MENTAL HEALTH CLINICAL DOCUMENTATION STANDARDS MANUAL

2019

Yolo County
Health and Human Services

Collaborative
Accountable
Respectful
Equitable
Strategic

YOLO COUNTY MENTAL HEALTH PLAN

Last Revised: November 15, 2019

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Chapter 1: INTRODUCTION/COMPLIANCE

1.1 WHY DO WE HAVE THIS MANUAL?

This manual has been developed as a resource for outpatient behavioral health providers in Yolo County. It outlines the clinical documentation standards and practices required by the Yolo County Health and Human Services Agency (HHSA) Mental Health Plan (MHP). As a behavioral health system, it is our mission to provide high quality, culturally competent services and supports that enhance recovery from substance use disorders, serious mental illness, and serious emotional disturbance. Our vision is to promote the overall well-being, recovery and health of individuals and families in our community. Specialty Mental Health services and interventions are designed to reduce mental illness and/or facilitate improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

Part of promoting resiliency and recovery is good documentation. There's a saying throughout the healthcare industry that "if it isn't documented, it didn't happen". In order to give evidence that the services provided by the Yolo County MHP and partner agencies reflect the values stated above, solid documentation practices must be followed. This clinical documentation guide serves to ensure that behavioral health providers within Yolo County meet regulatory and compliance standards of competency, accuracy, and integrity in the provision and documentation of their services.

As with any manual, updates will need to be made as policies and regulations change. As this is a living document, please be sure to replace old sections as updated sections are distributed. **Sources of Information:** This Clinical Documentation Guide is to be used as a reference resource and is intended for use during clinical documentation trainings and supervision. The reader is strongly encouraged to contact the Behavioral Health Quality Management (BH-QM) Unit if additional clarification or interpretation of this guide is required. This manual includes information based on the following sources: Code of Federal Regulations (CFR) 42 and 45; California Code of Regulations (CCR) Title 9; California Department of Health Care Services' (DHCS) Manuals, Letters and Information Notices, including IN 17-040 and IN 18-002; Yolo County HHSA policies & procedures, directives, and memos; and the BH-QM Unit's interpretation and determination of documentation standards. While the terms "client/consumer/patient/beneficiary" may often be used interchangeably, BH-QM has opted to use the term "client" to refer to a person or family who is receiving Specialty Mental Health Services (SMHS) from HHSA or a provider agency. Readers are encouraged to review the manual thoroughly and refer to it during trainings and supervision.

We welcome your feedback, questions, and concerns. Please contact the BH-QM Unit with your input and questions at:

(**HHSAQualityManagement@yolocounty.org**)

Thank You,
The BH-QM Unit

1.2 COMPLIANCE

The Yolo County Mental Health Plan provides services to the community and contracts with local providers, then seeks reimbursement from state and federal funding sources. There are many rules associated with billing the state and federal government, thus the need for this documentation standards guide. In general, good ethical standards meet nearly all the requirements. At times, there is a need to provide some guidance and clarity so staff can effectively and efficiently document the services they provide.

Yolo County HHSA has adopted a Compliance Unit based on guidance and standards established by the Office of Inspector General, U.S. Department of Health and Human Services. The Office of Inspector General (OIG) is primarily responsible for Medicare and Medicaid fraud investigations and provides support to the U.S. Attorney's Office for cases which lead to prosecution. The State of California also has a Medicaid/Medicare Fraud Control Unit. Many California county behavioral health departments have already been investigated by state and federal agencies, and, in all those counties, either severe compliance plans or fraud charges have been implemented. The intent of the compliance plan is to prevent fraud and abuse at all levels. The compliance plan particularly supports the integrity of all health data submissions, as evidenced by accuracy, reliability, validity, and timeliness. As part of this plan we must work to ensure that all services submitted for reimbursement are based on accurate, complete, and timely documentation. It is the responsibility of every provider to submit a complete and accurate record of the services they provide and to document services in compliance with all applicable laws and regulations. This guide reflects the current requirements for direct services reimbursed by Medi-Cal Specialty Mental Health Services (Division 1, Title 9, California Code of Regulations (CCR)) and serves as the basis for all documentation and claiming by HHSA, regardless of payer source. All staff in County Units, contracted agencies, and contracted providers are expected to abide by the information found in this guide.

Compliance is accomplished by:

- Adherence to legal, ethical, code of conduct, and best-practice standards for billing/coding and documentation;
- Participation by all providers in proactive training and quality improvement processes;
- Providers working within their professional scope of practice; and
- Having a Compliance Plan to ensure there is accountability for all HHSA and Contracted Providers' activities and functions. (This includes the accuracy of progress note documentation by defined practitioners who will select correct procedures and service locations to support the documentation of services provided.)

Compliance related questions, concerns, or reports can be directly and anonymously made to the HHSA MHP Compliance Officer at 1 (800) 391-7440.

Chapter 2: GENERAL PRINCIPLES OF DOCUMENTATION

2.1 GENERAL PRINCIPALS OF DOCUMENTATION

1. All Providers must adhere to HHSA policies on documentation standards.

2. Until the Electronic Health Record (EHR) is completely electronic, HHSA continues to maintain a hybrid health record system, which includes both paper-based and electronic documents. For new client admission and re-admission in Avatar, the hybrid health record continues to include chart forms that require client's signature until system wide implementation of signature pads and/or scanning capabilities.

3. HHSA county-operated and Contract Providers must incorporate all HHSA required documentation elements as referenced in this Manual and adhere to the forms/guidelines identified in HHSA policy.

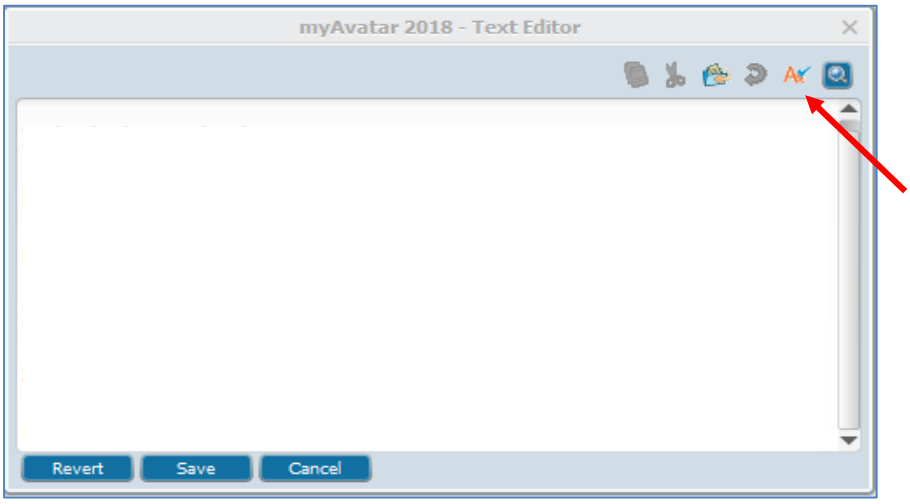
4. Required documents include an accurate and timely Assessment/Psychiatric Evaluation, Client Treatment Plan/Medication Services Client Plan, and on-going Progress Notes. All medical records, including electronic and paper, are legal documents.

5. Only services that have been entered in Avatar (or claims with accompanying progress notes for any programs not directly entering clinical records into Avatar) can be claimed.

6. All services shall be provided by staff within the scope of practice of the individual delivering the service. See Chapter 6: Scope of Practice/Competence/Work for Scope of Service delineation. Practitioners shall follow specific scope of practice requirements as determined by the applicable license regulations of their governing board; any questions should be directed to HHSA Behavioral Health Quality Management.

7. Progress Notes shall provide enough detail so that other service providers and auditors can easily ascertain the client's status and needs, and they can understand why the service was provided without having to refer to previous Progress Notes. In other words, each Progress Note shall be a "stand-alone" note.

8. Documentation must be readable and legible. Staff are strongly encouraged to use the spell check function prior to finalizing a document. In Avatar, the spell check function button is located near the bottom of the page (see Helpful Tip below).



Helpful Tip!

The Avatar Spell Check Function is within the Text Editor and can be utilized by clicking on the clipboard with the pencil icon.

Click on the orange A with a blue check mark

9. The use of abbreviations in clinical documentation must be consistent with approved HHSA abbreviations.

10. Restriction of Quality Management and Mandated Reporting Information:

- The following shall not be scanned into the EHR or filed into the paper chart. Completion of these forms is not billable to Medi-Cal or Medicare; no Progress Note shall be completed for these activities.:
  - Incident Reports
  - Sentinel Events
  - Unusual Occurrence Forms
  - Grievances
  - Utilization Review findings, forms and audit worksheets

- The following may be scanned into the EHR or filed into the paper chart for the purpose of capturing relevant clinical information; however, this information shall be redacted if records are released. Completion of these forms is not billable to Medi-Cal or Medicare:
  - A copy of an Adult Protective Services/Child Welfare Services report

Questions regarding other forms (not already listed) and their inclusion into the medical record should be directed to the Behavioral Health Compliance Officer. The Compliance Officer can be reached at 1 (800) 391-7440.

11. Confidentiality: If another client must be identified in the record, (such as the family member of the client who is also receiving services), that individual shall not be identified as a behavioral health client. Names of family members or support persons should be recorded only when needed to complete intake registration, financial documents, client treatment plans, and/or releases of information. Otherwise, the relationship (e.g., mother, husband, friend) shall be used; first names or initials of another person when needed for clarification are acceptable.

12. **"COPYING AND PASTING" IS STRICTLY PROHIBITTED IN A CLIENT'S MEDICAL RECORD**. Each progress note needs to be specific to the service provided. If using an Avatar template that brings forward text from the

previous note, **the narrative must be changed to reflect the current service being documented.** Progress notes that are submitted which appear to be worded exactly alike, or too similarly to, previous entries may be assumed to be pasted, e.g., containing inaccurate, outdated, or false information. Claiming associated with such notes could be considered fraudulent.

2.2 SIGNATURES

A Practitioner signature is a required part of most clinical documents. In an EHR, the signature is electronic. In order to be able to sign documents electronically, the following are required:

- The writer's signature must be on file in order to use the EHR. Avatar maintains a file of staff's unique identifiers/signatures.
- Authentication – agencies must have and adhere to an electronic signature policy and procedure. Otherwise, a written signature must be documented on every Progress Note, Assessment and Client Treatment Plan.

Each practitioner signature, whether electronic or on paper, must include a license or designation (e.g., ASW, MD, MFT Intern, LCSW, MFT, MHRS, MHW, PhD waivered, etc.).

Co-Signatures

Licensed Supervisors shall ensure their staff are operating within their scope of practice and notes are co-signed when appropriate. When a co-signature is required, a practitioner will be unable to file a document as "final" until said co-signature has been obtained. Co-Signatures for staff may be required on documents for several reasons. For example:

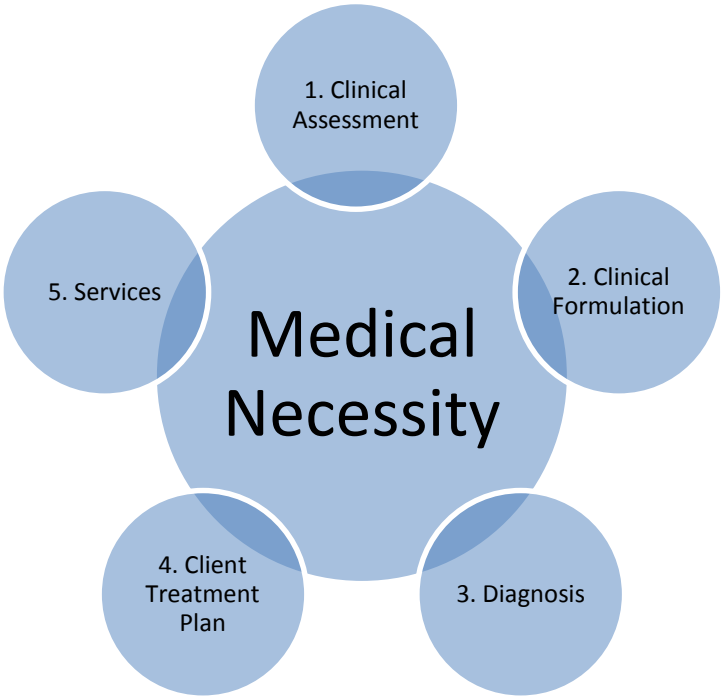
- All documentation completed by graduate level students enrolled in an academic program but not yet eligible to be registered or waivered must be co-signed by the licensed mental health professional (LMHP) supervising their work
- All Client Treatment Plans completed by a Mental Health Rehabilitation Specialist (MHRS) must be approved and co-signed by a LMHP
- Please refer to Service and Staff Billing Privileges Matrix in Appendix A: Yolo County Scope of Practice Guidelines for additional guidance on co-signatures

The State Department of Health Care Services (DHCS) requires that some documents (e.g., Client Treatment Plans) be approved by a Licensed, Registered, or Waivered Clinician. Also, some staff may be required to have Progress Notes co-signed for specific or indefinite periods, and other co-signature requirements may be assigned for purposes of quality assurance and/or compliance. Staff should consult with their supervisor and agency Policies and Procedures for additional information.

Chapter 3: ESTABLISHING MEDICAL NECESSITY

3.1 THE FLOW OF CLINICAL INFORMATION ("THE GOLDEN THREAD")

There is a flow of information designed to evaluate the need of each client who receives services. This process assists staff in evaluating medical necessity and supports the provision of appropriate/available services to meet clients' recovery goals. "The Golden Thread" is a term often used to describe the consistent presentation of relevant clinical information throughout all documentation for a client. In other words, the client plan should be informed from the information gathered during the assessment process, and each progress note should reflect how the service provided addresses the impairments outlined in the assessment to help the client achieve their treatment goals.



1. The **Clinical Assessment** is the first step toward establishing medical necessity for specialty mental health services. The assessment is critical for establishing the diagnostic impression and identifying functional impairments that will be the focus of treatment. The Clinical Assessment identifies the client's needs and informs the Clinical Formulation.

2. The **Clinical Formulation**, also known as a case formulation or problem formulation, is a theoretically based explanation or conceptualization of the information obtained from a clinical assessment. It offers a hypothesis about the cause(s), nature, and context of the presenting problem(s) and ultimately supports the diagnosis and recommendations for treatment.

3. The **Diagnosis** (based on *Diagnostic and Statistical Manual of Mental Disorders, fifth edition* [*DSM–5]*) summarizes the areas of need, challenges, symptoms, and impairments; and provides the ICD-10 code required to submit a claim for each service rendered. The list of included diagnoses is maintained and updated annually by the California Department of Health Care Services (DHCS) and can be found on the DHCS website, under the appropriate calendar year of MHSUDS Information Notices.

4. The **Client Treatment Plan** is a collaborative effort with the client and support persons, as appropriate, in identifying the client's strengths, resources, challenges, barriers, and personal life goals. It provides a framework for clients and assists them in achieving stability, progress, wellness, recovery, and independence. The Client Treatment Plan takes the information gathered during the assessment process and directs the focus of services. It must be updated at least annually and/or when there are significant changes in the client's condition. The County may require more frequent updates (e.g., as defined in EPSDT provider contracts). As stated in DHCS Information Notice 17-040, there is no specific language in regulation defining a "significant change" in a client's condition. Examples may include a client who has never been suicidal making a suicide attempt; or, a client who regularly participates in services suddenly stops coming to appointments. Major life events that might lead to a change in the client's condition include, but are not limited to: job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), or change in residence/living situation.

5. Each **Service** (or intervention) provided should be clearly linked to the mental health issues identified in the Clinical Assessment, Formulation, Diagnosis, and Client Treatment Plan. The Client Treatment Plan clearly states how each intervention plans to address one or more identified functional impairments or prevent significant deterioration in an important area of life functioning. Each progress note describes the *actual* intervention provided and clearly links the intervention to the identified functional impairment(s) resulting from the client's identified mental health diagnosis.

3.2 MEDICAL NECESSITY

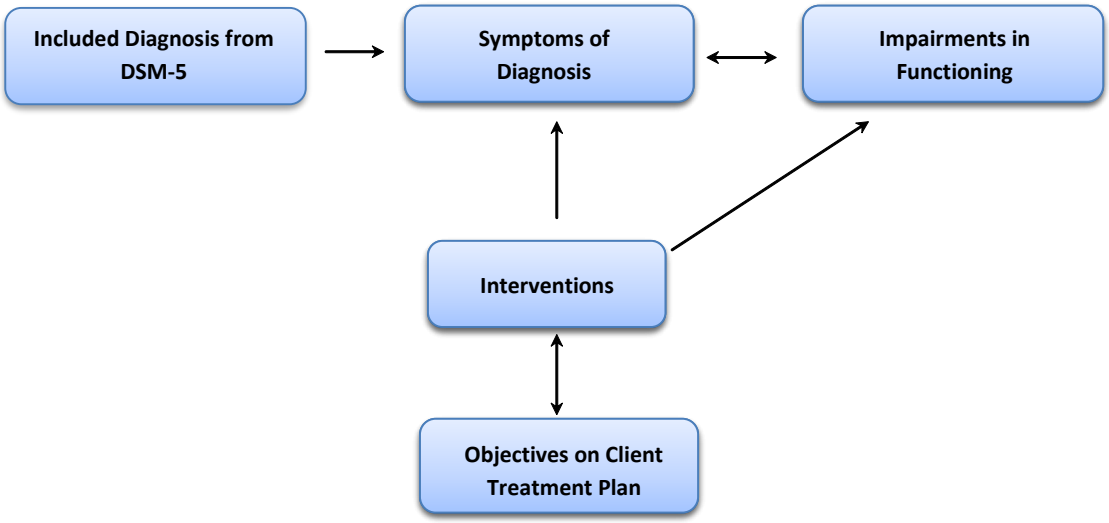
Medical necessity refers to the identified need for treatment and services; it is established through the flow of clinical information process. Medical Necessity must be determined during the initial and re-assessment processes, must be well documented with each service provided, and must continually be evaluated through the course of treatment. Every service provided to the client/family should be justified and supported as a medically necessary component of the behavioral health treatment to support the client/family in their path to recovery. A primary included diagnosis, which is clearly supported by symptoms and resulting functional impairments, further strengthens and reaffirms Medical Necessity. The Progress Note describes the specific interventions provided, as identified in the client plan, to address the functional impairments determined through the assessment process.

