clear behavioral expectations
- Set clear limits/boundaries
- Suggested
- Supported
- Used humor to

Response Starters

- Appeared interested/uninterested
- Agreed to
- Child's behavior mimicked/paralleled staff's
- Child modified his/her behavior
- Complied with expectations Did not respond
- Initially…
- Listened quietly
- …Limited response
- Made eye contact
- Negotiated Nodded
- Refused to
- Responded age-appropriately
- Responded (in) appropriately
- Was receptive
- Smiled
- Was able to de-escalate
- Was responsive

Avoid

- Shopped
- Subjective statements (must use words like seemed, appeared, etc.)
- Trained
- Transported
- Drove
- Job coached
- Names of specific community locations
- (Macy's, Valley Fair, Raging Waters, the beach, etc.)
- Provided (material items)
- Purchased
- Naming specific recreational activities soccer, video games, movies, park, etc.)

Useful Phrases (be sure to follow with a description of specific, individualized interventions)

- Assisted child with accessing community resources for an extended period of time/in a variety of settings.
- Assisted child with accessing opportunities to interact with others/peers in a social setting/out in the community.
- Brainstormed with child possible alternatives to… *behavior describe alternative to his/her behavior*
- Child seemed attentive to modeling/redirection.
- Role modeled appropriate interactions with _____ continually throughout our meeting…
- Consulted with …to assist child with his/her behavioral goals/plan. (case mgmt)
- Assisted child in developing increased skills regarding money matters/hygiene/personal safety/the usefulness of an education…
- Engaged child in a problem-solving session regarding…
- Upon this staff's arrival, child appeared/seemed/looked to be in a …*describe the mood then follow with a qualify statement* i.e. bright affect, flat affect, friendly disposition/demeanor, talkative, etc.

Appendix W
DSM-IV-TR to ICD-9 Crosswalk to AHIMA Publication

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
290.0 through 290.3 in AHIMA book not in DSM-IV-TR book			
290.40	Vascular Dementia Uncomplicated	290.40	Arteriosclerotic Dementia, Uncomplicated
290.41	Vascular Dementia with Delirium	290.41	Arteriosclerotic Dementia with Delirium
290.42	Vascular Dementia with Delusions	290.42	Arteriosclerotic Dementia with Delusional Features
290.43	Vascular Dementia with Depressed Mood	290.43	Arteriosclerotic Dementia with Depressive Features
291.0	Alcohol Intoxication Delirium	291.0	Alcohol Withdrawal Delirium
	Alcohol Withdrawal Delirium		
291.1	Alcohol-Induced Persisting Amnestic Disorder	291.1	Alcohol Amnestic Syndrome
291.2	Alcohol-Induced Persisting Dementia	291.2	Other Alcoholic Dementia
291.3	Alcohol-Induced Psychotic Disorder w/ Hallucination	291.3	Alcohol Withdrawal Hallucinosis
291.5	Alcohol-Induced Psychotic Disorder w/ Delusions	291.5	Alcohol Jealousy
291.81	Alcohol Withdrawal	291.81	Alcohol Withdrawal
291.89	Alcohol-Induced Mood Disorder	291.89	Other Specific Alcoholic Psychosis
	Alcohol-Induced Anxiety Disorder		
	Alcohol-Induced Sexual Dysfunction		
	Alcohol-Induced Sleep Disorder		
291.9	Alcohol-Related Disorder NOS	291.9	Unspecified alcoholic psychosis
292.0	Amphetamine Withdrawal	292.0	Drug Withdrawal Syndrome
	Cocaine Withdrawal		
	Nicotine Withdrawal		
	Opioid Withdrawal		
	Sedative, Hypnotic or Anxiolytic Withdrawal		
	Other (or Unknown) Substance Withdrawal		
292.11	Amphetamine-Induced Psychotic Disorder w/Delusions	292.11	Drug-induced Organic Delusional Syndrome
	Cannabis-Induced Psychotic Disorder w/delusions		
	Cocaine-Induced Psychotic Disorder w/Delusions		
	Hallucinogen-Induced Psychotic Disorder w/Delusions		
	Inhalant-Induced Psychotic Disorder w/Delusions		
	Opioid-Induced Psychotic Disorder w/Delusions		
	Other (or Unknown) Substance-Induced Psychotic Disorder w/Delusions		
	Phencyclidine-Induced Psychotic Disorder w/Delusions		
	Sedative, Hypnotic, or Anxiolytic-Induced Psychotic Disorder w/delusions		
292.12	Amphetamine-Induced Psychotic Disorder w/Hallucinations	292.12	Drug-induced Hallucinosis
	Cannabis-Induced Psychotic Disorder w/Hallucinations		
	Cocaine-Induced Psychotic Disorder w/Hallucinations		
	Hallucinogen-Induced Psychotic Disorder w/Hallucinations		
	Inhalant-Induced Psychotic Disorder w/Hallucinations		
	Opioid-Induced Psychotic Disorder w/Hallucinations		
	Other (or Unknown) Substance-Induced Psychotic Disorder w/Hallucinations		
	Phencyclidine-Induced Psychotic Disorder w/Hallucinations		
	Sedative, Hypnotic, or Anxiolytic-Induced Psychotic Disorder w/Hallucinations		
292.81	Amphetamine Intoxication Delirium	292.81	Drug Induced Delirium
	Cannabis Intoxication Delirium		
	Cocaine Intoxication Delirium		
	Hallucinogen Intoxication Delirium		
	Inhalant Intoxication Delirium		
	Opioid Intoxication Delirium		
	Phencyclidine Intoxication Delirium		
	Sedative, Hypnotic, or Anxiolytic Intoxication Delirium		
	Other (or Unknown) Substance-Induced Delirium		
	Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium	292.0	Drug Withdrawal Syndrome

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
292.82	Inhalant-Induced Persisting Dementia Sedative, Hypnotic, or Anxiolytic-Induced Persisting Dementia Other (or Unknown) Substance-Induced Persisting Dementia	292.82	Drug-Induced Dementia
292.83	Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder Other (or Unknown) Substance-Induced Persisting Amnestic Disorder	292.83	Drug-Induced Amnestic Syndrome
292.84	Amphetamine-Induced Mood Disorder Cocaine-Induced Mood Disorder Hallucinogen-Induced Mood Disorder Inhalant-Induced Mood Disorder Opioid-Induced Mood Disorder Phencyclidine-Induced Mood Disorder Sedative, Hypnotic, or Anxiolytic-Induced Mood Disorder Other (or Unknown) Substance-Induced Mood Disorder	292.84	Drug-induced Organic Affective Syndrome - Depressive State
292.89	Amphetamine-Induced Anxiety Disorder Amphetamine-Induced Sexual Dysfunction Amphetamine-Induced Sleep Disorder Caffeine-Induced Anxiety Disorder Caffeine-Induced Sleep Disorder Cannabis-Induced Anxiety Disorder Cocaine-Induced Anxiety Cocaine-Induced Sexual Dysfunction Cocaine-Induced Sleep Disorder Hallucinogen Persisting Perception Disorder Hallucinogen-Induced Anxiety Disorder Inhalant-Induced Anxiety Disorder Opioid-Induced Sexual Dysfunction Opioid-Induced Sleep Disorder Other (or Unknown) Substance-Induced Anxiety Disorder Other (or Unknown) Substance -Induced Sexual Dysfunction Other (or Unknown) Substance-Induced Sleep Disorder Phencyclidine-Induced Anxiety Disorder Sedative, Hypnotic or Anxiolytic-Induced Anxiety Disorder Sedative, Hypnotic or Anxiolytic-Induced Sexual Dysfunction Sedative, Hypnotic or Anxiolytic-Induced Sleep Disorder	292.89	Other Unspecified Drug-Induced Mental Disorders
	Amphetamine Intoxication Cannabis Intoxication Cocaine-Induced Anxiety Hallucinogen Intoxication Inhalant Intoxication Opioid Intoxication Other Intoxication Phencyclidine Intoxication Sedative, Hypnotic or Anxiolytic Intoxication	292.2	Pathological drug intoxication
292.9	Amphetamine-Related Disorder NOS Caffeine-Related Disorder NOS Cannabis-Related Disorder NOS Cocaine-Related Disorder NOS Hallucinogen-Related Disorder NOS Inhalant-Related Disorder NOS Nicotine-Related Disorder NOS Opioid-Related Disorder NOS Phencyclidine-Related Disorder NOS Sedative, Hypnotic or Anxiolytic-Related Disorder NOS Other (or Unknown) Substance-Related Disorder NOS	292.9	Unspecified Drug-Induced Mental Disorder
293.0	Delirium Due To (General Medical Condition)	293.0	Acute delirium
293.81	Psychotic Disorder due to (General Medical Condition) w/Delusions	293.81	Organic Delusional Syndrome
293.82	Psychotic Disorder due to (General Medical Condition) w/Hallucinations	293.82	Organic Hallucinosis Syndrome
293.83	Mood Disorder Due to General Medical Disorder (specify)	293.83	Organic Affective Syndrome
293.84	Anxiety Disorder due to general medical condition	293.84	Organic Anxiety syndrome

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
293.89	Catatonic Disorder Due to (indicate General Medical Condition)	293.89	Other Specified Transient Organic Mental Disorders - Other
293.9	Mental Disorder NOS Due to (indicate General Medical Condition)	293.9	Unspecified Transient Organic Mental Disorder (Chronic)
294.0	Amnestic Disorder Due to (Indicate the General Medical Condition)	294.0	Amnestic Syndrome (Korsakoff's Psychosis or Syndrome
294.10	Dementia of the Alzheimer's Type, with early onset, Without Behavioral Disturbance	294.10	Dementia in Conditions Classified elsewhere **without** behavioral disturbance
	Dementia of the Alzheimer's Type, with late onset, Without Behavioral Disturbance		
	Dementia Due to … (General Medical Condition) without Behavioral Disturbance		
	Dementia Due to Head Trauma without Behavioral Disturbance		
	Dementia Due to HIV Disease without Behavioral Disturbance		
	Dementia Due to Huntington's Disease without Behavioral Disturbance		
	Dementia Due to Parkinson's Disease without Behavioral Disturbance		
294.11	Dementia of the Alzheimer's Type, with early onset, With Behavioral Disturbance	294.11	Dementia in Conditions Classified elsewhere **with** behavioral disturbance
	Dementia of the Alzheimer's Type, with late onset, With Behavioral Disturbance		
	Dementia Due to … (General Medical Condition) with Behavioral Disturbance		
	Dementia Due to Head Trauma with Behavioral Disturbance		
	Dementia Due to HIV Disease with Behavioral Disturbance		
	Dementia Due to Huntington's Disease with Behavioral Disturbance		
	Dementia Due to Parkinson's Disease with Behavioral Disturbance		
294.8	Amnestic Disorder NOS	294.8	Other Specified Organic Brain Syndromes (Chronic) (Including Mixed States)
	Dementia NOS	294.0	Amnestic Syndrome
294.9	Cognitive Disorder NOS	294.9	Unspecified Organic Brain Syndrome (Chronic)
295.10	Schizophrenia, Disorganized Type	295.10	Schizophrenic Disorder, Disorganized Type, **Unspecified**
		295.11	Schizophrenic Disorder, Disorganized Type, **Subchronic**
		295.12	Schizophrenic Disorder, Disorganized Type, **Chronic**
		295.13	Schizophrenic Disorder, Disorganized Type, **Subchronic w/Acute Exacerbation**
		295.14	Schizophrenic Disorder, Disorganized Type, **Chronic w/Acute Exacerbation**
		295.15	Schizophrenic Disorder, **Disorganized Type, in Remission**
295.20	Schizophrenia, Catatonic Type	295.20	Schizophrenic Disorder, Catatonic Type, **Unspecified**
		295.21	Schizophrenic Disorder, Catatonic Type, **Subchronic**
		295.22	Schizophrenic Disorder, Catatonic Type, **Chronic**
		295.23	Schizophrenic Disorder, Catatonic Type, **Subchronic w/Acute Exacerbation**
		295.24	Schizophrenic Disorder, Catatonic Type, **Chronic w/Acute Exacerbation**
		295.25	Schizophrenic Disorder, Catatonic Type, **in Remission**
295.30	Schizophrenia, Paranoid Type	295.30	Schizophrenic Disorder, Paranoid Type, **Unspecified**
		295.31	Schizophrenic Disorder, Paranoid Type, **Subchronic**
		295.32	Schizophrenic Disorder, Paranoid Type, **Chronic**
		295.33	Schizophrenic Disorder, Paranoid Type, **Subchronic w/acute Exacerbation**
		295.34	Schizophrenic Disorder, Paranoid Type, **Chronic w/acute Exacerbation**
		295.35	Schizophrenic Disorder, Paranoid Type, **in Remission**
295.40	Schizophreniform Disorder	295.40	Acute Schizophrenic Episode, **Unspecified**
		295.41	Acute Schizophrenic Episode, **Subchronic**
		295.42	Acute Schizophrenic Episode, **Chronic**
		295.43	Acute Schizophrenic Episode, **Subchronic w/acute Exacerbation**
		295.44	Acute Schizophrenic Episode, **Chronic w/acute Exacerbation**
		295.45	Acute Schizophrenic Episode, **in Remission**