During the assessment process, the clinician shall identify the client's areas of life functioning which are impacted by their mental health condition and related to their included diagnosis; these functional impairments become the focus of Specialty Mental Health Services. Impacted areas of functioning may include:

- Primary support
- Social environment
- Educational
- Occupational
- Housing
- Economic
- Access to healthcare

- Interaction with legal system/criminal justice
- Other psychological or environmental problems

A medically necessary service is one which attempts to impact a functional impairment brought about by symptoms of an included diagnosis.



3.3 COMPONENTS OF MEDICAL NECESSITY

For a client to receive Specialty Mental Health Services, Medical Necessity must be established through a clinical assessment at the initial, periodic, and annual marks. Medical Necessity must continue to be reestablished and documented throughout treatment. There are three criteria of Medical Necessity that must be clearly documented for treatment to be reimbursed through Medi-Cal:

A. Diagnostic Criteria: The focus of the service is related to functional impairments related to an included DSM-5/ICD-10 Diagnosis, which includes onset, frequency, duration, and list of symptoms. The list of included diagnoses is maintained and updated annually by the California Department of Health Care Services (DHCS) and can be found on the DHCS website, under the appropriate calendar year of MHSUDS Information Notices. The diagnosis reflects the current status of the client's mental, emotional, or behavioral health. "By history", "Rule Out" and "Provisional" diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a client may have a "by history", "rule out", or "provisional" diagnosis as long as there is also at least one included diagnosis.

B. Impairment Criteria: The client must have at least one of the following as a result of the mental disorder(s) identified in the diagnostic criteria A:
   a. A significant impairment in an important are of life functioning, or
   b. A probability of significant deterioration in an important area of life functioning, or
   c. Children also qualify if there is a probability the child (a person under the age of 21 years) will not progress developmentally as individually appropriate. Children under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated

C. Intervention Criteria: All three criteria below must be met:
    a. The focus of the proposed intervention is to address the condition identified in criteria B above, and
    b. It is expected that the proposed intervention will benefit the client by significantly diminishing the impairment, or prevent significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enable to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated), and
    c. The condition would not be responsive to physical health care based treatment

Additional information on Medical Necessity can be found in regulations (e.g., Federal CFR 42 and State CCR Title 9). The medical necessity standards and expectations for Mental Health Medi-Cal's Outpatient/Non-Hospital SMHS benefit are defined in CCR Title 9, Chapter 11:

- § 1830.205 Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services
- § 1830.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age

Please also refer to Appendix D FAQs on Medical Necessity and Diagnosis for additional information.

Chapter 4: ASSESSMENTS & CLIENT PLANS

4.1 ASSESSMENTS

The Assessment is more than an information gathering process. The Assessment is a step towards building a trusting and therapeutic relationship between client and service provider/agency. It is also the start of understanding and appreciating the client's self- and world- view, and the interrelationship between the client's symptoms/behaviors and the client as a whole person. Providers have a responsibility to fully understand the individual and family, their strengths, abilities, and past successes, along with their hopes, dreams, needs, and problems with obtaining or maintaining stable community integration. Attending to the issues of culture in the process of the assessment is critically important. The provider must understand how culture and social context shape an individual's and family's behavioral health symptoms, presentation, meaning and coping styles along with attitudes towards seeking help, stigma and the willingness to trust.

The assessment can be completed in one contact or over the course of several contacts.

Required Elements of an Assessment

The Assessment must contain the following eleven (11) elements:

1. **Presenting Problem:** The client's chief complaint, history of presenting problem(s), including current relevant family history and current family information.
    - *Include details related to client's identifier (gender, age, language spoken, identified race/ethnicity), current symptoms/concerns, frequency, severity, and examples, primary diagnosis provided by treating psychiatrist, functional impairments and difficulty in daily living, reported challenges/problems and other relevant conditions affecting physical and mental health status (stressors, trauma anniversaries, co-morbid medical/SUD issues, poor social support),* ***cultural and linguistic factors*** *and current implications from past trauma exposure)*
    - *Use the client's and/or caregiver's own words whenever possible.*

2. **Relevant Conditions and Psychosocial Factors:** Affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma.
    - *Include details related to client's social history: current living situation (housing issues), history of living situation (born, raised, communities lived in), physical/emotional/sexual abuse, marital history (status, children), employment history, social support network, school history (special education, grade completed, literacy level), relevant family dynamics (guardian, siblings, closest with and current connections, family structure), and personal resources (strengths, skills, talents, abilities, preferred activities, intrinsic source of motivation).*

3. **Mental Health History:** Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.
    - *Include mental health history, previous treatment dates, previous providers, therapeutic interventions and responses, sources of clinical data, lab tests, history of difficulty in functioning, warning signs of possible decompensation, and consultation reports*
    - *Include psychiatric history such as previous psychiatric providers and past hospitalizations (place, location, date, duration, response to treatment).*

4. **Medical History:** Relevant physical health conditions reported by the client or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
    - *Include relevant medical history such as physical health conditions reported by the client are prominently identified and updated, diagnosed medical problems, hospitalizations, surgeries, illnesses, allergies (sensitivities, known drug allergy),* ***name and contact information for primary care physician and specialists****, date of last physical, and scheduled follow up. For children and adolescents, include prenatal events, and complete developmental history.*

5. **Medications:** Information about medications the client has received, or is receiving, to treat mental health and medical conditions; including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications.
    - *Include medication names, dosage, side effects, adverse reactions, frequency of Rx and OTC medications, relevant past Rx, dates of initial prescription and refills, informed consent(s), and alternative medicines.*

6. **Substance Exposure / Use:** Note past/present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over the counter medication, and illicit drugs.

7. **Client Strengths:** Documentation of the client's strengths in achieving Client Treatment Plan goals related to the client's mental health needs and functional impairments as a result of the mental health diagnosis.

8. **Risks:** Situations that present a risk to the client and/or others, including past or current trauma.
    - *Include special status situations such as suicidality (past, present, plan description, attempts/gestures, methods, safety plan), violence (assault, spousal abuse, child abuse, property damage, drug related), and grave disability (history of restoration, history or current conservatorship status).*
    - *Examples of "risks" include:*
        - *History of Danger to Self (DTS) or Danger to Others (DTO);*
        - *Previous inpatient hospitalizations for DTS or DTO;*
        - *Prior Suicide Attempts*
        - *Lack of family or other support systems;*
        - *Arrest history, if any;*
        - *Probation Status;*
        - *History of alcohol/drug abuse;*

- *History of trauma or victimization;*
- *History of self-harm behaviors (i.e. cutting);*
- *History of assaulting behavior;*
- *Physical impairments (i.e. limited vision, deaf, wheelchair bound) which makes the client vulnerable to others; and,*
- *Psychological or intellectual vulnerabilities (i.e. intellectual disability [low IQ], traumatic brain injury, dependent personality).*

9. **Mental Status Examination:** Note factors including appearance, speech, affect and mood, thought, perception, memory, intellect, insight, somatization.

10. **Diagnosis**: The diagnosis(es) should be consistent with the presenting problems, history, mental status examination and/or other clinical data. The symptom criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) should be used for diagnostic determinations; once a DSM-5 diagnosis is determined, determine the corresponding ICD-10 numerical code.

11. Additional clarifying information as needed; examples may include:
    - Legal: *Past/present probation, parole, incarceration, Child Protective Services (CPS) involvement, and conservatorship status.*
    - Support Services: *Include outside agencies, in-home support, home delivered meals, CWS, regional center, AA/NA, Alta Regional Center, Church groups, Spiritual/Religious affiliation, SSI/SSDI/GA benefits, payee services, Medi-Cal/Medicare benefits, and pharmacy (bubble pack meds, delivery service);*

The Universal MH Clinical Assessment/Reassessment is compliant with all State and Federal Regulations; however, the service provider (author) must ensure that all sections of the Universal MH Clinical Assessment/Reassessment are completed. **DO NOT LEAVE ANY SECTIONS BLANK** as this may cause a mandated section to remain unassessed and may lead to disallowances.

Disposition, Recommendations, Referrals, Summary and Timeliness of Assessment

The client intake, assessment, and client plan process shall be completed within ninety (90) days (or longer, if need is documented, as per DHCS Mental Health Medi-Cal Billing Manual) of an initial opening for both Adult and Children's Systems of Care providers, or for an episode where the client was closed for services for over 30 days (1 month) and is being re-opened to services. Within this intake period, the provider is to establish medical necessity, develop the client plan in collaboration with the client, and coordinate the arrangement of necessary services. The intake period is not exempt from the medical necessity requirements for claiming Medi-Cal.

Yolo County HHSA requires that assessment information be updated at least annually for clients under the age of 18 and/or in a Full-Service Partnership (FSP), and at least every (3) three years for adult mental health. A re-assessment may be required when a client has experienced a significant medical or clinical change. The interventions applied by each provider must be appropriate to address the beneficiary's included diagnosis and associated functional impairments.

4.2 CLIENT PLANS

Types of Client Plans

Client plans are co-created by the client/family and the provider, outline the problems reported by the client, strengths the client possesses, the client's means of coping, challenges the client reports, the client's natural sources of support, the client's goals, objectives to help measure the client's progress, interventions the treating practitioner will use to help the client meet his/her goal(s), and timeframes of the treatment. Writers are encouraged to include client quotes in the plan. Client plans must substantiate current and ongoing medical necessity for treatment and services by focusing on diminishing the functional impairment(s) and/or the prevention of deterioration that has been identified through the Assessment process and the Clinical Formulation. The functional impairment(s) and/or deterioration to be addressed must be consistent with the diagnosis, which is the focus of treatment. Program objectives should be consistent with the client's/family's goals, as well. Strength-based and recovery-oriented treatment planning is strongly encouraged.

- The Client Treatment Plan is a broad category of client plans that is developed when a client receives any Specialty Mental Health Services. Client Treatment Plans may be developed by a range of mental health staff. See Chapter 6: Scope of Practice/Competence/Work for Scope of Service delineation.

- The Medication Services Client Plan (MSCP) is a specific category of client plans that is developed when a client receives medication support services. All documentation requirements that exist for a Client Treatment Plan exist for the MSCP; medication consent is required for any medication prescribed as part of the treatment, addressed below. The only level of practitioner who may develop a MSCP is a physician or a nurse practitioner.

Translating client goals into specific, observable/measurable objectives requires considerable skill. It usually involves uncovering concrete issues, behaviors, and/or barriers that are preventing the client/family from accomplishing their goals. An ideal objective is one that meets both the client/family's needs in working towards the goal and is specific and measurable enough to be able to chart progress. It is helpful to follow the acronym SMART when formulating goals and objectives: Specific, Measurable, Attainable, Realistic, Time Limited.

Refer to Appendix D FAQs on Client Plans for additional information.

Required Elements of a Client Plan

The Client Plan must contain the following elements:

1. Lists objective(s) to be accomplished during treatment, which must:
   a. Be specific observable and/or specific quantifiable
   b. Focus on functional impairments which are related to an included mental health diagnosis.
2. Identifies intervention(s), which must include:
   a. The proposed type(s) / modality(ies) for completing the intervention (e.g., Rehabilitation, Case Management, Medication Services)
   b. A detailed description of the interventions to be provided
   c. Howthe service provider intends to address the functional impairment(s)
   d. Be consistent with the client's goals / listed objectives

e. Indicate expected frequency and duration for each intervention

3. Completed prior to the delivery of planned services and updated at least annually or when there are significant changes in the client's condition.
4. Include documentation of the client's participation in and agreement with the client plan. Evidence may include but is not limited to: reference to the client's participation and agreement in the body of the plan, the client's signature on the plan, or a description of the client's participation and agreement in the client record.
5. Include documentation that a copy of the client plan was offered to the client.
6. The client's signature (or their legal representative's signature) is required on the client plan when the client is determined to be a "Long-term care beneficiary" (*HHSA Policy & Procedure 05-05-001*), as defined as:
   a. After a face-to-face assessment, the client is expected to require treatment for more than one (1) year, and/or
   b. The client is likely to require more than one (1) type of specialty mental health service.
7. If the client (or legal representative) is unable to sign the client plan or refuses to sign, the client plan shall include a written explanation of the refusal or unavailability.

Planned, Unplanned, and Urgent Services

Planned Services: are outlined in the current client plan and identified prior to delivery; they include interventions identified as necessary to help a client reach his/her goals and must be documented on the current client plan in order to bill Medi-Cal. Examples include:

- Individual/Group Therapy
- Individual/Group Rehabilitation
- Routine Targeted Case Management (TCM)
- Routine Intensive Care Coordination (ICC)
- Collateral Services
- Intensive Home Based Services (IHBS)
- Routine Medication Support Services

Unplanned Services: may be provided and billed to Medi-Cal without being included on the Client Treatment Plan. These services include:

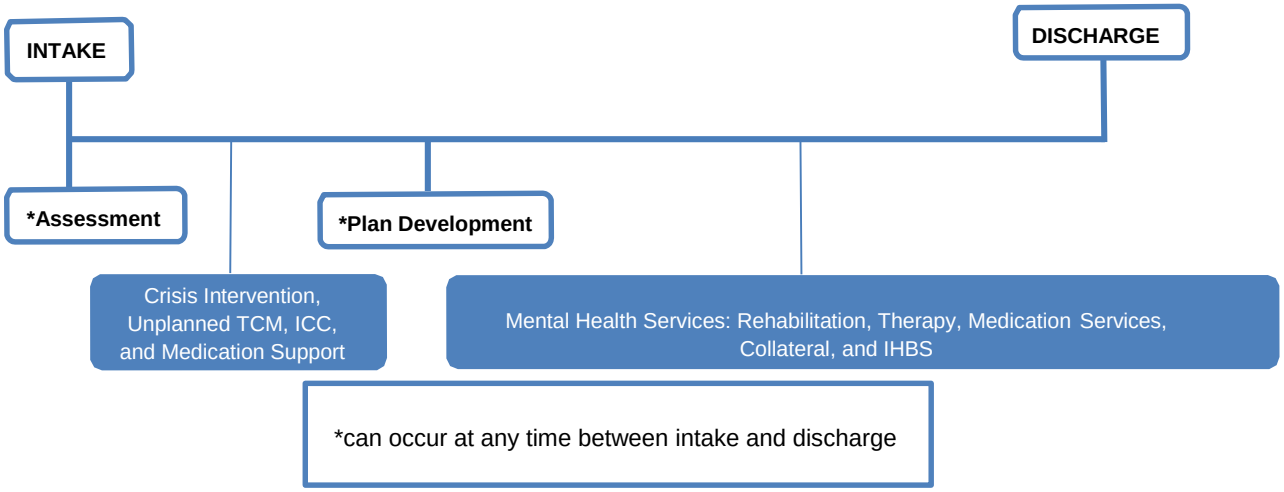
- Assessment
- Plan Development
- Crisis Intervention
- The following services, which are typically provided as planned services, may be provided without being included on the Client Treatment Plan / MSCP when the client's condition requires urgent intervention AND the need is substantiated in the documentation:
  - Targeted Case Management (TCM)
  - Intensive Care Coordination (ICC)
  - Medication Support Services

Urgent Services: Whether a condition is urgent is a *clinical determination* made by the service provider. Urgency is defined as a situation that without timely intervention is highly likely to result in an immediate emergency psychiatric condition, usually within 48 hours.

Providing Services After the Assessment and Prior to Completion of the Client

Doing a thorough Assessment and developing a client plan is the initial priority to ensure services are focused on creating goals and objectives to address the medical necessity for services and treatment. Only Assessment, Plan Development, Case Management, Crisis Intervention, Intensive Care Coordination (ICC), and Medication Support Services procedures may be claimed until the plan is finalized, as described above. Intake is the process in which clients are referred for services.

Refer to Appendix D FAQs on the Provision of Services Prior to a Client Plan Being in Place for more information.



Client Plan Effective Date

A client plan becomes effective the date it is signed by the licensed, registered, or waivered practitioner who completed it.

If completed by an MHRS or Graduate Intern, the client plan becomes effective the date it is co-signed by a licensed practitioner.

Planned services cannot be billed to Medi-Cal before this date.