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
295.60	Schizophrenia, Residual Type	295.60	Schizophrenic Disorder, Residual Type, **Unspecified**
		295.61	Schizophrenic Disorder, Residual Type, **Subchronic**
		295.62	Schizophrenic Disorder, Residual Type, **Chronic**
		295.63	Schizophrenic Disorder, Residual Type, **Subchronic w/acute Exacerbation**
		295.64	Schizophrenic Disorder, Residual Type, **Chronic w/acute Exacerbation**
		295.65	Schizophrenic Disorder, Residual Type, **in Remission**
295.70	Schizoaffective Disorder (Bipolar or Depressive Type)	295.70	Schizophrenic Disorder, Schizo-Affective Type, **Unspecified**
		295.71	Schizophrenic Disorder, Schizo-Affective Type, **Subchronic**
		295.72	Schizophrenic Disorder, Schizo-Affective Type, **Chronic**
		295.73	Schizophrenic Disorder, Schizo-Affective Type, **Subchronic w/acute Exacerbation**
		295.74	Schizophrenic Disorder, Schizo-Affective Type, **Chronic w/acute Exacerbation**
		295.75	Schizophrenic Disorder, Schizo-Affective Type, **in Remission**
295.90	Schizophrenia, Undifferentiated Type	295.90	Schizophrenic Disorder, Unspecified, **Unspecified**
		295.91	Schizophrenic Disorder, Unspecified, **Subchronic**
		295.92	Schizophrenic Disorder, Unspecified, **Chronic**
		295.93	Schizophrenic Disorder, Unspecified, **Subchronic w/acute Exacerbation**
		295.94	Schizophrenic Disorder, Unspecified, **Chronic w/acute Exacerbation**
		295.95	Schizophrenic Disorder, Unspecified, **in Remission**
296.00	Bipolar I Disorder, Single Manic Episode, Unspecified	296.00	Manic Disorder, single episode, Unspecified
296.01	Bipolar I Disorder, Single Manic Episode, Mild	296.01	Manic Disorder, single episode, Mild
296.02	Bipolar I Disorder, Single Manic Episode, Moderate	296.02	Manic Disorder, single episode, Moderate
296.03	Bipolar I Disorder, Single Manic Episode, Severe, without psychotic behavior	296.03	Manic Disorder, single episode, Severe without mention of psychotic behavior
296.04	Bipolar I Disorder, Single Manic Episode, Severe, with psychotic features	296.04	Manic Disorder, single episode, Severe, specified as with psychotic behavior
296.05	Bipolar I Disorder, Single Manic Episode, In partial remission	296.05	Manic Disorder, single episode, in partial or unspecified remission
296.06	Bipolar I Disorder, Single Manic Episode, In full remission	296.06	Manic Disorder, single episode, in full remission
296.20	Major Depressive Disorder, single episode, Unspecified	296.20	Major Depressive Disorder, Single Episode, Unspecified
296.21	Major Depressive Disorder, single episode, Mild	296.21	Major Depressive Disorder, single episode, Mild
296.22	Major Depressive Disorder, single episode, Moderate	296.22	Major Depressive Disorder, Single Episode, Moderate
296.23	Major Depressive Disorder, single episode, Severe, without psychotic features	296.23	Major Depressive Disorder, single episode, Severe, without mention of psychotic behavior
296.24	Major Depressive Disorder, single episode, Severe, with psychotic features	296.24	Major Depressive Disorder, single episode, Severe, specified as with psychotic behavior
296.25	Major Depressive Disorder, single episode, In partial remission	296.25	Major Depressive Disorder, single episode, In partial or unspecified remission
296.26	Major Depressive Disorder, single episode, In full remission	296.26	Major Depressive Disorder, single episode, In full remission
296.30	Major Depressive Disorder, Recurrent, Unspecified	296.30	Major Depressive Disorder, Recurrent Episode, Unspecified
296.31	Major Depressive Disorder, Recurrent, Mild	296.31	Major Depressive Disorder, Recurrent Episode, Mild
296.32	Major Depressive Disorder, Recurrent, Moderate	296.32	Major Depressive Disorder, Recurrent Episode, Moderate
296.33	Major Depressive Disorder, Recurrent, Severe without psychotic features	296.33	Major Depressive Disorder, Recurrent, Severe without psychotic features
296.34	Major Depressive Disorder, Recurrent, Severe, with psychotic features	296.34	Major Depressive Disorder, Recurrent, Severe, with psychotic features
296.35	Major Depressive Disorder, Recurrent, In partial remission	296.35	Major Depressive Disorder, Recurrent Episode, in Partial or Unspecified Remission
295.36	Major Depressive Disorder, Recurrent, In full remission	296.36	Major Depressive Disorder, Recurrent Episode, in Full Remission
296.40	Bipolar I Disorder, Most Recent Episode Hypomanic	296.40	Bipolar Affective Disorder, Manic, Unspecified
	Bipolar I Disorder, Most Recent Episode Manic, Unspecified		
296.41	Bipolar I Disorder, Most Recent Episode Manic, Mild	296.41	Bipolar Affective Disorder, Manic, Mild
296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	296.42	Bipolar Affective Disorder, Manic, Moderate
296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe, without psychotic features	296.43	Bipolar Affective Disorder, Manic, Severe, without mention of psychotic behavior
296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe, with psychotic features	296.44	Bipolar Affective Disorder, Manic, Severe, specified as with psychotic behavior

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
296.45	Bipolar I Disorder, Most Recent Episode Manic, In partial remission	296.45	Bipolar Affective Disorder, Manic, in Partial or Unspecified Remission
296.46	Bipolar I Disorder, Most Recent Episode Manic, In full remission	296.46	Bipolar Affective Disorder, Manic, in Full Remission
296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	296.50	Bipolar Affective Disorder, Depressed, Unspecified
296.51	Bipolar I Disorder, Most Recent Episode Depressed, Mild	296.51	Bipolar Affective Disorder, Depressed, Mild
296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	296.52	Bipolar Affective Disorder, Depressed, Moderate
296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe without psychotic features	296.53	Bipolar Affective Disorder, Depressed, Severe, w/o Mention of Psychotic Behavior
296.54	Bipolar I Disorder, Most Recent Episode Depressed, with psychotic features	296.54	Bipolar Affective Disorder, Depressed, Severe, specified as with psychotic behavior
296.55	Bipolar I Disorder, Most Recent Episode Depressed, in partial remission	296.55	Bipolar Affective Disorder, Depressed, in Partial or Unspecified Remission
296.56	Bipolar I Disorder, Most Recent Episode Depressed, in full remission	296.56	Bipolar Affective Disorder, Depressed, in Full Remission
296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified	296.60	Bipolar Affective Disorder, Mixed, Unspecified
296.61	Bipolar I Disorder, Most Recent Episode Mixed, Mild	296.61	Bipolar Affective Disorder, Mixed, Mild
296.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate	296.62	Bipolar Affective Disorder, Mixed, Moderate
296.63	Bipolar I Disorder, Most Recent Episode Mixed, Severe, without psychotic features	296.63	Bipolar Affective Disorder, Mixed, Severe, w/o Mention of Psychotic Behavior
296.64	Bipolar I Disorder, Most Recent Episode Mixed, Severe, with psychotic features	296.64	Bipolar Affective Disorder, Mixed, Severe, specified as with psychotic behavior
296.65	Bipolar I Disorder, Most Recent Episode Mixed, In partial remission	296.65	Bipolar Affective Disorder, Mixed, in Partial or Unspecified Remission
296.66	Bipolar I Disorder, Most Recent Episode Mixed, In full remission	296.66	Bipolar Affective Disorder, Mixed, in Full Remission
296.7	Bipolar I Disorder, Most Recent Episode Unspecified	296.7	Bipolar Affective Disorder, Unspecified
296.80	Bipolar Disorder NOS	296.80	Bipolar Affective Disorder, Unspecified
296.89	Bipolar II Disorder	296.89	Manic-Depressive Psychosis, Other and Unspecified
296.90	Mood Disorder NOS	296.90	Unspecified Affective Psychosis
297.1	Delusional Disorder	**297.9**	Unspecified paranoid state
297.3	Shared Psychotic Disorder	297.3	Shared Paranoid Disorder
298.8	Brief Psychotic Disorder	298.8	Other and Unspecified Reactive Psychosis
298.9	Psychotic Disorder NOS	298.9	Unspecified Psychosis
299.00	Autistic Disorder	299.00	Infantile Autism - Current or active state
		299.01	Infantile Autism - residual state
299.10	Childhood Disintegrative Disorder	299.10	Disintegrative Psychosis - current or active state
		299.11	Disintegrative Psychosis - residual state
299.80	Rett's Disorder	299.80	Other specified early childhood psychoses - **current or active state**
	Asperger's Disorder		
	Pervasive Developmental Disorder NOS	299.81	Other specified early childhood psychoses - **residual state**
300.00	Anxiety Disorder NOS	300.00	Anxiety State, Unspecified
300.01	Panic Disorder without Agoraphobia	300.01	Panic disorder
300.02	Generalized Anxiety Disorder	300.02	Generalized Anxiety Disorder
300.11	Conversion Disorder	300.11	Conversion Disorder
300.12	Dissociative Amnesia	300.12	Psychogenic Amnesia
300.13	Dissociative Fugue	300.13	Psychogenic Fugue
300.14	Dissociative Identity Disorder	300.14	Multiple Personality
300.15	Dissociative Disorder NOS	300.15	Dissociative Disorder or Reaction, Unspecified
300.16	Factitious Disorder with predominantly psychological signs and symptoms	300.16	Factitious Illness with Psychological Symptoms
300.19	Factitious Disorder w predominantly physical signs and symptoms	300.19	Other and Unspecified Factitious Illness
	Factitious Disorder with combined psychological and physical signs and symptoms		
	Factitious Disorder NOS		
300.21	Panic Disorder with Agoraphobia	300.21	Agoraphobia with Panic Attacks
300.22	Agoraphobia without History of Panic Disorder	300.22	Agoraphobia without mention of Panic Attacks
300.23	Social Phobia	300.23	Social Phobia
300.29	Specific Phobia	300.29	Other Isolated or simple phobias