(MHP Contract; California Code of Regulations, Title 9. § 1810.440 (c)(1))

The client/family's participation and understanding of all elements in their plan is essential for successful outcomes and is required by state regulations. The only exception is when a person has a legal status that removes his/her decision-making power, e.g., LPS Conservatorship. It is good practice to routinely review the client plan with the client/family/Conservator and with the treatment team throughout the authorization period in order to consistently review Medical Necessity and the appropriateness of services provided.

W&I Code Sec. 5600.2. (a) (2) states (Persons with mental disabilities) "Are the central and deciding figure, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. Planning should also include family members and friends as a source of information and support.

Program Considerations: EPSDT

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program client plans shall be completed during client's first visit for on-going services following initial assessment, but in no case later than before the third visit following assessment.
- Client plans to be reviewed every 6 months for on-going mental health services and to be updated no less frequently than every 12 months. A client plan may be updated sooner as is appropriate per case situation.
- All updates for client plans are to be completed during the 30-day window period prior to the Plan's expiration
- Client plans for EPSDT consumers who receive only Medication Services are to be renewed at least annually, or when there is a significant change in client's condition.
- All updates for Client Treatment Plans are to be completed during the 30-day window period prior to the Plan's expiration; for MSCPs, all updates are to be completed as close to or within 3 months of expiration.
- The plan's 6-month period starts on the date on-going services are first provided or the date subsequent plans are signed and dated.
- End date is 6 months to the calendar day (i.e., if 1/12/14 is the start date then 7/11/14 is the end date). The subsequent plan must be signed and dated by 7/11/14 to avoid providing services without a plan in effect.
- If the plan expires, any services provided after the expiration of the Client Treatment Plan and prior to the formulation and approval of a new and current Client Treatment Plan shall be disallowed.

Program Considerations: TBS

- Therapeutic Behavioral Services (TBS) Client Treatment Plans are to be completed during client's first visit for on-going services following initial assessment, but in no case later than before the third visit following assessment.
- Client Treatment Plans to be updated at minimum every 12 months for on-going mental health services. A Client Treatment Plan may be updated sooner as is appropriate per case situation, and specific programs may require more frequent updates.
- Under certain circumstances, a MHP may authorize the provision of TBS for a maximum of 30 calendar days when TBS class membership cannot be established for a child/youth (IN 08-38).
- Client Treatment Plans for consumers who receive only Medication Services are to be updated annually.

- All updates to be completed during the 30-day window period prior to the Plan's expiration.
- The plan's 12-month period starts on the date on-going services are first provided or the date subsequent plans are signed and dated.
- End date is 12 months to the calendar day (i.e., if 1/12/14 is the start date then 1/11/15 is the end date). The subsequent plan must be signed and dated by 1/11/15 to avoid providing services without a plan in effect.
- If the plan expires, any services provided after the expiration of the Client Treatment Plan and prior to the formulation and approval of a new and current Client Treatment Plan shall be disallowed.

Program Considerations: MHSA FSP & AOT

- MHSA Full Service Partnership (FSP) & Assisted Outpatient Treatment (AOT) Client Treatment Plans are to be completed during client's first visit for on-going services following initial assessment, but in no case later than before the third visit following assessment. Crisis residential staff to complete document within 72 hours of client's admission.
- Client Treatment Plans to be updated at minimum every 12 months for on-going mental health services. A Client Treatment Plan may be updated sooner as is appropriate per case situation, and specific programs may require more frequent updates.
- Client Treatment Plans for consumers who receive only Medication Services are to be updated annually.
- All updates to be completed during the 30-day window period prior to the Plan's expiration.
- The plan's 6-month period starts on the date on-going services are first provided or the date subsequent plans are signed and dated.
- End date is 6 months to the calendar day (i.e., if 1/12/14 is the start date then 7/11/14 is the end date). The subsequent plan must be signed and dated by 7/11/14 to avoid providing services without a plan in effect.
- If the plan expires, any services provided after the expiration of the client
- plan and prior to the formulation and approval of a new and current Client Treatment Plan shall be disallowed.

Program Considerations: IHBS & ICC

- Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC) Client Treatment Plans are to be completed during client's first visit for on-going services following initial assessment, but in no case later than before the third visit following assessment.
- Client Treatment Plans to be reviewed every 6 months for on-going mental health services and updated no less frequently than every 12 months. A Client Treatment Plan may be updated sooner as is appropriate per case situation.
- Client Treatment Plans for consumers who receive only Medication Services are to be updated annually.
- All updates to be completed during the 30-day window period prior to the Plan's expiration.
- The plan's 12-month period starts on the date on-going services are first provided or the date subsequent plans are signed and dated.
- End date is 12 months to the calendar day (i.e., if 1/12/14 is the start date then 11/11/15 is the end date). The subsequent plan must be signed and dated by 1/11/15 to avoid providing services without a plan in effect.
- If the plan expires, any services provided after the expiration of the Client Treatment Plan and prior to the formulation and approval of a new and current Client Treatment Plan shall be disallowed.

Program Considerations: Medication Consent

In most circumstances, treatment with psychotropic medication is a significant part of the services outlined in the MSCP. Providers are required to obtain and retain a medication consent form signed by the beneficiary agreeing to the administration of all psychiatric medication. The documentation shall include, but not be limited to: the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to clients taking such medication beyond three (3) months; and, that the consent, once given, may be withdrawn at any time by the client. (MHP Contract) These requirements apply to all clients.

Additional requirements for informed consent for antipsychotic medications include:

- *A voluntary patient shall be treated with antipsychotic medications only after such person has been informed of his or her right to accept or refuse such medications and has consented to the administration of such medications.*

Yolo County HHSA's Medication Consent Policy, PP 5-11-003, identifies the following twelve (12) required elements of Medication Consent:

1. For each client receiving medication support services, the provider shall discuss the following information with the client/client's representative/conservator/parent or guardian (CCR, Title 9, Chapter 11, Section 851; MHP Contract):
    a. The diagnosis and target symptoms for each medication recommended.
    b. The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment.
    c. The possible initial and long-term side effects of each medication recommended, including risk of medications to pregnant women and women who are breast feeding.
    d. The possible reasonable alternatives and complementary treatments.
    e. The possible results of not taking the recommended medication(s).
    f. The possibility that medication dose and/or frequency may need to be adjusted over time, based on response and tolerability.
    g. The right to actively participate in treatment by discussing medication concerns or questions.
    h. The right to withdraw consent for medication at any time, except in cases where treatment with medication is court-ordered.
    i. For any individual under the age of 18 years, the FDA status of medication and the level of evidence supporting the recommended medication.

2. The following types of medications require informed consent: Antidepressants; Antispychotics; Anxiolytics; Hypnotics/Sedatives; Mood Stabilizers; Psychostimulants; and all other medications used for psychiatric purposes (e.g., alpha antagonists, anticonvulsants, beta blockers).

3. If the client is a minor, the provider shall discuss the information outlined above with the parent or legal guardian, and obtain his/her consent on behalf of the minor. If the minor can reasonably comprehend the information and make informed decisions, the minor shall also sign consent.

If the client is unable to make decisions for himself/herself, the provider shall discuss the information with the client's representative or conservator.

4. If medication is refused, the provider shall document that the information was provided, consent was refused and provide a reason for refusal (e.g., client does not like the potential side effects, client does not believe in treatment using medications).

5. Written information about each medication discussed should be offered to the client, client's representative, or parent/guardian.

6. JV-220 forms shall be used to ask for an order to give, or continue giving, psychotropic medications to children who are a ward or dependent of the juvenile court and living in an out-of-home placement or in foster care (WIC, Section 727.4). Refer to HHSA Policy 5-11-002-J, "Prescribing Psychotropic Medications to Minors", for further JV-220 information.

7. The client, client's representative, or parent/guardian, shall be given the chance to review the information provided and ask questions.

8. Consent must be obtained using the medication consent form either in AVATAR or paper copy, as attached (HHSA PP 5-11-003-A). Multiple medications may be listed on one consent form, as long as risks, benefits, side effects, and drug information for each medication is provided.

9. Any time new medication is prescribed, or the route changed (e.g., PO to IM), a new consent form must be completed and signed for that medication. Changes to dosage and/or frequency do not require new consent, unless outside of the range(s) given on the consent form, or above the FDA recommended maximum dose. Any medication changes should be documented in the progress note.

If a female client becomes pregnant or is breastfeeding, medication consent should be reviewed, and the risks and benefits of currently prescribed medications and/or safe alternatives discussed.

If no changes are made, document this information in the progress note. If changes are made, a new consent shall be obtained and signed.
Except for the circumstances listed above, medication consent will remain in the client's chart and is valid indefinitely from date of signature.

10. The client, client's representative, or parent/guardian may withdraw consent at any time by notifying the provider. The reason for withdrawing consent shall be documented in the progress note and the medication order discontinued.

11. At a minimum, the medication consent form shall be signed by the prescribing provider. The client should also sign the medication consent form to acknowledge his/her agreement, however, if a client refuses to sign or only verbally agrees, then the prescriber shall document the refusal and provide a reason why client signature is unobtainable. If a client has a legal representative or guardian, they shall also the sign the form.

To be considered complete, medication consent forms shall be signed, dated, and finalized.

12. A copy of the medication consent form shall be offered to the client in his/her preferred language. Copies are available in HHSA's threshold languages of English, Spanish, and Russian.

Refer to Appendix D FAQs on Medication Consent for additional information.

Chapter 5: PROGRESS NOTES & SPECIALTY MENTAL HEALTH SERVICES

5.1 PROGRESS NOTES

The Clinical Assessment is the first step toward establishing medical necessity for specialty mental health services (SMHS). The client plan takes the information gathered during the assessment process and directs the focus of services. Progress notes are a "point in time" snapshot of progress toward treatment goals. Progress notes describe the *actual* interventions provided and clearly document how the services reduced the impairment(s), restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the Client Treatment Plan / Medication Services Client Plan (MSCP). The following sections outline specific progress note standards, preferred progress note formats, and descriptions of the different types of SMHS.

Content Requirements – General

The content of each Progress Note shall:

a) Clearly indicate the type of service provided and how the service was medically necessary to address an area of functional impairment identified in the client plan (*include how interventions reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning)*;
b) Address the progress (or lack of progress) toward treatment goals;
c) Describe unresolved or ongoing issues from previous contacts, referrals to community resources/other agencies, or a discharge summary, when appropriate;
d) Clearly document interventions applied, the client's response to the interventions, the location of the interventions, and the time it took to provide the service (*the exact number of minutes used by staff providing a reimbursable service shall be reported and billed*);
e) Describe client encounters, relevant clinical decisions, and alternative approaches for future interventions;
f) Include evidence of linkage to culture-specific and/or language assistance services, and when information was provided to the client in an alternative format (e.g., braille, audio, large print), when applicable;
g) When services are being provided by two or more persons at one point in time, each person's involvement shall be documented in the context of the mental health needs of the client and the exact number of minutes should be allocated appropriately by each person providing the service (Note: if documented in Avatar, each staff must write their own progress note so the signature of each staff providing the service is captured);
h) For group notes, document the total number of group participants and clearly indicate the length of group session with documentation time included, or documentation time clearly recorded separately (see example under Group Rehabilitation Section for how to properly allocate group time across multiple clients); and
i) Include the signature of the person providing the service (or electronic equivalent), including the date of signature and the person's type of professional degree, licensure or job title.

Clinical staff are encouraged to use the PIRP Format or SOAP Format and nursing staff are encouraged to use the SOAP Format for documentation.

Content Requirements – Medication Support Services

In addition to the General Content requirements above, medication support progress notes for medical staff (MD/DO/NP) must also:

a) Indicate whether the client is "New" or "Established" (or be easily inferred from the note);
b) Include chief complaint and reason for encounter;
c) Include Interval History for Established clients, or a complete Past Medical, Family, Social History (PFSH) for New clients
   - *New Client: Individual has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty belonging to the same group practice within the previous 3 years.*
   - *Established Client: Individual who has received professional services from the physician/NPP or another physician of the same specialty belonging to the same group practice within the previous 3 years.*
d) Include relevant Medical History
e) Include three (3) of seven (7) Vital Signs (blood pressure – sit/stand, blood pressure – supine, pulse and regularity, respiration, temperature, height, weight) *Note: This may be in body of note or in a separate nursing note;
f) Document a psychiatric review of systems (e.g., key symptoms of the diagnosis)
g) Indicate current labs (within the last year), prior diagnostic results (if applicable), and rationales for new diagnostic/lab/ancillary service orders (if applicable); *Note: New clients being seen for the first time may not have any labs until a subsequent visit
h) Elaborate or comment on any abnormal lab or diagnostic findings
i) Document allergies or lack thereof;
j) For female clients, indicate pregnancy/breastfeeding/ menopausal status;
k) For antipsychotics, document annual Abnormal Involuntary Movement Scale (AIMS);
l) Document the client's response to medications, including any side effects of adverse reactions;
m) Document the client's compliance/adherence to medication;
n) List the current medications;
o) Include a rationale for changes in medication made by the provider (if applicable);
p) Document appropriate health risks factors;
q) Document the client's progress;
r) Document CURES as needed; either "N/A" or report findings
s) If applicable, document changes in treatment and the client response (including change of Diagnosis, if applicable);
t) Include a Mental Status Exam (MSE);
u) Include a clinical impression and diagnosis; and
v) Include a plan for next steps and follow-up.

Nursing staff and medical support staff (RN/LVN/LPT/MA) shall follow the General Content requirements above for medication support services progress notes.

Service Coding

To receive the correct reimbursement for services provided, practitioners must:

a) Select the correct procedure code (e.g., treatment or service code) that identifies the service provided;
b) Select the correct location that identifies where the service was provided; and
c) Document to support and substantiate the service provided and coded.

Descriptions of the service codes are included in Section 5.2 below.

Service Time

Practitioners shall account for the actual time spent providing the service, not a specified period of time based on a categorical activity (*e.g., an hour for each individual therapy or ten minutes for charting*). The following components related to Service Time must be clearly documented in each Progress Note:

a) Date of Service: The date when the service was provided;
b) Service Start Time: The exact time when staff begins working directly with a client, in person or via telephone (*e.g., if a 2:00 pm appointment begins at 2:03 pm, the staff shall document a Start Time of 2:03 pm)*;
c) Direct Time: The total amount of time staff spends providing a service to the client, collateral contact, or completing a supportive case management activity;
d) Documentation Time: The amount of time staff spends writing the Progress Note. (*Documentation Time is an activity that is billable to Medi-Cal, but not to Medicare*.)
e) Travel Time: The amount of time staff spends traveling from the worksite to the client and back again to the worksite. Time spent traveling to/from a staff's home from/to a client is not considered "travel time" for these purposes and may not be claimed. Refer to Appendix D FAQs on Claiming for Travel Time for more information (*Travel Time is an activity billable to Medi-Cal, but not to Medicare*);
f) Service Duration: The sum of Direct Time, Documentation Time, and Travel Time. (*Avatar will automatically calculate the Service Duration based on separate time component* entries);
g) Face to Face with Client (FTF): Defined as the service provider and the client being in the same physical location. Services provided over the phone, even if provided directly to the client, do not constitute FTF time. Medicare will only reimburse for FTF services. *(Note about Telemedicine: Per Medi-Cal Billing Manual Section 5.6.4, services provided by telephone differ from telemedicine services. Telemedicine services are Medicare reimbursable when provided from a clinic through interactive voice and visual interface between the provider and the client and when provided in specific, eligible geographic regions. Services provided via telemedicine should be claimed to Medicare prior to Medi-Cal unless another exception to prior Medicare claiming exists.)*

Refer to Appendix D FAQs on Claiming for Service Functions Based on Minutes of Time and Claiming for Chart Review for additional information.

Other Avatar Requirements

Other critical components for each Progress Note when documented in Avatar include:

a) Client: client name and medical record match;
b) Episode: the service is documented in the appropriate open episode;
c) Progress Note for: Select if the service provided was for an existing service (a service connected to a progress note that was already started), an existing appointment (a service connected to a scheduled Avatar appointment), a new service (a service not connected to an appointment in Avatar), or if the note is independent (a note not connected to any service).

d) Service Program: the specific Service Program is selected (e.g., Davis Clinic, Woodland CSS MH Court, West Sac INN Urgent Care) to which the service is linked; this field is **critically important** and linked to funding. **When in doubt, seek clarification from a supervisor or manager**;
e) Location: the place of service based on location (e.g., office, field, jail);
f) Note Type: Select based on each provider's classification. **Important**: When a note requires co-signature, ensure the correct selection is made (e.g., select "MHRS-Requiring Co-Signature" for a Crisis Intervention service provided by a MHRS. *Licensed Supervisors shall ensure their staff are operating within their scope of practice and notes are co-signed when appropriate*)
g) Client's Preferred Language:
    i. Select client's preferred language
    ii. Select whether the service was provided in the client's preferred language
    iii. Note who provided the service in the client's preferred language
    iv. If applicable, note the reason the service was not delivered in the client's preferred language

Progress Note Frequency, Timeliness, and Finalization

Each documented service must be finalized in a timely manner, according to the following frequency and timelines standards:

Progress Note Frequency

- Per-minute documentation is required for each of the following services, for each encounter:
    - Mental Health Services
    - Medication Support Services
    - Crisis Intervention
    - Targeted Case Management
    - Intensive Care Coordination (ICC)
    - Intensive Home-Based Services (IHBS)
    - Therapeutic Behavioral Services (TBS)

- Daily documentation is required for the following service types:
    - Crisis Residential
    - Crisis Stabilization (1 per 23-hour period)
    - Day Treatment Intensive
    - Therapeutic Foster Care

- Weekly documentation is required for the following service types:
    - Day Treatment Intensive (clinical summary, in addition to daily Notes)
    - Day Rehabilitation
    - Adult Residential

Progress Note Timeliness

- Every effort shall be made to complete Progress Note on the same date of the encounter / service activity and must be entered within five (5) business days.