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
300.3	Obsessive-Compulsive Disorder	300.3	Obsessive-Compulsive Disorder
300.4	Dysthymic Disorder	300.4	Neurotic Depression
300.6	Depersonalization Disorder	300.6	Depersonalization Syndrome
300.7	Hypochondriasis	300.7	Hypochondriasis
	Body Dysmorphic Disorder		
300.81	Somatization Disorder	300.81	Somatization Disorder
300.82	Somatoform Disorder NOS	300.82	Undifferentiated Somatoform Disorder
	Undifferentiated Somatoform Disorder		
300.9	Unspecified Mental Disorder	300.9	Unspecified Neurotic Disorder
301.0	Paranoid Personality Disorder	301.0	Paranoid Personality Disorder
301.13	Cyclothymic Disorder	301.13	Cyclothymic Disorder
301.20	Schizoid Personality Disorder	301.20	Schizoid Personality Disorder, Unspecified
301.22	Schizotypal Personality Disorder	301.22	Schizotypal Personality
301.4	Obsessive-Compulsive Personality Disorder	301.4	Compulsive Personality Disorder
301.50	Histrionic Personality Disorder	301.50	Histrionic Personality Disorder, Unspecified
301.6	Dependent Personality Disorder	301.6	Dependent Personality Disorder
301.7	Antisocial Personality Disorder	301.7	Antisocial Personality Disorder
301.81	Narcissistic Personality Disorder	301.81	Narcissistic Personality
301.82	Avoidant Personality Disorder	301.82	Avoidant Personality
301.83	Borderline Personality Disorder	301.83	Borderline Personality
301.9	Personality Disorder NOS	301.9	Unspecified Personality Disorder
302.2	Pedophilia	302.2	Pedophilia
302.3	Transvestic Fetishism	302.3	Transvestism
302.4	Exhibitionism	302.4	Exhibitionism
302.6	Gender Identity Disorder in children	302.6	Disorders of Psychosexual Identity
	Gender Identity Disorder NOS		
302.70	Sexual Dysfunction NOS	302.70	Psychosexual Dysfunction, Unspecified
302.71	Hypoactive Sexual Desire Disorder	302.71	Psychosexual Dysfunction w/Inhibited Sexual Desire
302.72	Female Sexual Arousal Disorder	302.72	Psychosexual Dysfunction w/Inhibited Sexual Excitement
	Male Erectile Disorder		
302.73	Female Orgasmic Disorder	302.73	Psychosexual Dysfunction w/Inhibited Female Orgasm
302.74	Male Orgasmic Disorder	302.74	Psychosexual Dysfunction w/Inhibited Male Orgasm
302.75	Premature Ejaculation	302.75	Psychosexual Dysfunction w/Premature Ejaculation
302.76	Dyspareunia (not due to a general medical condition)	302.76	Psychosexual Dysfunction w/Functional Dyspareunia
302.79	Sexual Aversion Disorder	302.79	Psychosexual Dysfunction w/other Specified Psychosexual Dysfunction
302.81	Fetishism	302.81	Fetishism
302.82	Voyeurism	302.82	Voyeurism
302.83	Sexual Masochism	302.83	Sexual Masochism
302.84	Sexual Sadism	302.84	Sexual Sadism
302.85	Gender Identity Disorder in Adolescents or Adults	302.85	Gender Identity Disorder of Adolescent or Adult Life
302.89	Frotteurism	302.89	Other Specific Psychosexual Disorders, Other
302.9	Paraphilia NOS	302.9	Unspecified Psychosexual Disorder, NOS
	Sexual Disorder NOS		
303.00	Alcohol Intoxication	303.00	Acute Alcoholic Intoxication, Unspecified
		303.01	Acute Alcoholic Intoxication, Continuous
		303.02	Acute Alcoholic Intoxication, Episodic
		303.03	Acute Alcoholic Intoxication, In Remission
		305.00	"Acute Intoxication with Alcoholism" (Alcoholism must be documented), - Unspecified
		305.01	"Acute Intoxication with Alcoholism" (Alcoholism must be documented), - Continuous
		305.02	"Acute Intoxication with Alcoholism" (Alcoholism must be documented), - Episodic
		305.03	"Acute Intoxication with Alcoholism" (Alcoholism must be documented), - In Remission
303.90	Alcohol Dependence	303.90	Other and Unspecified Alcohol Dependence, Unspecified
		303.91	Other and Unspecified Alcohol Dependence, Continuous
		303.92	Other and Unspecified Alcohol Dependence, Episodic
		303.93	Other and Unspecified Alcohol Dependence, In Remission