- Progress Notes entered after five (5) business days shall be considered a Late Entry and must include the phrase "Late Entry" in the beginning of the Progress Note.

- Any Progress Notes entered more than thirty (30) calendar days after the date of service requires supervisor review and documentation, followed by manager approval. ***This exception is permissible only in rare and extenuating circumstances***.

Progress Note Format

While there are specific requirements that must be included in each Progress Note (see Section 5.1), there is flexibility in the format providers may use to capture this information. Below are two examples of preferred formats.

PIRP is the preferred format for Progress Notes written by non-medical staff, including the following Practitioner Types: L/R/W Clinicians, MHRS, MHW, and Graduate Student Interns.

SOAP is the preferred format for Progress Notes written by nursing staff, including RN, LVN, LPT, and MA.

PIRP:

PRESENTING PROBLEM/**P**LACE

a. Place and people involved

b. Reason for the contact

c. Medical necessity/Functional impairment(s)

d. Assessment of client's current clinical presentation

INTERVENTION (or what was attempted by the clinician)

a. Specific mental health/clinical intervention(s) by provider, per type of service and scope of practice

b. Information provided

RESPONSE

a. Client's response to intervention(s)

b. Unresolved issues from previous contacts

c. Information received

PLAN

a. Plans, next steps, and/or clinical decisions.

b. If little or no progress toward goals/objectives, describe why

c. Include date of next planned contact and/or clinical action

d. Indicate referrals made

e. Address any issues of risk

SOAP:

SUBJECTIVE

a. Statement about relevant client behavior or status, list anything client and/or family may say during the session
b. Chief complaint, history of present illness, review of systems, current medications, allergies

OBJECTIVE

a. Measurable, quantifiable, and observable data
b. Mental status exam
c. Vital signs, physical exam findings, labs/imaging/diagnostic data
d. Review of documentation of other clinical notes for the client

ASSESSMENT

a. Interpret the subjective and objective data
b. Indicate progress being made, or lack thereof, towards goals
c. Adjust or set new goals, if necessary
d. Problem, Diagnosis

PLAN

a. Any interventions or treatment rendered during the session
b. Course of action for treatment, next session, and/or clinical decisions
c. Anticipated frequency or duration of interventions or treatments
d. Recommendations, referrals, medication changes

5.2 DESCRIPTIONS OF MENTAL HEALTH SERVICE PROCEDURES AND MEDI-CAL BILLING

Specialty Mental Health Services (SMHS) include individual or group therapies and interventions that are designed to reduce mental disability and/or facilitate improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self- sufficiency. Services are directed toward achieving the client's/family's goals and must be consistent with the current Client Treatment Plan. Service activities may include, but are not limited to, assessment, plan development, individual rehabilitation, group rehabilitation, individual therapy, group therapy, collateral, targeted case management, crisis intervention, and medication support (9 CCR § 1810.227).

Refer to Appendix D FAQs on Claiming for Specialty Mental Health Services-General for additional information.

Assessment

Title 9 §1810.204 – defines assessment as a service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the client's clinical history; analysis of relevant cultural issues and history, diagnosis; and the use of testing procedures.

The assessment service codes (see below) are used to document the clinical analysis of the history and current status of the individual's mental, emotional, or behavioral condition. It includes appraisal of the individual's functioning in the community such as living situation, daily activities, social support systems, health history, and status. Assessment includes screening for substance use/abuse, establishing diagnoses and may include the use of testing procedures. Assessment services must be provided by a licensed and/or licensed waived practitioner consistent with his/her scope of practice

- **ASSESSMENT 90791:** Assessment is defined as a service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. All 11 components of an assessment must be documented to meet Medi-Cal documentation standards for a comprehensive mental health assessment. Assessment may be provided as an unplanned service.

- **REASSESSMENT 90791R:** Re-assessment is a service activity designed to re-evaluate the current status of a client's mental, emotional, or behavioral health.

- **ASSESSMENT with MED SERVICES 90792**: A diagnostic evaluation with medical services is a biopsychosocial and medical assessment. This code requires a complete medical and psychiatric history (including past, family, social), mental status exam, establishment of diagnosis, evaluation of client's ability and capacity to respond to treatment, and plan of treatment. Medical services may consist of performing elements of a physical exam, considering writing a prescription, or modifying psychiatric treatment based on medical comorbidities.

- **REASSESSMENT with MED SERVICES 90792R**: A diagnostic re-evaluation with medical services is a biopsychosocial and medical assessment.

Please also refer to Chapter 4: Assessments & Client Plans of this manual for further guidance on required elements of a comprehensive mental health assessment.

Who May Bill for Assessment Services:

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Graduate Student Interns*

**Requires co-signature by LMHP*

Assessment Services May Include:

- Gathering information to gain a complete clinical picture
- Interviewing the client and/or significant support person
- Formulating a diagnosis
- Completing an Initial Clinical Assessment and Annual Clinical Reassessment
- Psychological testing
- Observing the client in a setting such as milieu, school, etc., which may be indicated for clinical purposes
- Conducting a Functional Assessment to inform a behavioral plan

A good Assessment Progress Note includes some observations or findings relating to the Assessment. *It is not acceptable to simply write a note indicating an Assessment was completed.* The Progress Note needs to include why the Assessment is being completed and preliminary findings or observations of the client's behaviors during the assessment process.

Assessment notes may contain elements which only licensed/registered or waivered staff can perform, such as assigning diagnoses and/or conducting mental status examinations. Staff should only provide and document assessment services within their scope of practice.

Initial and annual assessment progress notes MUST include documentation that staff reviewed and explained the necessity of the following required materials: Consent to Treatment, Release of Information, Notice of Privacy Practices, Problem Resolution Guide, Advanced Healthcare Directives, Provider List, Medi-Cal Guide to Mental Health Services, and Acknowledgement of Receipt. Note if the client is unwilling to sign ROIs, Consent to Treat and/or Acknowledgement of Receipt with explanation. Provide evidence that cultural and linguistic needs were discussed and offered.

Plan Development

Title 9 §1810.232 – defines Plan Development as a service activity that consists of development of Client Treatment Plans, approval of Client Treatment Plans, and/or monitoring of a client's progress.

The Plan Development service code (H0032) is used to document the development of Client Treatment Plans, obtaining client/family approval and signature on the plan and updating or revising the Client Treatment Plan. Plan Development is expected to be provided during the development of the initial plan and for subsequent Client Treatment Plan updates. However, it may be used during other times than the periodic update cycle, as clinically indicated to modify the plan to make it relevant to client needs. For example, when the client's status changes (i.e., significant improvement or deterioration), there may be a need to update the Client Treatment Plan.

Who May Bill for Plan Development Services:

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Mental Health Rehabilitation Specialist (MHRS)
- Graduate Student Interns*

**Requires co-signature by LMHP*

Plan Development Services May Include:

- Development and client/family approval of Client Treatment Plans
- Negotiating plan objectives with client or significant support persons
- Verification of medical or service necessity for services listed on Client Treatment Plan
- Evaluation and justification for modifying the Client Treatment Plan
- Updating, revising, renewing Client Treatment Plans
- Development of a behavioral plan connected to the Client Treatment Plan
- Creation of a crisis or safety plan

Client Treatment Plans developed by a MHRS or Graduate Student Intern must be approved and co-signed by a LMHP.

Please also refer to Chapter 4: Assessment & Client Plans of this manual for further guidance on regarding staff who may develop client treatment plans and staff who may sign them.

Rehabilitation

Title 9 §1810.243 – defines Rehabilitation as a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a client's or group of clients' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

The Rehabilitation service codes (97535-Individual, 97535G-Group) are used to document services that assist the client in improving a skill or developing a new skill set. "Rehabilitation" means a recovery or resiliency focused service activity identified to address a behavioral health need that is documented in the Client Treatment Plan. This service activity provides assistance in restoring, improving and/or preserving functional, social, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. This procedure may be provided in an individual or group format. Rehabilitative Mental Health Services are provided as part of a comprehensive specialty behavioral health services unit available to Medicaid (Medi-Cal) clients that meet medical necessity criteria established by the State, based on the client's need for Rehabilitative Services established by an Assessment and documented in the Client Treatment Plan.

Who May Bill for Rehabilitation Services:

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Mental Health Rehabilitation Specialist (MHRS)
- Mental Health Workers (MHW)

- Graduate Student Interns*
  **Requires co-signature by LMHP*

Rehabilitation Services May Include:

- Practicing daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication compliance
- Counseling of the client including psychosocial education aimed at helping achieve the individual's goals
- Education around medication, such as understanding benefits of medication (within the practitioner's scope)

Group Rehabilitation

The Group Rehabilitation service code (97535G) is used to document services that assist the client in improving a skill or assist the client with the development of a new skill set in a group setting. If there is more than one provider facilitating the service, each staff member's role must be documented as unique, unduplicated, and necessary.

Specialty Mental Health Services (SMHS) may be provided to more than one (1) individual at the same time. One or more practitioners may provide these services and the total time for intervention and documentation may be claimed. "When services are being provided by two or more persons at one point in time, the number of staff group facilitators and the unique involvement of each shall be documented in the context of the mental health needs of the beneficiary. The progress note should include the total number of group participants (Medi-Cal and non-Medi-Cal participants) and clearly indicate length of group session with documentation time included (or documentation time clearly recorded separately). In addition, when multiple providers rendered a covered service to more than one participant, the total number of minutes of the session must be distributed among the group participants (regardless of payer source) and prorated among the providers at the group session" (Cal. Code Regs., tit 9 § 1840.314(c); Medi-Cal Billing Manual Chapter 7, section 7.5.5). The examples below demonstrate the approach to determine the number of minutes each provider may claim for each Medi-Cal beneficiary participating in the group session.

Example 1: One provider facilitates a group service.

Set of Facts:

1. Group: 100 minutes
2. # of Providers: 1
3. # of Participants: 10
4. Provider 1: renders 100 minutes of a covered service
5. Documentation Time: Provider 1 spends 80 minutes to complete all 10 progress notes on all 10 clients

Method:

- Divide the provider's total minutes providing and documenting the covered service by the number of group participants.
- Provider 1: 100 minutes of service time + 80 minutes of documentation time = 180 minutes divided by 10 clients = 18 minutes
- Provider 1 would bill 18 minutes per Medi-Cal beneficiary.

Example 2: Two providers facilitate a group service and document separate progress notes.

Set of Facts:

1. Group: 100 minutes
2. # of Providers: 2
3. # of Participants: 10
4. Provider 1: renders 100 minutes of a covered service
5. Provider 2: renders 60 minutes of a covered service
6. Documentation Time: Provider 1 spends 80 minutes to complete progress notes on all 10 clients and Provider 2 spends 70 minutes to complete progress notes on all 10 clients.

Method:

- Provider 1: 100 minutes of service time + 80 minutes of documentation time = 180 minutes divided by 10 clients = 18 minutes
- Provider 2: 60 minutes of service time + 70 minutes of documentation time = 130 minutes divided by 10 clients = 13 minutes
- Provider 1 would bill 18 minutes per Medi-Cal beneficiary and Provider 2 would bill 13 minutes per Medi-Cal beneficiary.

Intensive Home Based Services (IHBS)

DHCS Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), & Therapeutic Foster Care (TFC) – defines IHBS as individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's or youth's functioning. These interventions are aimed at: helping the child/youth build skills for successful functioning in the home and community, as well as improving the family's ability to help the child/youth successfully function in the home and in the community.

The difference between IHBS (service code: KTAH2015) and more traditional outpatient Specialty Mental Health Services (SMHS) is that IHBS is expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the child's or youth's client plan, and will be predominantly delivered outside an office setting, and in the home, school, or community. IHBS activities support the engagement and participation of the child/youth and his/her significant support persons. In addition, IHBS activities help the child/youth develop skills and achieve the goals and objectives of the plan.

Who May Bill for IHBS Services: *Provider qualifications for IHBS are the same as those allowed for mental health services, and as approved by the MHP*

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Mental Health Rehabilitation Specialist (MHRS)
- Mental Health Workers (MHW)
- Graduate Student Interns*

  **Requires co-signature by LMHP*

IHBS services may include:

- Medically necessary, skills-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the client's family and/or significant others to assist them in implementing the strategies.
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace nonfunctional behavior that interferes with daily living tasks or to avoid exploitation by others.
- Development of skills or replacement behaviors that allow the child or youth to fully participate in the CFT and service plans, including, but not limited to, the client plan and/or child welfare service plan.
- Improvement of self-management of symptoms, including self-administration of medications, as appropriate.
- Education of the child/youth and/or his/her family or caregiver(s) about, and how to manage, the child's/youth's mental health disorder or symptoms.
- Support of the development, maintenance, and use of social networks, including the use of natural and community resources.
- Support to address behaviors that interfere with the achievement of a stable and permanent family life.
- Support to address behaviors that interfere with seeking and maintaining a job.
- Support to address behaviors that interfere with a child's or youth's success in achieving educational objectives in a community academic program.

- Support to address behaviors that interfere with transitional independent living objectives, such as seeking and maintaining housing and living independently.

Lockouts for IHBS:

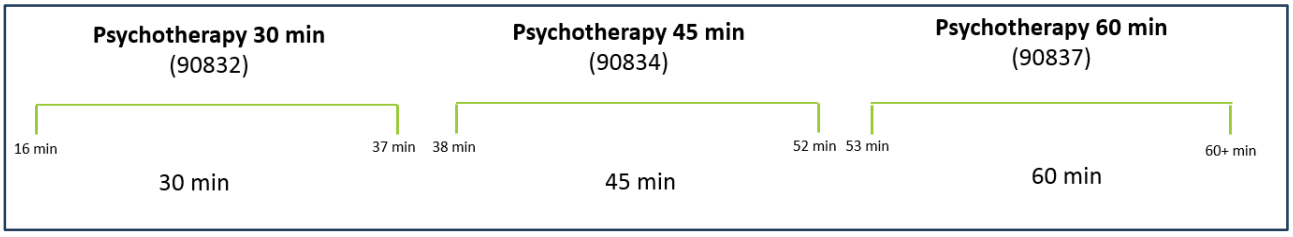
IHBS is intended to be provided to children and youth living and receiving services in the community. Effective July 1, 2017, IHBS may be provided to Medi-Cal beneficiaries, under the age of 21, who are placed in group homes or Short-Term Residential Therapeutic Program (STRTPs), if medically necessary. (Prior to July 1, 2017, IHBS could not be provided in a group home or STRTP. This limitation is no longer in effect).

Therapy

Title 9 §1810.250 – defines Therapy as a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of clients and may include family therapy at which the client is present.

The Therapy service codes (Individual-90832, 90834, or 90837; Group-90853) are used to document services that assist the client in acquiring greater personal, interpersonal, and community functioning and/or to modify feelings, thought processes, conditions, attitudes, or behaviors. Therapeutic intervention includes the application of strategies incorporating the principles of development, wellness, adjustment to impairment, recovery and resiliency. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a client or group of clients and may include family therapy directed at improving the client's functioning and at which the client is present. The specific type of therapy (group, individual, family) must be listed on the Client Treatment Plan prior to delivering this service.

Progress notes must adequately document the therapeutic intervention(s) or therapy activity that was provided; the service code is based on the time spent face to face with the client:



Who May Bill for Therapy Services:

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Graduate Student Interns*

**Requires co-signature by LMHP*

Therapy is Defined as a Service Activity Which is:

- A therapeutic intervention

- Focused primarily on symptom reduction
- Utilized to improve functional impairments

Individual Therapy and Group Therapy Services May Include:

- Introduction to symptom management techniques to work on treatment goals
- Process past trauma, grief, abuse
- Utilization of varied effective modalities (interventions, practices, exercises) including: Cognitive Behavior Therapy (CBT), Interpersonal Psychotherapy (IPT), Narrative Therapy, Family Therapy and family-based interventions, Parent-Child Interaction Therapy (PCIT), Acceptance and Commitment Therapy (ACT), Solution-Focused Brief Therapy (SFBT), Dialectical Behavioral Therapy (DBT), Schema-Focused Therapy, Psychodynamic Psychotherapy, Emotion-Focused Therapy (EFT), and Motivational Interviewing (MI).
- May also incorporate using play equipment, physical devices, language interpreter or other mechanism of non-verbal communication

Please reference Group Rehabilitation and Co-Practitioner Claiming sections for specifics regarding co-practitioner claims and group service progress notes.

Family Therapy

Family therapy is not a specifically defined services under Medi-Cal; however, these services may be provided, when medically necessary, and claimed as Therapy. Each client for which a family therapy claim will be submitted must be present at the therapy session. They also must have family therapy identified as a Client Treatment Plan intervention. Progress notes for each therapy session must clearly document how the session focused primarily on reducing each client's symptoms as a means to improve his or her functional impairments or to prevent deterioration and to assist the client in meeting the goals of their Client Treatment Plan.