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
304.00	Opioid Type Dependence	304.00	Opioid Type Dependence, Unspecified
		304.01	Opioid Type Dependence, Continuous
		304.02	Opioid Type Dependence, Episodic
		304.03	Opioid Type Dependence, In Remission
304.10	Sedative, Hypnotic, or Anxiolytic Dependence	304.10	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, Unspecified
		304.11	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, Continuous
		304.12	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, Episodic
		304.13	Barbiturate and Similarly Acting Sedative or Hypnotic Dependence, In Remission
304.20	Cocaine Dependence	304.20	Cocaine Dependence, Unspecified
		304.21	Cocaine Dependence, Continuous
		304.22	Cocaine Dependence, Episodic
		304.23	Cocaine Dependence, In Remission
304.30	Cannabis Dependence	304.30	Cannabis Dependence, Unspecified
		304.31	Cannabis Dependence, Continuous
		304.32	Cannabis Dependence, Episodic
		304.33	Cannabis Dependence, In Remission
304.40	Amphetamine Dependence	304.40	Amphetamine and Other Psychostimulant Dependence, Unspecified
		304.41	Amphetamine and Other Psychostimulant Dependence, Continuous
		304.42	Amphetamine and Other Psychostimulant Dependence, Episodic
		304.43	Amphetamine and Other Psychostimulant Dependence, In Remission
304.50	Hallucinogen dependence	304.50	Hallucinogen dependence, Unspecified
		304.51	Hallucinogen Dependence, Continuous
		304.52	Hallucinogen Dependence, Episodic
		304.53	Hallucinogen Dependence, In Remission
304.60	Inhalant Dependence Phencyclidine Dependence	304.60	Other Specified Drug Dependence
		304.61	Other Specified Drug Dependence
		304.62	Other Specified Drug Dependence
		304.63	Other Specified Drug Dependence
304.80	Polysubstance Dependence	304.80	Combinations of drug dependence excluding opioid type drug, Unspecified
		304.81	Combinations of Drug Dependence Excluding Opioid Type Drug, Continuous
		304.82	Combinations of Drug Dependence Excluding Opioid Type Drug, Episodic
		304.83	Combinations of Drug Dependence Excluding Opioid Type Drug, in Remission
304.90	Other (or Unknown) Substance Dependence	304.90	Unspecified Drug Dependence, Unspecified
		304.91	Unspecified Drug Dependence, Continuous
		304.92	Unspecified Drug Dependence, Episodic
		304.93	Unspecified Drug Dependence, in Remission
305.00	Alcohol Abuse	305.00	Alcohol Abuse, Unspecified
		305.01	Alcohol Abuse, Continuous
		305.02	Alcohol Abuse, Episodic
		305.03	Alcohol Abuse, In Remission
305.10	Nicotine Dependence	305.10	Tobacco use disorder
305.20	Cannabis Abuse	305.20	Cannabis Abuse, Unspecified
		305.21	Cannabis Abuse, Continuous
		305.22	Cannabis Abuse, Episodic
		305.23	Cannabis Abuse, In Remission
305.30	Hallucinogen Abuse	305.30	Hallucinogen Abuse, Unspecified
		305.31	Hallucinogen Abuse, Continuous
		305.32	Hallucinogen Abuse, Episodic
		305.33	Hallucinogen Abuse, In Remission

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
305.40	Sedative, Hypnotic, or Anxiolytic Abuse	305.40	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, Unspecified
		305.41	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, Continuous
		305.42	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, Episodic
		305.43	Barbiturate and Similarly Acting Sedative or Hypnotic Abuse, In Remission
305.50	Opioid Abuse	305.50	Opioid Abuse, Unspecified
		305.51	Opioid Abuse, Continuous
		305.52	Opioid Abuse, Episodic
		305.53	Opioid Abuse, In Remission
305.60	Cocaine Abuse	305.60	Cocaine Abuse, Unspecified
		305.61	Cocaine Abuse, Continuous
		305.62	Cocaine Abuse, Episodic
		305.63	Cocaine Abuse, In Remission
305.70	Amphetamine Abuse	305.70	Amphetamine or Related Acting Sympathomimetic Abuse, Unspecified
		305.71	Amphetamine or Related Acting Sympathomimetic Abuse, Continuous
		305.72	Amphetamine or Related Acting Sympathomimetic Abuse, Episodic
		305.73	Amphetamine or Related Acting Sympathomimetic Abuse, In Remission
305.90	Caffeine Intoxication, Inhalant Abuse, Other (or Unknown) Substance Abuse, Phencyclidine Abuse	305.90	Other, Mixed, or Unspecified Drug Abuse, Unspecified
		305.91	Other, Mixed, or Unspecified Drug Abuse, Continuous
		305.92	Other, Mixed, or Unspecified Drug Abuse, Episodic
		305.93	Other, Mixed, or Unspecified Drug Abuse, in Remission
306.51	Vaginismus (Not due to a general medical condition)	306.51	Psychogenic Vaginismus
307.0	Stuttering	307.0	Stammering and stuttering
307.1	Anorexia Nervosa	307.1	Anorexia Nervosa
307.20	Tic Disorder NOS	307.20	Tic Disorder, Unspecified
307.21	Transient Tic Disorder	307.21	Transient tic Disorder of Childhood
307.22	Chronic Motor or Vocal Tic Disorder	307.22	Chronic Motor Tic Disorder
307.23	Tourette's Disorder	307.23	Gilles de la Tourette's Disorder
307.3	Stereotypic Movement Disorder	307.3	Stereotyped Repetitive Movements
307.42	Primary Insomnia	307.41	Transient disorder of initiating or maintaining sleep
	Insomnia Related to (specify the Axis I or II Disorder)	307.42	Persistent Disorder of Initiating or Maintaining Sleep
307.44	Primary Hypersomnia (specify if recurrent)	307.43	Transient disorder of Initiating or Maintaining Wakefulness
	Hypersomnia Related to (specify the Axis I or II Disorder)	307.44	Persistent disorder of Initiating or Maintaining Wakefulness
307.45	Circadian Rhythm Sleep Disorder	307.45	Phase-shift Disruption of 24-Hour Sleep-Wake Cycle
307.46	Sleep Terror Disorder	307.46	Somnambulism or Night Terrors
	Sleepwalking Disorder		
307.47	Dyssomnia NOS	307.47	Other Dysfunctions of Sleep Stages or Arousal From Sleep
	Nightmare Disorder		
	Parasomnia NOS		
307.50	Eating Disorder NOS	307.50	Eating Disorder, Unspecified
307.51	Bulimia Nervosa, Purging Type/Nonpurging Type	307.51	Bulimia
307.52	Pica	307.52	Pica
307.53	Rumination Disorder	307.53	Psychogenic Rumination
307.50	Eating Disorder, NOS	307.54	Psychogenic Vomiting
307.59	Feeding Disorder of Infancy or Early Childhood	307.59	Other Eating Disorder, Unspecified
307.6	Enuresis (Not due to a general medical condition)	307.6	Enuresis
307.7	Encopresis w/o constipation and overflow incontinence	307.7	Encopresis
307.80	Pain Disorder Associated with Psychological Factors	307.80	Psychogenic Pain, Site Unspecified
307.89	Pain Disorder Assoc with Both Psychological Factors and a General Medical Condition	307.89	Other Psychogenic Pain (Psychogenic Backache)
307.9	Communication Disorder NOS	307.9	Other and unspecified special symptoms or syndromes NEC
308.3	Acute Stress Disorder	308.3	Other Acute Reactions to Stress
309.0	Adjustment Disorder with Depressed Mood	309.0	Brief Depressive Reaction
309.21	Separation Anxiety Disorder	309.21	Separation Anxiety Disorder
309.24	Adjustment Disorder with Anxiety	309.24	Adjustment Reaction with Anxious Mood