Refer to Appendix D FAQs on Collateral, Family Therapy, and Family Counseling for additional information on the difference between family therapy (claimed as therapy) and family counseling (claimed as collateral).

Collateral and Family Counseling

Title 9 §1810.206 – defines Collateral as a service activity to a significant support person in a client's life for the purpose of meeting the needs of the client in terms of achieving the goals of the client's Client Treatment Plan. Collateral may include but is not limited to: consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The client may or may not be present for this service activity.

The Collateral service code (90887) is used to document contact with any "Significant Support Person" in the life of the client (e.g., family members, roommates) with the intent of improving or maintaining the mental health of the client. Collateral must be for the purpose of the client, not the support person. This generally excludes other professionals involved in the client's care. Collateral may include helping significant support persons understand and accept the client's challenges/barriers and involving them in planning and

provision of care. Remember, there must be a current release of information in the chart to include these supports, and these services must be included in the client's Client Treatment Plan to support the client's recovery. The client may or may not be present for a collateral service.

Who May Bill for Collateral Services:

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Mental Health Rehabilitation Specialist (MHRS)
- Mental Health Workers (MHW)
- Graduate Student Interns*

  **Requires co-signature by LMHP*

Collateral Services May Include:

- Consultation and training of the significant support person to assist in better utilization of behavioral health services by the client
- Consultation and training of the significant support person to assist in better understanding of the client's serious emotional disturbance or serious mental illness (e.g., psychoeducation)

Collateral documentation should include who was involved in the service and their role, a description of training/counseling provided to the significant support person, how the client's behavioral health goals were addressed through collateral support, the collateral support person's response to the interventions, and a follow-up plan (if needed).

When consulting with other professionals involved with the client's care, use the Targeted Case Management or Plan Development service type rather than Collateral, depending on the purpose of the case consultation. For more information, refer to section on billing for *Case Conferences*.

Targeted Case Management (TCM)

Title 9 §1810.249 – defines Targeted Case Management as services that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.

The Targeted Case Management (TCM) service code (T1017), also known as Brokerage, Case Management (CM), or Linkage, refers to services that assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service; monitoring of the client's progress once he/she receives access to services; and development of the plan for accessing services. While included among the Specialty Mental Health Services (SMHS) as a core service to clients, TCM services are not technically categorized as SMHS under Title 9.

TCM must be listed as an intervention on the Client Treatment Plan, as it will be provided to support a client to reach program and personal goals. It is an integral function of assisting clients in accessing needed supports and resources. TCM interventions should be directed to functional impairments related to an included diagnosis and should substantiate medical necessity.

Who May Bill for Targeted Case Management Services:

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Mental Health Rehabilitation Specialist (MHRS)
- Mental Health Workers (MHW)
- Graduate Student Interns*

**Requires co-signature by LMHP*

TCM services may include:

- Inter-and intra-agency communication, coordination, and referral
- Monitoring service delivery to ensure an individual's access to service and the service delivery system
- Linkage services focused on acquiring transportation, housing, or securing financial needs
- TCM services may also include placement service such as:
    - Locating and securing an appropriate living environment
    - Locating and securing funding
    - Pre-placement visit(s)
    - Negotiation of housing or placement contracts
    - Placement and placement follow-up
    - Accessing services necessary to secure placement

Institutional reimbursement limitations apply when TCM is billed for clients in acute settings such as a hospital (e.g. Woodland Memorial Hospital, 3B North).

For Clients in Acute Facilities, the Following Lockout Circumstances Apply:

When a client is in one of the following locations, no services, including TCM, are claimable to Medi-Cal: IMDs (Institutions for Mental Disease), MHRCs (Mental Health Rehabilitation Centers), Psychiatric Skilled Nursing Facilities, FFS (Fee for Service) Psychiatric Inpatient Hospital, Jail and Juvenile Hall, Acute Psychiatric Inpatient, and Psychiatric Health Facilities; unless directly related to admission and/or discharge.

- Use TCM when services are directly related to discharge planning for the purpose of coordinating placement of the client upon discharge
- Use keywords like "Placement" or "Discharge Planning" in the narrative
- For services not related to placement or discharge planning, document services using the "Other Non-Billable" service procedure/code

Example*:* Client is currently at 3BN and will be discharged in five (5) days. A provider can utilize non-lockout TCM code if services are for the purpose of discharge planning. Refer to Appendix H Lockout Grid Cheat Sheet for more detailed guidance.

Intensive Care Coordination (ICC)

DHCS Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), & Therapeutic Foster Care (TFC) – defines ICC as an intensive form of TCM that facilitates assessment of, care planning for, and coordination of services for children and youth. ICC includes urgent services for beneficiaries with intensive needs.

While the key service components of ICC (service code: is KTAT1017) are similar to TCM, a difference between ICC and the more traditional TCM is that ICC is intended for children and youth who: (a) involved in multiple child-serving systems; (b) have more intensive needs; and/or (c) whose treatment requires cross-agency collaboration. ICC also differs from TCM in that there needs to be a CFT in place, to provide feedback and recommendations to guide the provision of ICC services. A key element of ICC is the establishment of an ICC coordinator, who often is an MHP employee or contractor.

Who May Bill for ICC Services: *Provider qualifications for ICC are the same as those allowed for TCM services, and as approved by the MHP*

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Mental Health Rehabilitation Specialist (MHRS)
- Mental Health Workers (MHW)
- Graduate Student Interns*

**Requires co-signature by LMHP*

ICC services may include:

- Comprehensive Assessment and Periodic Reassessment: These assessment activities are different from the clinical assessment to establish medical necessity for specialty mental health services but must align with the mental health client plan. Information gathering and assessing needs is the practice of gathering and evaluating information about the client and family which includes gathering and assessing strengths, as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of clients.
- Development and Periodic Revision of the Plan: Planning within the Core Practice Model (CPM) is a dynamic and interactive process that addresses the goals and objectives necessary to assure that clients are safe, live in permanent loving families and achieve well-being. This process is built on an expectation that the planning process and resulting plans reflect the client's and family's own goals and preferences and that they have access to necessary services and resources that meet their needs. The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (child welfare, education, juvenile probation, etc.) are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with service to the client and/or family are coordinated to support and ensure successful and enduring change.
- Referral, Monitoring and Follow-Up Activities: Monitoring and adapting is the practice of evaluating the effectiveness of the plan; assessing circumstances and resources; and reworking the plan, as needed. The ICC coordinator conducts referral, linkages, monitoring, and follow up activities, to ensure that the child's/youth's needs are met. This includes ensuring that services are being furnished in accordance with the child's/youth's client plan, and that services are adequate to meet the child's/youth's needs

- Transition: When the child or youth has achieved the goals of his/her client plan, the CFT should engage in developing a transition plan for the child/youth and family, to promote long-term stability. This transition plan includes the effective use of natural supports and community resources.

Lockouts for ICC:

When ICC is provided in a hospital, psychiatric health facility, community treatment facility, or psychiatric nursing facility, it will be used solely for the purpose of coordinating placement of the child or youth on discharge from those facilities. In this circumstance, ICC may be provided for the purpose of discharge planning, during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, nonconsecutive periods of 30 calendar days, or less, per continuous stay in the facility.

Effective July 1, 2017, ICC may be provided to Medi-Cal beneficiaries, under the age of 21, who are placed in group homes or Short-Term Residential Therapeutic Program (STRTPs), if medically necessary. There is no limitation on the number of days that ICC may be provided or reimbursed. (Prior to July 1, 2017, ICC was available to children and youth in group homes and STRTPs, solely for the purposes of discharge planning, and only for a limited number of days. These limitations are no longer in effect.)

Crisis Intervention

Title 9 §1810.209 – defines Crisis Intervention as a service, lasting less than 24 hours, to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, one or more of the following: assessment, collateral, and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contract, site, and staffing requirements described in Sections 1840.338 and 1840.348.

The Crisis Intervention service code (90839) is used when there is an immediate emergency response that is intended to help a client cope with a crisis (potential danger to self or others, and/or a severe reaction/behavior that is above the client's normal baseline).

Crisis Intervention may include services to clients experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves (including provision/utilization of food, clothing and shelter) due to a mental disorder. Service activities may include, but are not limited to Assessment, Collateral and Therapy to address the immediate crisis. Crisis Intervention activities are typically face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.

Who May Bill for Crisis Intervention:

- Licensed Mental Health Practitioner (LMHP)
- Registered/ Waivered Practitioner
- Mental Health Rehabilitation Specialist (MHRS)*
- Graduate Student Interns*

**Must be determined to be qualified to provide the service by the MHP, and services must be under the immediate supervision of and co-signed by a LMHP*

Crisis Intervention Progress Notes Describe:

- The immediate emergency requiring crisis response
- Interventions utilized to stabilize the crisis
- Safety Plan developed
- The client's response and the outcomes
- Follow-up plan and recommendations

Examples of Crisis Intervention Activities:

- Client in crisis – assessed mental status and current needs related to immediate crisis
- Danger to self and others – assessed/provided immediate therapeutic responses to stabilize crisis
- Gravely disabled client/current danger to self – provided therapeutic responses to stabilize crisis
- Client is having a severe reaction to current stressors and is an imminent danger to self/others – assessed/provided immediate therapeutic and safety interventions to stabilize crisis

Crisis Intervention Progress Notes must include the following elements (in order to claim crisis intervention even when the service did not result in a 5150 hold):

- Assessment for DTS/DTO/GD
- Statement why or why not the client did or did not meet those thresholds
- Development of a safety plan
- Plan for follow-up care and referrals

Crisis Intervention progress notes may not always link to the client's Client Treatment Plan, which is acceptable.

Lockouts for Crisis Intervention (§1840.366):

- When a client is in one of the following locations, no services, including Crisis Intervention, are claimable to Medi-Cal: IMDs, MHRCs, Jail, and Juvenile Hall.

- Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services. Crisis Intervention is allowed on day of admission and discharge from those facilities.

- Limits for Crisis Intervention - The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours and is based on staff time and is not unit specific, as described for medication support services.

Refer to Appendix H Lockout Grid Cheat Sheet for more detailed guidance.

Medication Support Services

Title 9 §1810.225 – defines Medication Support as services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.

The medication support service codes (99201-99205, 99211-99215, 90899, H2010A) are used exclusively by medical staff where it is within their scope of practice to provide such services. This service type may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate); how the use of the medication may improve the effectiveness of other services a client is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing to not take medications. Medication Support Services assist clients in taking an active role in making choices about their behavioral health care and help them make specific, deliberate, and informed decisions about their treatment options.

Who May Bill for Medication Support Services:

- Medication Support Services may only be provided within the scope of practice of the following: Physician/Psychiatrist; Nurse Practitioner; Clinical Nurse Specialist; Registered Nurse; Licensed Vocational Nurse; Licensed Psychiatric Technician; and Pharmacist.

- Medical and Nurse Practitioner students can provide Medication Support Services as long as they are co-signed by the Medical Director or internal MD supervisor.

Types of Medication Services:

Medication Assessment

- Initial Assessment including medical and psychiatric history, current medication, observation of need for medication due to acuity, and consultation with clinician, M.D., or nurse regarding medication.

Medication:

- Prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, side effects and compliance to medication, and obtaining informed consent for medications.

Medication Injection:

- Specifically, for the injection and all that an injection entails under guidelines of administration/evaluation of medication.

Please refer to Appendix G Billable Services Cheat Sheet - Medical for additional information on each service code.

Limits for Medication Support Services:

The maximum amount claimable for Medication Support Services for a client in a 24-hour period is 4 hours. The limits are client specific and based on staff time, i.e., staff and co-staff providing a 2-hour service to a client would equal four (4) hours. Note that these maximums are based on total staff time. For example, if an MD and an RN are co-staffing a med service that takes two (2) hours, the claimed time is 4 hours.

Case Conferences

A "case conference" is not a specific service type. Rather, it refers to a discussion between direct service providers involved in the care of the client and may be similar to a multi-disciplinary team meeting. Which service code to select for the Case Conference depends on the purpose of the conference and activities performed, for example:

- If the discussion focuses on the development of a treatment plan for a shared client, the conference would be claimed as Plan Development.
- If the discussion focuses on coordination of services and linkage or referrals, the conference would be claimed as Targeted Case Management.
- If the discussion focuses on the assessment of the client (e.g., clarifying diagnosis or medical necessity), the conference would be claimed as Assessment.

Staff participating in case conferences must describe their role and involvement in the conference. Involvement may include both sharing and receiving of information. Any participation time claimed, which may include active listening time, must be supported by documentation showing what information was shared and how it can/will be used in planning for client care or services to the client (i.e., how the information discussed will impact the client plan). Case Conference progress notes must adhere to all progress note standards.

Co-Practitioner Claiming

Regarding Co-Practitioner Claim Submission, MHPs must comply with this requirement abiding by the following criteria:

1. Submit a separate claim for each rendering provider using his/her assigned individual NPI number;
2. Document the total number of providers and their specific involvement in the context of the mental health needs of the beneficiary in the progress note;
3. Document the specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable in the progress note;
4. Document the number of clients participating in the service activity in the progress note; and
5. Determine the time for each provider claim based on the provider's unique involvement in the service, and their unique documentation and/or travel time, all of which must be clearly documented.

Reminder: For co-practitioner services, each practitioner must independently document services delivered to each client

5.3 NON-BILLABLE SERVICES

Some services are not claimable to Medi-Cal. Non-Reimbursable procedures and certain service locations block the service from being claimed. Un-claimable services may include a wide variety of services which may be useful and beneficial to the client but are not reimbursable by Medi-Cal as a Specialty Mental Health Service (SMHS). This category of services permits flexibility in Client Treatment Planning and promotes the adoption of recovery-based services to individual clients. Even though these are not claimable, these services should be documented by all staff working with clients.

The following services are not Medi-Cal reimbursable:

1. Any service after the client is deceased; this Includes supportive ("collateral") services to family members of the deceased
2. Services under 5 minutes
3. No service provided, including missed appointments / "no shows" and related documentation time
4. Purely clerical activities, such as faxing, copying, calling to reschedule an appointment, completing any forms when not linked to a direct service, etc.
5. Childcare/babysitting
6. Preparing documents for court testimony to fulfill a requirement
    a. *However, if the preparation of documents is directly related to and reflects how the intervention impacts the client's behavioral health treatment and / or progress in treatment, then the service may be reimbursable*
7. Completing the reports for mandated reporting such as a CWS or APS report
    a. *However, any direct services provided that are linked to the report may be reimbursable*
8. Personal care services provided to individuals including grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals
    a. *However, skill-building activities related to these services may be reimbursable*
9. Recreation or general play, such as teaching a client how to lift weights
    a. *However, helping a client acclimate to a Wellness Center and debriefing his / her visits may be reimbursable*
10. Socialization and generalized social activities which do not provide individualized feedback
    a. *However, if direct services provided in a group rehabilitation setting focus on socialization skill building, these direct services may be reimbursable; in this example, both intervention and client response need to be documented*
11. Academic/Educational services, such as assisting the client with his / her homework or teaching a typing class at an adult residential treatment facility
    a. However, providing support to client while in a community college class to help reduce the client's anxiety and then debriefing the experience afterward may be reimbursable
12. Vocational services which have, as a purpose, actual work or work training, such as visiting the client's job site to teach him / her how to use a cash register
    a. *However, visiting the client's job site to assist in decreasing his / her anxiety enough to concentrate on the task of learning a new skill while at work may be reimbursable*
13. Multiple practitioners in Case Conference or meeting
    a. *However, plan development services for a specific client, conducted during a case conference,*

may be reimbursable for the practitioners directly involved in the case; each practitioner's unique contribution must be clearly noted

14. Clinical supervision of staff or interns
    a. *However, reviewing and amending / updating the Client Treatment Plan with a supervisor may be reimbursable (e.g. the topic of discussion is centered on exploring alternative interventions that may assist the client in reaching his / her goals)*
15. Utilization management, peer review, or other quality improvement activities
    a. *While these activities are not reimbursable through client-specific, per-minute Medi-Cal claiming, they are reimbursable services under a different claiming process*
16. Interpretation / Translation
    a. *However, an intervention provided in a language other than English may be reimbursable*
17. Travel / Transportation Situations
    a. Not reimbursable:
        i. Taking a client from one place to another during which time no Specialty Mental Health Service is provided
        ii. Traveling to a site when no service is provided due to a "no show"; e.g., leaving a note on a client's door or leaving a message with another individual about the missed visit
    b. May be reimbursable:
        i. Providing supportive interaction with a client while accompanying the client from one place to another in a vehicle; claimable time is limited to time spent interacting and must be specific to interventions identified in the Client Treatment Plan
        ii. Traveling to the location where a Specialty Mental Health Service is delivered may be claimed as part of the associated service delivered

Lockouts

Lockout means a situation or circumstance where Medi-Cal cannot be billed for specialty mental health services, due to the location where services are delivered or the timing of the service delivery (Title 9 § 1840.100(d)). When a service is locked out, the corresponding non-billable "Y-Code" must be used in the progress note. Common lockout settings or situations include:

- Psychiatric Inpatient Hospital
- Psychiatric Health Facility
- Psychiatric Nursing Facility
- Institute of Mental Disease (IMD)
- Crisis Stabilization Unit (CSU) – providers can use billable codes prior to the client's admission to the CSU
- Crisis Residential Treatment Facilities (CRT) – providers can only bill Targeted Case Management or Medication services when a client is placed at a CRT. All other services that would otherwise be reimbursable would be coded as a Y-Code with their corresponding service code
- Jail
- Juvenile Hall
- Day Treatment program hours

Refer to Appendix H Lockout Grid Cheat Sheet for more detailed guidance.

Chapter 6: SCOPE OF PRACTICE/COMPETENCE/WORK

6.1 SCOPE OF PRACTICE/COMPETENCE/WORK

The State Plan describes Specialty Mental Health Services (SMHS) and specifies the provider types for each service. SMHS must be delivered by mental health professionals working within their scope of practice. (Section 3, Supplement 3 to Attachment 3.1-A, pages 2d, 2m; See also Cal. Code Regs., tit. 9, §1840.314(d)). Please refer to appropriate professional licensing boards for specific information about scope of practice; as well as any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations.

The following mental health professionals may provide and direct others in providing SMHS within their respective scope of practice:

- Physicians;
- Psychologists;
- Licensed Clinical Social Workers;
- Licensed Professional Clinical Counselors;
- Marriage and Family Therapists;
- Registered Nurses;
- Certified Nurse Specialists; and,
- Nurse Practitioners. (State Plan, Section 3, Supplement 3 to Attachment 3.1-A, pages 2m-2o)

Waivered/registered mental health professionals may only direct services under the supervision of a Licensed Mental Health Professional (LMHP) in accordance with applicable laws and regulations governing the registration or waiver (Cal. Code Regs., tit. 9 § 1840.314 (e) (1)(F)).

Direction may include, but is not limited to, being the person directly providing the service, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of Client Treatment Plans. Individuals are not required to be physically present at the service site to execute direction. The licensed professional directing service assumes ultimate responsibility for the SMHS provided (State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2b; Cal. Code Regs., tit. 9 § 1840.314 (e)(2)). SMHS may be provided by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for SMHS established by Department of Health Care Services (DHCS), to the extent authorized under state law.

The following types of providers must be licensed in accordance with applicable state of California licensure requirements, and, in addition must work "under the direction of" a licensed professional operating within his or her scope pf practice:

- Licensed Vocational Nurses;
- Licensed Psychiatric Technicians;
- Physician Assistants;
- Pharmacists; and,
- Occupational Therapists. (See State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p).

Additional providers who may operate "under the direction of" a LMHP include:

Mental Health Rehabilitation Specialists (MHRS):

A MHRS shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting. A MHRS may provide Mental Health Services (excluding Therapy), Targeted Case Management (TCM), Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential, and Crisis Residential Treatment services.

Mental Health Workers (MHW):

The State Plan permits the provision of services by "Other Qualified Providers," defined as, "an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department." Refer to Appendix A for the Yolo County Scope of Practice Guidelines. State law requires these "Other Qualified Providers" to provide services "under the direction of" a LMHP within their respective scope of practice (State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p; Cal. Code Regs., title 9, section 1840.344, Service Function Staffing Requirements – General).

"Waivered Professional" is defined as:

A person who is in the process of obtaining a Psy.D. or Ph.D., is gaining the experience required for licensure, and has been granted a professional licensing waiver by the State of California to the extent authorized under State law. (DHCS "Professional Licensing Waivers").

"Registered Professional" (AMFT, ASW, APCC) is defined as:

A marriage and family therapist candidate, a licensed clinical social worker candidate, or a professional clinical counselor candidate who has registered with the corresponding state licensing authority for marriage and family therapists, clinical social workers, or professional clinical counselors to obtain supervised clinical hours for marriage and family therapist, clinical social worker, or professional clinical counselor licensure, to the extent authorized under state law.

Graduate Level Student Intern is defined as:

An individual, not yet eligible to be registered or waivered, participating in a field internship/trainee placement while enrolled in an accredited and relevant graduate program. The scope of practice depends on the particular program in which the student or trainee is enrolled and the requirements for that particular program, including any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations. In accordance with the Business and Professions Code, the Board of Psychology, and the Board of Behavioral Sciences, non-licensed trainees, interns, and assistants must be under the immediate supervision of a LMHP who shall be responsible for ensuring that the extent, kind, and quality of the services performed are consistent with his or her training and experience and be responsible for his or her compliance with applicable state law (Business and Professions Code §§2913, 4980.03, 4980.43(b), and 4996.18(d)).

Graduate interns must work "under the direction" of a licensed, registered, or waivered mental health professional, and once determined to be qualified, may conduct the following service activities: comprehensive assessments including mental status exams (MSE) and diagnosis; development of Client Treatment Plans; individual and group therapy; write progress notes (co-signature by LMHP required on all notes); and, claim for any service within the scope of practice of the discipline of his/her graduate program.

If students and trainees do not meet the definition of any of the other defined providers under the State Plan, they may provide some services as Mental Health Worker under the direction of a LMHP who is authorized to direct services (See Section 3, Supplement 3 to Attachment 3.1-A; Cal. Code Regs., tit. 9, §1840.314(e)).

Yolo County adheres to the requirements outlined by the California Board of Psychology (BOP) and Board of Behavioral Sciences (BBS); for more information, visit the BOP and BBS websites.

6.2 HHSA PROFESSIONAL CLASSIFICATIONS AND LICENSES

Below are tables containing the most common licenses or professional classifications in the Behavioral Health field, with brief definitions and characteristics. In conjunction with information and tables from the preceding sections, these tables can be used to help further clarify what clinical activities are within the scope of practice of particular professionals.

AA, BACHELOR'S, AND/OR ACCRUED EXPERIENCE
• **MHRS (Mental Health Rehabilitation Specialist):** Possesses a bachelor's degree (BS or BA) in a mental health related field *and* a minimum of four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. *Or,* an associate arts degree *and* a minimum of six (6) years of experience in a mental health setting. *Or,* graduate education may be substituted for the experience on a year-for-year basis. For example, someone with a bachelor's degree, two (2) years of graduate school, and two (2) years of experience in a mental health setting can qualify to be an MHRS. • **Mental Health Worker, Unlicensed:** Any other direct service staff providing client support services that does not meet any of the other specified licensure or classification definitions or characteristics, i.e., Staff without BA/BS and four (4) years' experience/or AA & Six (6) years' experience. Must have graduated from high school, be 18 years of age or older, and have at least one (1) year of direct care experience in a Mental Health setting.

GRADUATE SCHOOL (POST-BACHELOR'S AND PRE-MASTER'S OR PRE-DOCTORAL)

- **Psychologist Intern (Pre-Doctoral):** Completed academic courses but have not been awarded doctoral degree. *Or* Completing one of the final steps of clinical training, which is one (1) year of full-time work in a clinical setting supervised by a licensed psychologist. Intern status requires a formal agreement between the student's school and the licensed psychologist that is providing supervision.

- **Psychologist Trainee (Pre-Doctoral):** In the process of completing a qualifying doctoral degree. Often called "Practicum Students." *Or* receiving academic credit while acquiring "hands-on" experience in psychology by working within a variety of community agencies, institutions, businesses, and industrial settings. Supervised by a licensed psychologist.

- **MSW Intern:** In the process of completing an accredited Master of Social Work program. Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. Completing clinical hours as part of their graduate school internship field placement.

- **MFT Trainee:** In the process of completing a qualifying doctorate or master's program. Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. Completing clinical hours as part of their graduate school trainee practicum course.

- **PCC Trainee:** In the process of completing a qualifying doctorate or master's program. Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. Completing clinical hours as part of their graduate school trainee practicum course.

POST-MASTER'S OR POST-DOCTORAL, PRE-LICENSE

- **ASW (Associate Clinical Social Worker):** Completed an accredited Master of Social Work (MSW). In the process of obtaining clinical hours towards a CSW license. Registered with the CA Board of Behavioral Sciences (BBS) as an ASW. Possesses a current BBS *registration* certificate (which contains a valid BBS *registration* number).

- **AMFT (Associate Marriage and Family Therapist):** Completed a qualifying Doctorate or Master's degree. In the process of obtaining clinical hours towards an MFT license. Registered with the CA Board of Behavioral Sciences (BBS) as an Associate Marriage and Family Therapist (this is the official BBS title but it is interchangeable with AMFT). Possesses a current BBS *registration* certificate (which contains a valid BBS *registration* number).

- **APCC (Associate Professional Clinical Counselor):** Completed a qualifying Doctorate or Master's degree. In the process of obtaining clinical hours towards an PCC license Registered with the CA Board of Behavioral Sciences (BBS) as an APCC. Possesses a current BBS *registration* certificate (which contains a valid BBS *registration* number).

- **Psychologist (Waivered):** Issued a waiver by the State of CA Department of Health Care Services to practice psychology in CA. Possess valid waiver. Waiver is limited to 5 years.

LICENSED

- **Psychologist (Licensed):** Licensed by the CA Board of Psychology Possesses a current CA Board of Psychology *license* certificate (which contains a valid *license* number).
- **LCSW (Licensed Clinical Social Worker):** Licensed by the CA Board of Behavioral Sciences (BBS). Possesses a current BBS *license* certificate (which contains a valid BBS *license* number).
- **LMFT (Licensed Marriage and Family Therapist):** Licensed by the CA Board of Behavioral Sciences (BBS). Possesses a current BBS *license* certificate (which contains a valid BBS *license* number).
- **LPCC (Licensed Professional Clinical Counselor):** Licensed by the CA Board of Behavioral Sciences (BBS). Possesses a current BBS *license* certificate (which contains a valid BBS *license* number).

MEDICAL

- **Registered Nurse (RN):** Registered with the California Board of Registered Nursing (BRN).
- **Clinical Nurse Specialist (CNS):** An RN with a Master's Degree in an area of specialization and certification by BRN.
- **Psychiatric/ Mental Health Nurse (PMHN):** A CNS with a specialization in Psychiatry/Mental Health, certified by BRN.
- **Psychiatric Mental Health Nurse Advanced Practice RN (PMH-APRN):** Master's or doctoral degree in PMHN. Can practice as a CNS or NP; RN-BC in PMHN.
- **Nurse Practitioner (NP):** An RN who has completed a Nurse Practitioner program, certified by BRN.
- **Licensed Psychiatric Technician (LPT):** Licensed by California Board of Vocational Nursing and Psychiatric Technicians
- **Physician (MD/DO):** Licensed by the Medical Board of California.
- **Medical Assistant (MA):** Unlicensed individual with training as a Medical Assistant by an MD, NP, or PA, under supervision of same.

Scope of Practice is defined by Title 9, CCR, Section 1810.227 and further clarified by DMH Letter No. 02-09, The tables above provide an outline of scope of practice but do not authorize individual practitioners to work outside their own scope of competence.

Some staffing classifications require a co-signature where the clinical supervisor provides clinical supervision using the co-signature as a supervision tool. State laws and regulations specify that a co-signature does not enable someone to provide services beyond his/her scope of practice.

APPENDIX A: YOLO COUNTY SCOPE OF PRACTICE GUIDELINES

Who Can Provide What Service?
Yolo County Scope of Practice Guidelines

	Physician	Licensed or Waivered Psychologist (Post PhD)	Licensed or Registered LCSW, LMFT, LPCC (Post MA/MS)	RN with Masters in MH Nursing or Related Field	MH Nurse Practitioner	Registered Nurse (RN)	Licensed Vocational Nurse, Psych Tech	Trainee Enrolled in MFT, PhD program (Post BA/BS but Pre MA/MS/PhD)	MHRS (Staff with BA/BS in MH related field and 4 Year Exp. in MH)	MHW (Staff without BA/BS and 4 years exp/or AA and 6 Yrs. Exp.)
Assessment (90791)/ Reassessment (90791R)										
History & Data Collection	YES	YES	YES	YES	YES	YES	YES+	YES+	NO	NO
MSE & Diagnosis	YES	YES	YES	YES	YES	NO	NO	YES+	NO	NO
Complete Client Plan	YES	YES	YES	YES	YES	YES+	NO	YES+	YES+	NO
Crisis Intervention (90839, First 60 min)	YES	YES	YES	YES	YES	YES++	YES++	YES+ ++	YES+ ++	NO
Medication Administration	YES	NO	NO	YES	YES	YES	YES	NO	NO	NO
Medication Dispensing	YES	NO	NO	YES*	YES	YES*	NO	NO	NO	NO
Medication Prescribing or Furnishing	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO
Medication Support Services (90899)	YES	NO	NO	YES	YES	YES	YES	NO	NO	NO
Psychological Testing	NO^	YES	NO^	NO	NO^	NO	NO	NO*	NO	NO
Psychotherapy (90832 – 30 min.; 90834 – 45 min.; 90837 – 60 min.; 90853 – Group)	YES	YES	YES	YES	YES	NO	NO	YES+	NO	NO
Rehabilitation Counseling (97535 – Ind.; 97535G – Group)	NO	YES	YES	YES	NO	YES	NO	YES+	YES	YES
Targeted Case Management/ Brokerage (T1017)	YES	YES	YES	YES	YES	YES	NO	YES+	YES	YES
Therapeutic Behavioral Services	NO	YES	YES	NO	NO	NO	NO	YES+	YES	NO
Collateral (90887)	YES	YES	YES	YES	YES	YES	YES	YES+	YES	YES
Plan Development (H0032)	YES	YES	YES	YES	YES	YES	YES	YES+	YES	NO
KTA ICC (KTAT1017)	NO	YES	YES	NO	NO	NO	NO	YES+	YES	YES
KTA IHBS (KTAH2015)	NO	YES	YES	NO	NO	NO	NO	YES+	YES	YES

+ Co Signature Required
^ Staff w/ specific training and experience may qualify, upon approval of the MH Director
* Psychological Testing is within the scope of practice for doctoral student interns (PhD in psychology or PsyD)
** RN's may dispense if trained in dispensing and re-certified annually;
*** LVNs/Psych Techs may not administer IV medications
++ Must have immediate supervision by an LMHP if issues of danger to self or others are present

APPENDIX B: INTERACTIVE VERBS USEFUL IN WRITING PROGRESS NOTES

Sample Interactive Verbs

accessed
acknowledged
actively listened
advised
affirmed
aided
analyzed
appraised
assessed
assisted
assured
brainstormed
briefed
built rapport
challenged
checked in
clarified
coached
collaborated
commended
compiled
confronted
connected
contracted
consulted
coordinated
counseled
cued
demonstrated
developed
devised
diffused
directed
discussed
educated
elaborated
elicited
emphasized
employed
enabled
encouraged
engaged
enhanced
enlisted
evaluated
examined
explained
explored
facilitated
familiarized
focused
followed up
fostered
gave cues/prompts
generated
guided
helped
identified
implemented
informed
initiated
instructed
integrated
interpreted
intervened
interviewed
involved
lead
listened
located
maintained
mentioned
mirrored
mobilized
(resources)
modeled
monitored
negotiated
observed
offered (support, feedback, assistance)
organized
practiced
praised
prepared
prioritized
processed
problem solved
promoted
prompted
provided (feedback)
reality tested
reassured
redirected
reflectively listened
referred
reframed
reinforced
reminded
reported
reviewed
revised
role-modeled
role-played
set clear (limits, boundaries, expectations)
shared
specified
suggested
summarized
supported
taught
used (humor)
validated

APPENDIX C: SAMPLE CLIENT RESPONSES TO INTERVENTIONS

Sample Client Responses

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

APPENDIX D: FREQUENTLY ASKED QUESTIONS, ADOPTED FROM DHCS IN 17-040

The following Frequently Asked Questions (FAQs) are excerpted from the Mental Health and Substance Use Disorders (MHSUDS) Information Notice, IN 17-040, which was issued by the California Department of Health Care Services in August, 2017 to provide clinical documentation guidance to the Mental Health Plans.

FAQs: Medical Necessity and Diagnosis

Who can formulate a diagnosis?

Formulation of a diagnosis requires a provider, working within his/her scope of practice, to be licensed, waivered and/or under the direction of a licensed provider in accordance with California State law. Diagnosis is in the scope of practice for the following provider types: Physicians, Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, and Advanced Practice Nurses in accordance with the Board of Registered Nursing. (*Please also see HHSA Clinical Documentation Standards Guide: Chapter 6, Scope of Practice/Competence/Work*)

Can "By History", "Rule Out", or "Provisional" diagnoses be used in meeting Medical Necessity?

"By history", "Rule Out" and "Provisional" diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a client may have a "by history", "rule out", or "provisional" diagnosis as long as there is also at least one included diagnosis.

Can a client's diagnosis determined during a recent inpatient stay be used as the diagnosis for an outpatient assessment?

The assessment, which includes diagnosis, is designed to evaluate the current status of a client's mental, emotional, or behavioral health. The status of the client's mental, emotional, or behavioral health may change as a client transitions from inpatient to outpatient services. As such, the MHP and its providers should not rely on an inpatient diagnosis when performing an assessment for outpatient services. However, the outpatient provider should review the inpatient assessment documentation to inform the outpatient assessment and verify that the diagnosis reflects the client's current mental, emotional, or behavioral health status.

If the determination about a diagnosis differs between a physician and a non-physician LMHP, which diagnosis should be used for the assessment?