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood	309.28	Adjustment Reaction with Mixed Emotional Features
309.3	Adjustment Disorder with Disturbance of Conduct	309.3	Adjustment Reaction with Predominant Disturbance of Conduct
309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct	309.4	Adjustment Reaction with Mixed Disturbance of Emotions and Conduct
309.81	Posttraumatic Stress Disorder, acute/chronic/with delayed onset	309.81	Prolonged Posttraumatic Stress Disorder
309.9	Adjustment Disorder Unspecified	309.9	Unspecified Adjustment Reaction
310.1	Personality Change Due to (indicate General Medical Condition)	310.1	Organic Personality Syndrome (Code Axis III with General Medical Condition Contributing to Mental Illness)
311	Depressive Disorder NOS	311	Depressive Disorder, Not Elsewhere Classified
312.30	Impulse-Control Disorder NOS	312.30	Impulse Control Disorder, Unspecified
312.31	Pathological Gambling	312.31	Pathological Gambling
312.32	Kleptomania	312.32	Kleptomania
312.33	Pyromania	312.33	Pyromania
312.34	Intermittent Explosive Disorder	312.34	Intermittent Explosive Disorder
312.39	Trichotillomania	312.39	Disorders of Impulse Control, Not Elsewhere Classified, Other
312.81	Conduct Disorder Childhood-Onset Type	312.81	Conduct disorder, childhood onset type
312.82	Conduct Disorder Adolescent-Onset Type	312.82	Conduct Disorder Adolescent-Onset Type
312.89	Conduct Disorder Unspecified Onset	312.89	Other conduct disorder
312.9	Disruptive Behavior Disorder NOS	312.9	Unspecified Disturbance of Conduct
313.23	Selective Mutism	313.23	Elective Mutism
313.81	Oppositional Defiant Disorder	313.81	Oppositional Disorder
313.82	Identity Problem	313.82	Identity Problem
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	313.89	Other or Mixed Emotional Disturbances of Childhood or Adolescence; Other
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	313.9	Unspecified Emotional Disturbance of Childhood or Adolescence
314.00	Attention-Deficit/Hyperactivity Disorder - Predominantly Inattentive Type	314.00	Attention Deficit Disorder without mention of hyperactivity
314.01	Attention-Deficit/Hyperactivity Disorder - Combined Type Attention-Deficit/Hyperactivity Disorder - Predominantly Hyperactive-Impulse Type	314.01	Attention Deficit Disorder with hyperactivity
314.9	Attention-Deficit/Hyperactivity Disorder NOS	314.9	Unspecified Hyperkinetic Syndrome
315.00	Reading Disorder	315.00	Reading Disorder, unspecified
315.1	Mathematics Disorder	315.1	Specified arithmetical disorder
315.2	Disorder of Written Expression	315.2	Other specified learning difficulties
315.31	Expressive Language Disorder	315.31	Developmental Language Disorder
315.32	Mixed Receptive-Expressive Language Disorder	315.32	Receptive Language Disorder
315.39	Phonological Disorder	315.39	Developmental speech or language disorder; Other
315.4	Developmental Coordination Disorder	315.4	Coordination Disorder
315.9	Learning Disorder NOS	315.9	Unspecified delay in development
316	…(Specified Psychological Factor) Affecting…(Indicate the General Medical Condition) Mental Disorder Affecting Medical Condition Psychological Symptoms Affecting Medical Condition Personality Traits or Coping Style Affecting Medical Condition Maladaptive Health Behaviors Affecting Medical Condition Stress-Related Physiological Response Affecting Medical Condition Other or Unspecified Psychological Factors Affecting Medical Condition	316	Psychic Factors Associated with Diseases Classified Elsewhere
317	Mild mental retardation	317	Mild mental retardation
318.0	Moderate Mental Retardation	318.0	Moderate Mental Retardation
318.1	Severe Mental Retardation	318.1	Severe Mental Retardation
318.2	Profound Mental Retardation	318.2	Profound Mental Retardation
319	Mental Retardation, Severity Unspecified	319	Unspecified mental retardation
332.1	Neuroleptic-Induced Parkinsonism	332.1	Secondary Parkinsonism
333.1	Medication-Induced Postural Tremor	333.1	Essential and Other Specified Forms of Tremor
333.7	Neuroleptic-Induced Acute Dystonia	333.7	Symptomatic Torsion Dystonia
333.82	Neuroleptic-Inducted Tardive Dyskinesia	333.82	Orofacial Dyskinesia
333.90	Medication-Induced Movement Disorder NOS	333.90	Unspecified Extrapyramidal Disease&Abnormal Movement Disorder
333.92	Neuroleptic Malignant Syndrome	333.92	Neuroleptic Malignant Syndrome
333.99	Neuroleptic-Induced Acute Akathisia	333.99	Other and Unspecified Extrapyramidal Diseases and Abnormal Movement Disorders
347	Narcolepsy	347	Cataplexy and Narcolepsy