The MHP is ultimately responsible for certifying the accuracy, truthfulness, and completeness of the diagnosis and the provision of SMHS. If there is a difference of opinion regarding a client's diagnosis, the provider should follow the MHP's direction in how to resolve the stated differences. Best practices would indicate that the physician and non-physician providers involved would consult and collaborate to determine the most accurate diagnosis (Cal. Code Regs., tit. 9 §§ 1820.205 and 1830.205; and State Plan Section 3, Supplement 3 to Attachment 3.1-A, page 1).

FAQs: Client Plans

Who can develop client plans?

The MHP determines who can develop client plans. In Yolo County, licensed, registered and waivered clinicians, physicians, Nurse Practitioners, and Mental Health Rehabilitation Specialists (MHRS) staff may develop client plans; only physicians and Nurse Practitioners may develop MSCPs. Client plans shall include documentation of the client's participation in the development and agreement with the client plan (MHP Contract; California Code of Regulations, Title 9, Section 1810.44(c)(1)).

What staff must sign a beneficiary's client plan?

A client plan must be signed (or electronic equivalent) and dated by either:

- The person providing the services;
- A person representing a team or program providing services; or
- A person representing the MHP providing the services.

In addition to a signature by one of the above, the plan must be co-signed by one of the following providers, if the client plan indicates that some services will be provided by a staff member **under the direction** of one of the categories of staff listed below and/or the person signing the client plan is not one of the categories of staff listed below:

- A physician
- A licensed/waivered psychologist
- A licensed/registered/waivered social worker
- A licensed/registered/waivered marriage & family therapist
- A licensed/registered/waivered professional clinical counselor
- A registered nurse, including but not limited to nurse practitioners and clinical nurse specialists. (MHP Contract Cal. Code Regs., tit. 9. § 1810.440 (c)(1))

When is a client plan effective?

A client plan is effective once it has been signed (co-signed, if required) and dated by the required staff member(s) (MHP Contract; California Code of Regulations, Title 9, Section 1810.440 (c)(1)).

When is a client's signature required on a client plan?

The client's signature or the signature of the client's legal representative is required on the client plan when:

- The client is expected to be in long term treatment as defined by the MHP; **and**,
- The client plan provides that the client will be receiving more than one SMHS; **or**, The MHP Documentation standards require it.

If a client is ***not*** expected to be in "long term treatment" as defined by the MHP ***and*** is only receiving one SMHS; ***and*** the MHP does NOT require a client signature, the client is not required to sign the client plan (MHP Contract; California Code of Regulations, Title 9, Section 1810.440(c)(2)(A)).

HHSA Policy and Procedure 05-05-001 defines a long-term beneficiary as a client who, after a face to face assessment, is expected to require treatment for more than one (1) year and/or who is likely to require more than one (1) type of Specialty Mental Health Service.

If a client is not required to sign his or her client plan, what specifically must be documented to show that the client participated in the preparation of and agreed to their client plan?

Documentation of participation in the development of an agreement with the client plan may include, but is not limited to:

- Reference in the client plan to the client's participation in the development of an agreement with the client plan
- The client's signature on the client plan or
- A description in the medical record (i.e. in a progress note) of the client's participation in the development of an agreement with the client plan (MHP Contract; California Code of Regulations, Title 9, Section 1810.440 (c)(2)).

Documentation of participation in the development of, and agreement with, the client plan may include, but is not limited to:

- Reference in the client plan to the beneficiary's participation in the development of, and agreement with, the client plan;
- The beneficiary's signature on the client plan; or,
- A description in the medical record (e.g., in a progress note) of the beneficiary's Participation in the development of, and agreement with, the client plan…." (Cal. Code Regs, tit. 9, § 1810.440 (c)(2)); MHP Contract)

The following is an example of a progress note that would meet the requirement in the case where a client signature on the client plan is NOT required:

- *Client participated in treatment planning meetings on (date) and (date). The client participated in developing their treatment plan goals and interventions; in particular, the goals for (state goal or goals that the beneficiary gave specific input for). The client was satisfied with the client plan and stated verbal agreement at the meeting held on (date).*

Is there a minimum age for a minor (under 18 y/o) to independently sign his/her client plan?

There is no minimum age required for a minor to independently sign a client plan, assuming the client plan is not used to obtain the minor's consent to treatment. The client plan is a collaborative process between the client and the provider. Clients should understand what they are signing based on their participation in that process.

Does a client's signature on his or her client plan have to be dated?

No. There is currently no requirement that a client's signature on his or her client plan be dated.

What if a client refuses to sign his/her client plan?

Each time a client's signature or the signature of the client's legal representative is required on a client plan or an updated client plan "and the client refuses or is unavailable for signature, the client plan [or updated plan] shall include a written explanation of the refusal or unavailability." The written explanation may be on the plan itself or in a progress note. It is best practice to make additional attempts to obtain the client's signature and document the attempts in the client record (MHP Contract; Cal. Code Regs. Tit. 9. § 1810.440 (c)(2)(B)).

What is the maximum time period allowed for a provider to complete a client plan? How often must client plans be updated?

A client plan must be completed prior to service delivery for all planned services. The State Plan requires services to be provided based on medical necessity criteria, in accordance with an individualized client plan and approved and authorized according to the State of California requirements. (State Plan, Section 3, Supp. 3 to Att. 3.1-A, page 2c). In Yolo County, client plans shall be completed as soon as possible following the assessment, and no later than 60-days following the start of service (PP 5-7-002).

The client plan must be updated at least annually or when there are significant changes in the beneficiary's condition. MHPs may require more frequent updates. (MHP Contract)

- Client plan updates shall be completed during the 30-day window period prior to the Plan's expiration
- MSCP updates may be completed within three months in advance of the MSCP expiration date, at which point a new plan effective date is established.

What is considered a "significant change" in a client's condition that would require a provider to prepare an updated client plan?

There is no specific language in regulation or in the MHP contract defining a "significant change" in a client's condition. Examples may include a client who has never been suicidal makes a suicide attempt; or, a client who regularly participates in client plan services suddenly stops coming to appointments. Major life events that might lead to a change in the client's condition include, but are not limited to job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), change in residence/living situation.

If a provider treats a client with only one service modality, is the provider required to prepare a client plan for the client?

Yes. A client plan is required whether a client receives only one service modality or multiple service modalities. SMHS are to be provided, "based on medical necessity criteria, in accordance with an individualized client plan…." (State Plan, Section 3, Supp. 3 to Att. 3.1-A, page 2c*;* MHP Contract).

What is the difference between a "proposed intervention" on a client plan and an "actual intervention"?

Proposed interventions are the services a provider anticipates delivering to a client when preparing the client's plan. MHPs are required to ensure that client plans "identify the proposed type(s) of intervention/modality…to be provided" to the client. The actual interventions are those that are actually delivered to a client. The actual interventions are documented in progress notes.

Can the frequency for delivery of an intervention in a client plan be specified as "PRN," "as needed," "ad hoc," or as a frequency range (i.e., from 1-4 x's per month)?

Use of terms such as "as needed" and "ad hoc" do not meet the requirement that a client plan contain a proposed frequency for interventions. The proposed frequency for delivery of an intervention must be stated specifically (e.g., daily, weekly, etc.), or as a frequency range (e.g., 1-4 x's monthly). Duration must also be documented in the client plan and refers to the total expected timespan of the service (e.g., the client will be provided with two individual therapy sessions per week for 6 months) (MHP Contract).

FAQs: Provision of Services Prior to a Client Plan Being in Place

What SMHS can be provided to a client before his or her client plan is approved?

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

- Assessment
- Plan Development
- Crisis Intervention
- Crisis Stabilization (Not an approved service modality within Yolo County but may be approved within partnering counties)
- Medication Support Services (for assessment, evaluation, or plan development; or *if there is an urgent need, which must be documented*)
- Targeted Case Management (TCM) and Intensive Care Coordination (ICC) (for assessment plan development, and referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services)

For Medication Support Services, TCM, and ICC provided prior to a client plan being in place, the progress notes must clearly reflect that the service activity provided was a component of a service that is reimbursable prior to an approved client plan being in place, and not a component of a service that cannot be provided prior to an approved client plan being in place.

What services will be disallowed if, at the time the services were provided, the client being treated did not have an approved client plan?

The State Plan requires SMHS to be provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to State of California requirements. An approved client plan must be in place prior to service delivery for the following *planned* SMHS:

- Mental health services (except assessment, plan development, crisis intervention, and crisis stabilization; medication support, targeted case management, and ICC are only permissible under the circumstances defined above)
- Intensive Home-Based Services (IHBS)
- Specific component of TCM and ICC: Monitoring and follow up activities to ensure the client's plan is being implemented and that it adequately addresses the client's individual needs
- Therapeutic Behavioral Services (TBS)
- Day treatment intensive
- Day rehabilitation
- Adult residential treatment services
- Crisis residential treatment services
- Medication Support (non-emergency)
- Psychiatric Health Facility Services (Cal. Code Regs., tit. 22, § 77073.)
- Psychiatric Inpatient Services (Code Fed. Regs., tit. 42, § 456.180(a); Cal. Code Regs tit. 9 §§ 1820.230 (b), 1820.220 (l)(i))

What services are reimbursable during the time that there is a "gap" between client plans?

A "gap" between client plans results when a client plan has expired and there is an amount of time that passes before the updated client plan is in effect. When there is a gap between client plans, the requirements pertaining to services delivered prior to an approved client plan apply.

Can a provider prepare an initial client plan for a client in order to begin providing services to that client prior to completion of a comprehensive client plan?

Yes! The provider (or MHP) may prepare a client plan within a short period of time of the client coming into the system or program in order to quickly begin providing services that cannot be provided without a client plan. However, all client plan requirements must be met.

How often can a client plan be changed?

The client plan is a dynamic and living document and services can be added over time based on the individual client's needs. For example, if a client is initially assessed to need day rehabilitation services, the MHP or provider could prepare a client plan that includes day rehabilitation services only, as long as the other client plan requirements are met. As the assessment continues and a comprehensive assessment of the client is completed, other services would be added to the client plan based on medical necessity and individual client needs. At a minimum the client plan, even if for just one service, must include:

- Specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis;
- Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;
- Detailed description of the intervention to be provided;
- Proposed frequency and duration of intervention(s);
- Interventions that focus and address the identified functional impairments as a result of the mental disorder and are consistent with the client plan goal; and must be
- Consistent with the qualifying diagnoses; and
- Be signed (or electronic equivalent) by the required staff.

FAQs: Medication Consent

What are the Medication Consent requirements?

The MHP shall require providers to obtain and retain a written medication consent form signed by the client agreeing to the administration of psychiatric medication. The documentation shall include, but not be limited to: the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to clients taking such medication beyond three (3) months; and, that the consent, once given, may be withdrawn at any time by the client. (MHP Contract) These requirements apply to all clients.

Additional requirements for informed consent for antipsychotic medications include:

"A voluntary patient shall be treated with antipsychotic medications only after such person has been informed of his or her right to accept or refuse such medications and has consented to the administration of such medications. In order to make an informed decision, the patient must be provided with sufficient information by the physician prescribing such medications (in the patient's native language, if possible) which shall include the following:

- The nature of the patient's mental condition;

- The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;
- The reasonable alternative treatments available, if any;
- The type, range of frequency, and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications;
- The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient;
- The possible additional side effects which may occur to patients taking such medications beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued" (MHP Contract).

Can there be more than one medication listed on one form?

There may be more than one medication listed on a consent form as long as all the required elements are present for each of the medications.

Does a change in dosage require a new consent?

Yes, a change in dosage would require the client to sign a new consent form. MHPs may consider using a "dosage range" on the consent form to reduce the frequency with which medication consent forms would need to be changed (MHP Contract).

Is it acceptable for the medication consent to include an attestation by the physician that the required consent components were discussed with the client?

Yes, it is acceptable for the medication consent to include attestations, signed by the provider and the client, that the provider discussed each of the required components of the medication consent with the client. For example, a physician may indicate that he or she discussed the type, range of frequency, amount, method (i.e., oral or injection), and duration of the medication(s), rather than specifying, "Prozac, for depression, 10-20mg, po BID for 6 months." The provider and client must sign and acknowledge the statement of attestation.

Does the use of check boxes on the medication consent form indicating that the provider discussed the need for the medication and potential side effects with the client suffice without listing the specific reasons and side effects?

The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the client. The reasons a provider prescribed a medication for a client must be documented in the client's medical record, but is not required specifically on the medication consent form.

Do the Court Forms authorizing the administration of psychotropic medication to a foster child (Forms JV-217 through JV-224) suffice to meet the MHP Contract requirement for documenting informed consent to medication?

The court forms do not currently include all of the required components for informed consent to

medication(s); specifically, the court forms do not include information on the method of administration (oral or injection) or additional side effects if the child were to take the medication for more than three (3) months. The method of administration for each medication must be documented in the medical record. The side effects (if the child were to take the medication for more than three months) may be documented in the client's medical record or may be included in written information about the medication which is provided to the client or the client's legal representative. In addition, the client's and/or the client's legal representative's signature is required to be on the medication consent form.

Can a child of any age be the sole signatory on a medication consent form?

Under Family Code section 6924 and Health and Safety Code section 124260, children 12 years of age or older may provide legal consent to mental health treatment or counseling on an outpatient basis without the consent of their parent or legal guardian. However, this authority to consent to treatment does not extend to psychotropic medication. Family Code section 6924(f) and Health and Safety Code section 124260(e) clarify that, ***a parent or guardian's consent is needed for a child to receive psychotropic medication***. In the case of foster children, a court will determine who is authorized to consent to psychotropic medication on the child's behalf. (Welfare and Institutions Code sections 369.5(a) and 739.5(a)). If the medication is not a psychotropic medication and all statutory requirements are met, a child 12 years of age or older may be the sole signatory of a medication consent form.

FAQs: Claiming for Specialty Mental Health Services – General

Who can claim Medi-Cal reimbursement for providing SMHS?

Individuals, groups, and/or organizational providers who have been screened and enrolled (pursuant to 42 C.F.R. §438.214 and 438.602) with the MHP to provide SMHS may claim for Medi-Cal reimbursement if they are operating within their scope of practice and, if required, under the direction of a licensed mental health professional in accordance with the State Plan (State Plan, Section 3, Supplement 3 to Attachment 3.1-A; Cal. Code Regs., tit. 9, §§ 1840.314 and 1840.344).

Are claims for services provided to a client with a substance use disorder reimbursable?

If there is a co-occurring substance use disorder, interventions are claimable as long as the primary focus of the interventions is to address the functional impairment(s) that is a result of the included mental health diagnosis. The treatment of a client who has the requisite medical necessity for SMHS is reimbursable through Medi-Cal regardless of the co-occurrence of a substance use disorder (Cal. Code Regs., tit. 9 §§1820.205(a) (1)(H) and 1830.205).

Can assessment including diagnostic services be claimed when an assessment is in process or when the assessment results in a non-included diagnosis?

Assessment activities including diagnostic services, are reimbursable by a provider acting within his or her scope of practice when an assessment is in process or when the assessment results in a non-included diagnosis.

FAQs: Collateral, Family Therapy, and Family Counseling

How is "Significant Support Person" defined?

"Significant Support Person" is defined as "persons, in the opinion of the beneficiary or the person providing services, 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 a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary" (Cal. Code Regs., tit. 9 § 1810.246.1).

How is family counseling defined?

Family counseling is not a specifically defined service under Medi-Cal. However, family counseling may be provided, when medically necessary, and claimed as Collateral, and the client or clients may or may not be present at the family counseling session. Progress notes for family counseling sessions must clearly document how the purpose of the session was to meet "the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan" (Cal. Code Regs., tit. 9, § 1810.206).

What is the difference between family therapy and family counseling?

Family Therapy (individual or group) should be claimed under Mental Health Services as "Therapy" not as "Collateral" and the client must be present. On the other hand, family counseling should be claimed under Mental Health Services as "Collateral" and the client may or may not be present.

FAQs: Claiming for Service Functions Based on Minutes of Time

Which services are billed based on minutes of time? What requirements apply to claims for those services?

For the following services, the billing unit is the time of the person delivering the service in minutes of time:

- Mental Health Services
- Medication Support Services
- Crisis Intervention
- Targeted Case Management
- Therapeutic Behavioral Services (TBS)
- Intensive Care Coordination (ICC)
- Intensive Home-Based Services (IHBS)

The following requirements apply for claiming of services based on minutes of time:

- The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.
- When a person provides service to or on behalf of more than one client at the same time, the person's time must be prorated to each client. When more than one person provides a service to more than one client at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not

exceed the actual time utilized for claimable services.

- The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity (Cal. Code Regs., tit. 9 §1840.316).

Example 1: A Licensed Clinical Social Worker (LCSW) provides individual therapy (mental health services) in the Medi-Cal office to a client for 45 minutes. She spends 12 minutes following the therapy session documenting the interventions provided in a progress note that demonstrates that the interventions address the client's diagnosis, impairments, and client goals as indicated in the Client plan. This documentation time is reimbursable as mental health services. The total time for this service would be 57 minutes (45 for the individual therapy plus 12 minutes for the related documentation).