DSM-IV	DESCRIPTION	ICD-9	DESCRIPTION
607.84	Male Erectile Disorder Due to (specify general medical condition)	607.84	Impotence of Organic Origin
608.89	Male Dyspareunia Due to (specify general medical condition)	608.89	Other Specified Disorders of Male Genital Organs, Other
	Male Hypoactive Sexual Desire Disorder Due to (specify general medical condition)	302.89	Other Specified Psychosexual Disorders; Other
	Other Male Sexual Dsyfunction Due to (specify general medical condition)	302.79	Psychosexual Dysfunction; with other specified psychosexual dysfunctions
625.0	Female Dyspareunia Due to (specify general medical condition)	625.0	Dyspareunia
625.8	Female Hypoactive Sexual Desire Disorder Due to (specify general medical condition)	302.89	Other Specified Psychosexual Disorders; Other
	Other Female Sexual Dysfunction Due to (specify general medical condition)	302.79	Psychosexual Dysfunction; with other specified psychosexual dysfunctions
780.09	Delirium NOS	780.09	Other Alterations of Consciousness
780.52	Sleep Disorder, Insomnia Type, Due to (specify general medical condition)	780.52	Other Insomnia, NOS
780.54	Sleep Disorder, Hypersomnia Type, Due to (specify general medical condition)	780.54	Other Hypersomnia
780.59	Breathing-Related Sleep Disorder	780.59	Sleep Disturbances, Other
	Sleep Disorder, Parasomnia Type Due to (specify general medical condition)		
	Sleep Disorder, Mixed Type, Due to (specify general medical condition)		
780.9	Age-Related Cognitive Decline	797	Other General Symptoms (Retrograde Amnesia)
787.6	Encopresis with constipation and overflow incontinence	787.6	Incontinence of feces
799.9	Diagnosis or Condition Deferred on Axis I	799.9	Other Unknown and Unspecified Cause (Undiagnosed Disease)
	Diagnosis Deferred on Axis II		
995.2	Adverse Effects of Medication NOS	995.2	Unspecified Adverse Effect of Drug, Medicinal and Biological Substance
995.52	Neglect of Child (focus of attention is on the victim)	995.52	Child Neglect (Nutritional)
995.53	Sexual Abuse of Child (focus of attention is on the victim)	995.53	Child Sexual Abuse
995.54	Physical Abuse of Child (focus of attention is on the victim)	995.54	Child Physical Abuse
995.81	Physical Abuse by Partner (focus of attention is on the victim)	995.81	Adult Physical Abuse
995.83	Sexual Abuse of Adult (focus of attention is on the victim)	995.83	Adult Sexual Abuse
V15.81	Noncompliance with Treatment	V15.81	Noncompliance with Medical Treatment
V61.10	Partner Relational Problem	V61.10	Counseling For marital and Partner Problems, Unspecified
V61.12	Physical Abuse of Adult by Partner	V61.12	Counseling for perpetrator of spousal and partner abuse
	Sexual Abuse of Adult by Partner		
V61.20	Parent-child Relational Problem	V61.20	Parent-child problem, unspecified
V61.21	Physical Abuse of Child (Code 995.54 if focus of attention is on victim)	V61.21	Counseling for Victim of Child Abuse (including neglect)
	Sexual Abuse of Child (Code 995.53 if focus of attention is on victim)		
	Neglect of Child (Code 995.52 if focus of attention is on victim)		
V61.8	Sibling Relational Problem	V61.8	Other Specified Family Circumstance
V61.9	Relational Problem Related to a Mental Disorder or General Medical Condition	V62.89	Other Psychological or Physical Stress, NEC, Other
V62.2	Occupational Problem	V62.2	Other Occupational Circumstances or Maladjustment
V62.3	Academic Problem	V62.3	Education Circumstances
V62.4	Acculturation Problem	V62.4	Social Maladjustment
V62.81	Relational Problem NOS	V62.81	Interpersonal Problems, Not Elsewhere Classified
V62.82	Bereavement	V62.82	Bereavement, Uncomplicated
V62.83	Physical Abuse of Adult by Other than Partner	V62.83	Counseling for Perpetrator of Physical/Sexual Abuse
	Sexual Abuse of Adult by Other than Partner		
V62.89	Borderline Intellectual Function (Axis II)	V62.89	Other Psychological or Physical Stress, NEC, Other
	Religious or Spiritual Problem		
	Phase of Life Problem		
V65.2	Malingering	V65.2	Person Feigning Illness
V71.01	Adult Antisocial Behavior	V71.01	Adult Antisocial Behavior
V71.02	Child or Adolescent Antisocial Behavior	V71.02	Childhood or Adolescent Antisocial Behavior
V71.09	No Diagnosis or Condition on Axis I	V71.09	Other Suspected Mental Condition
	No Diagnosis on Axis II		