Example 2: An LCSW drives 23 minutes from the MHP clinic or a contract provider site to a client's home to provide individual therapy (mental health services) for 48 minutes to a client. Following the intervention, the clinician drives 24 minutes back to the clinic and spends 13 minutes documenting the intervention provided in a progress note in the client's client record. The travel and documentation time are reimbursable as they are
directly linked to providing the mental health service. (i.e.: 48-minute session, plus 47 minutes of travel time, plus 13 minutes of documentation time for a total of 108 minutes).

Example 3: An Associate Marriage and Family Therapist (AMFT) drives 15 minutes from her primary office to a client's school to provide 50 minutes of collateral services (mental health services) to a parent and teacher. Following the intervention, the AMFT travels 30 minutes to her next community-based client. At the end of the day, the AMFT spends 16 minutes documenting the collateral intervention to the client's significant support persons (collateral resources). The travel time to the school (15 minutes), the 50-minute session and the 16-minute documentation time can be claimed as a collateral service to the first client for a total of 81 minutes. The 30-minute travel time to the next community-based client would be included in the claim for the service provided to the next client, including travel time back to the office and documentation time.

Should the amount of time a provider claims for performing an assessment of a client be estimated? For example, if a provider conducts a face-to-face assessment of a client, but does not prepare the written assessment until a later day, should the provider estimate the time it would take to write the assessment and include it in the time claimed for the face-to-face assessment?

Providers **should not** estimate the amount of time they spend assessing a client. Time performing an assessment can either be claimed piece by piece or the time can be totaled and submitted as one claim (e.g., separate claims can be submitted for conducting the face-to-face assessment; for reviewing the client's records to obtain history, and for writing up the assessment; or, a single claim can be submitted detailing all of these activities).

FAQs: Claiming for Travel Time

Is travel time reimbursable?

The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity, as follows:

- Travel time from a provider site to an off-site location(s) where Medi-Cal SMHS are delivered is claimable. The travel time must be directly linked or related to the services provided which should be clearly documented in the progress note. In addition, the amounts of travel time and service time should each be reflected in the progress note.

- Travel time between provider sites or from a staff member's residence to a provider site may not be claimed.

- Travel time between a staff member's residence and a client's residence may be claimed as long as the MHP permits such activity and MHP travel guidelines are followed (Cal. Code Regs., tit. 9, § 1840.316(b)(3); Medi-Cal Billing Manual).

FAQs: Claiming for Chart Review

Is time spent reviewing a client's chart reimbursable? For which SMHS and under what circumstances is it reimbursable?

Record review is reimbursable when performed as part of the following services and service activities:

- Mental Health Services (assessment, plan development, collateral, rehabilitation, therapy)
- Targeted Case Management
- Medication Support Services, and
- Crisis Intervention

Chart review is included in the hourly, half day, full day, or calendar day rate for the following services and cannot be claimed separately:

- Day Treatment Intensive and Day Rehabilitation Services are claimed as either half or full days (Cal. Code of Regs., tit. 9, § 1840.318).

- Adult Residential, Crisis Residential, and Psychiatric Health Facility services are claimed based on calendar days (Cal. Code of Regs., tit. 9, § 1840.320). Crisis Stabilization services are claimed based on hours of time where each one-hour block that the client receives Crisis Stabilization services shall be claimed (Cal. Code of Regs., tit. 9, § 1840.322). **Only twenty (20) hours of Crisis Stabilization services may be claimed in a 24-hour period** (Cal. Code of Regs., tit. 9, § 1840.368(c).

If a provider reviews a client's chart, in preparation for a session with a client, and the client no-shows, is the time for chart review claimable? If so, can the provider submit a subsequent claim for chart review in preparation of the client's next appointment?

Yes, as long as the provider documents the circumstances of the client no-show, the time spent to review the chart in preparation for the client's appointment is reimbursable. The provider may submit another claim for chart review prior to the client's next appointment, as long as the time claimed is reasonable and in preparation for the client's appointment. The progress note must contain all required elements of a progress note, as explained in *HHSA Clinical Documentation Standards Guide: Chapter 5, Specialty Mental Health Services*.

FAQs: Day Treatment

What must be included in the Program Description for a Day Treatment Program?

Each provider is required to develop and maintain a written detailed program description for both Day Treatment Intensive and Day Rehabilitation programs that must describe the specific activities of the service and reflect each of the required components of the program.

In addition, both Day Treatment Intensive and Day Rehabilitation programs are required to have an established protocol for responding to clients experiencing a mental health crisis.

In most cases, the crisis protocol is included in the Program Description, but it may also be a separate document. The crisis protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other SMHS necessary to address the client's urgent or emergency psychiatric condition (crisis services).

What are the required service components of a Day Treatment Intensive or Day Rehabilitation Program and how often must they occur?

Day Treatment Intensive/Day Rehabilitation programs must include, at a minimum, the following service components:

- Therapeutic Milieu
- Community Meetings
- Process Groups
- Skill-building Groups
- Adjunctive Therapies

In addition, Day Treatment Intensive must include psychotherapy (which may be individual or group therapy), an established mental health crisis protocol, and written weekly schedules. Day Rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

In terms of program frequency requirements, community meetings must be conducted at least once per day, and, in the Day Treatment Intensive setting, must include a provider whose scope of practice includes psychotherapy. There are no explicit frequency requirements for other service components of the therapeutic milieu.

What are the requirements related to a Written Weekly Schedule for Day Treatment Intensive/Day Rehabilitation?

A written weekly schedule is required for both Day Treatment Intensive and Day Rehabilitation Programs and must include all required service components, as well as document when and where all service components of the program will be provided. The schedule must include the program staff delivering each component of the program, including their qualifications and scope of responsibilities. The weekly detailed schedule must be available to clients and as appropriate to their families, caregivers, or significant support persons.

What are the attendance expectations for a client in a Day Treatment Program?

The client is expected to be present for ALL scheduled hours of operation for each day. In addition, a Day Treatment Program consists of the following:

- Half day: Minimum of 3 program hours
- Full day: More than 4 program hours

Can breaks and mealtimes be counted towards the total required hours of operation?

No, breaks, including meals, cannot be counted towards the total hours of the daily program.

How is client attendance in Day Treatment Intensive programs to be documented?

Providers must document the actual number of hours and minutes a client attends a Day Treatment Intensive program each day (e.g., 3 hours and 58 minutes).

What can be claimed when a client attends the program on a given day but must arrive late or leave early due to an "unavoidable absence?"

Entire full or half days of day treatment/rehabilitation services may be claimed *only if* the client was present for at least 50% of the program time on a given day and there is a documented reason for an "unavoidable absence" which clearly explains why the client could not be present for the full program.

Examples of an "unavoidable absence" include:

- Family emergency,
- Client became ill,
- Court appearance,
- Appointment that cannot be rescheduled (note needs to explain why an appointment cannot be rescheduled),
- Family event (e.g., funeral, wedding),
- Transportation issues.

In cases where absences are frequent, it is the responsibility of the MHP to ensure that the provider re-evaluates the client's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

What are the chart documentation requirements for Day Treatment and Day Rehabilitation?

The documentation of both Day Treatment Intensive and Day Rehabilitation services shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, date of signature, and the total number of minutes/hours the client actually attended the program.

In addition, Day Treatment Intensive documentation requirements include the following:

- Daily progress note.
- Weekly clinical summary that must be reviewed and signed by an MD, RN, or licensed/waivered/registered psychologist, clinical SW, LPCC or MFT who is either staff to the day treatment intensive program or the person directing the services.
- Monthly – One documented contact with family, caregiver, or significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adults may decline this service component. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). The contacts should focus on the role of the support
  person in supporting the client's community reintegration. The MHP shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day

treatment intensive and day rehabilitation.

Day Rehabilitation documentation requirements include the following:

- Weekly progress note.
- Monthly – One documented contact with family, caregiver, or significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adults may decline this service component. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). The contacts should focus on the role of the support person in supporting the client's community reintegration. The MHP shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

APPENDIX E: BILLABLE SERVICES CHEAT SHEET – ADULT CLINICAL

MENTAL HEALTH CHEAT SHEET – BILLABLE CLIENT SERVICE CODES

ADULT & AGING BRANCH – CLINICIANS & CASE MANAGERS

BILLABLE SERVICE CODE	PRACTITIONER TYPE	SERVICE ACTIVITY DESCRIPTION
Assessment • 90791 **Reassessment** • 90791R	Clinician	• Evaluate the current status of mental, emotional, or behavioral health • All 11 components of an assessment must be documented to meet Medi-Cal documentation standards for a comprehensive mental health assessment • May be provided as an unplanned service *Title 9 §1810.204*
Psychotherapy • 90832 - 30 min • 90834 - 45 min • 90837 - 60 min • 90853 - Group	Clinician	• Symptom reduction as a means to reduce functional impairments • Individual Therapy is coded according to length of appointment / face-to-face • Must be documented in the Client Plan prior to service delivery *Title 9 §1810.250*
Plan Development • H0032	Clinician & MHRS	• Develop and approve client plans • Monitor and record progress toward goals identified in the Client Plan • May be provided as an unplanned service • All Client Plans developed by a MHRS must be approved and co-signed by a Licensed Clinician *Title 9 §1810.232*
Crisis Intervention +, ++ • 90839, first 60 min	Clinician & MHRS	• Service to client or support persons for a condition that requires more timely response than a regularly scheduled visit. • Services last less than 24 hours. • May be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. • May be provided as an unplanned service *Title 9 §1810.209*
Targeted Case Management (TCM) • T1017	Clinician & MHRS & MHW	• Linkage and brokerage (e.g., assist in accessing needed medical, educational, social, vocational, rehabilitative, or other community services) • May be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community • Generally, TCM services must be documented in a Client Plan prior to service delivery • TCM *may* be provided as an unplanned service when the condition requires urgent intervention and the need is substantiated in the documentation *Title 9 §1810.249*
Collateral • 90887	Clinician & MHRS & MHW	• Services provided to significant support person(s) for the purposes of improving, maintaining, and restoring the mental health status of the client • The client may or may not be present for this service activity. • Must be documented in the Client Plan prior to service delivery; significant support person must be identified by the client and specified in the Client Plan *Title 9 §1810.206*
Rehabilitation • 97535 - Individual • 97535G - Group	Clinician & MHRS & MHW	• Skill Development (e.g., social, hygiene, daily living, obtaining resources) • Must be documented in the Client Plan prior to service delivery *Title 9 §1810.243*

Clinician = Licensed/Registered/Waivered Clinician; MHRS = Mental Health Rehabilitation Specialist; MHW = Mental Health Worker

+ Progress note co-signature required if not a Licensed/Registered/Waivered Clinician ++ Immediate consultation with licensed staff is required when mandated reporting issue is present or suspected (DTS/DTO, child or elder/dependent adult abuse/neglect)

This cheat sheet is not comprehensive.

APPENDIX F: BILLABLE SERVICES CHEAT SHEET – CHILD/YOUTH CLINICAL

MENTAL HEALTH CHEAT SHEET – BILLABLE CLIENT SERVICE CODES

CHILD, YOUTH & FAMILY BRANCH – CLINICIANS & CASE MANAGERS

BILLABLE SERVICE CODE	PRACTITIONER TYPE	SERVICE ACTIVITY DESCRIPTION
Assessment • 90791 **Reassessment** • 90791R	Clinician	• Evaluate the current status of mental, emotional, or behavioral health • All 11 components of an assessment must be documented to meet Medi-Cal documentation standards for a comprehensive mental health assessment • May be provided as an unplanned service *Title 9 §1810.250*
Psychotherapy • 90832 - 30 min • 90834 - 45 min • 90837 - 60 min • 90853 – Group	Clinician	• Symptom reduction as a means to reduce functional impairments • Individual Therapy is coded according to length of appointment / face-to-face • Must be documented in the Client Plan prior to service delivery *Title 9 §1810.250*
Plan Development • H0032	Clinician & MHRS	• Develop and approve client plans • Monitor and record progress toward goals identified in the Client Plan • May be provided as an unplanned service • All Client Plans developed by a MHRS must be approved and co-signed by a Licensed Clinician ***Title 9 §1810.232***
Crisis Intervention +, ++ • 90839, first 60 min	Clinician & MHRS +, ++	• Service to client or support persons for a condition that requires more timely response than a regularly scheduled visit. • Services last less than 24 hours. • May be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. • May be provided as an unplanned service ***Title 9 §1810.209***
Targeted Case Management (TCM) • T1017	Clinician & MHRS & MHW	• Linkage and brokerage (e.g., assist in accessing needed medical, educational, social, vocational, rehabilitative, or other community services) • May be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community • Generally, TCM services must be documented in a Client Plan prior to service delivery • TCM *may* be provided as an unplanned service when the condition requires urgent intervention and the need is substantiated in the documentation ***Title 9 §1810.249***
Collateral • 90887	Clinician & MHRS & MHW	• Services provided to significant support person(s) for the purposes of improving, maintaining, and restoring the mental health status of the client • The client may or may not be present for this service activity. • Must be documented in the Client Plan prior to service delivery; significant support person must be identified by the client and specified in the Client Plan ***Title 9 §1810.206***

Rehabilitation • 97535 - Individual • 97535G – Group	Clinician & MHRS & MHW	• Skill Development (e.g., social, hygiene, daily living, obtaining resources) • Must be documented in the Client Plan prior to service delivery ***Title 9 §1810.243***
KTA ICC • KTAT1017	Clinician & MHRS & MHW	• TCM service that facilitates assessment of, care planning for and coordination of services to client under age 21 • Includes assessing; service planning and implementation; monitoring and adapting; and transition • Provided through the principles of the Core Practice Model (CPM), including the establishment of the Child and Family Team (CFT) • Generally, ICC services must be documented in a Client Plan prior to service delivery • ICC *may* be provided as an unplanned service when the condition requires urgent intervention and the need is substantiated in the documentation ***DHCS-MHP Contract***
KTA IHBS • KTAH2015	Clinician & MHRS & MHW	• Individualized, strength-based interventions aimed at helping the child/youth build skills • Provided to beneficiaries under 21 • Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral • Must be documented in the Client Plan prior to service delivery ***DHCS-MHP Contract***

Clinician = Licensed/Registered/Waivered Clinician; MHRS = Mental Health Rehabilitation Specialist; MHW = Mental Health Worker

+ Progress note co-signature required if not a Licensed/Registered/Waivered Clinician ++ Immediate consultation with licensed staff is required when mandated reporting issue is present or suspected (DTS/DTO, child or elder/dependent adult abuse/neglect)

This cheat sheet is not comprehensive.

APPENDIX G: BILLABLE SERVICES CHEAT SHEET – MEDICAL

MENTAL HEALTH CHEAT SHEET – BILLABLE CLIENT SERVICE CODES

BEHAVIORAL HEALTH – PRESCRIBERS & NURSING STAFF

Billable Service Code	Practitioner Type	Service Activity Description
Psychiatric Diagnostic Evaluation/Re-Evaluation with Medical Services • 90792 • 90792R	MD/DO PA NP	• Requires a complete medical and psychiatric history (including past, family, social), mental status exam, establishment of diagnosis, evaluation of client's ability and capacity to respond to treatment, and plan of treatment • Medical services may consist of performing elements of a physical exam, considering writing a prescription, or modifying psychiatric treatment based on medical comorbidities
Office or Other Outpatient Services – New Patient • 99201 – 99205	MD/DO PA NP	• Services for evaluation and management of a **new** client based on level of complexity • **New Patient:** an individual who did not receive any professional services from the physician/non-physician practitioner or another physician of the same specialty who belongs to the same group practice within the previous 3 years
Office or Other Outpatient Services – Established Patient • 99211 – 99215	MD/DO PA NP	• Services for evaluation and management of an **established** client based on level of complexity • **Established Patient:** an individual who received professional services form the physician/non-physician practitioner or another physician of the same specialty who belongs to the same group practice within the previous 3 years
Psychiatric Evaluation of Records • 90885	MD/DO PA NP	• Psychiatric evaluation of records, reports, and other data, without direct client contact, for diagnostic purposes • *Not reimbursable by Medicare*
Interpretation or Explanation to Family (Collateral) • 90887	MD/DO PA NP	• Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the client • *Not reimbursable by Medicare*
Preparation of Psychiatric Report • 90889	MD/DO PA NP	• Preparation of report of client's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers • *Not reimbursable by Medicare*
Comprehensive Medication Services • H2010A	MD/DO PA NP	• Medication management follow-up with psychiatrist for evaluation of medication effectiveness, side effects of current medications, prescribing medication, obtaining informed consent, medication education, treatment planning activities, and collateral and plan development activities related to the delivery of medication services • Service provided face-to-face, by phone contact directly with the client, or via telepsychiatry videoconferencing

Medication Support • 90899	RN LVN LPT	• Services provided by licensed nursing and/or psychiatric technician staff which include administering, dispensing, and monitoring psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness • Services may include evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; medication education; plan development related to the delivery of the service; assessment of the beneficiary; and/or medication refills per physician orders and nursing protocol • Services may be face-to-face or by phone with client and/or significant support person(s) • Generally, Medication Support Services must be documented in a Client Plan prior to service delivery • Medication Support Services *may* be provided as an unplanned service when the condition requires urgent intervention and the need is substantiated in the documentation

MD / DO = Medical Doctor / Doctor of Osteopathic Medicine; RN = Registered Nurse; LVN = Licensed Vocational Nurse; NP = Nurse Practitioner; LPT = Licensed Psychiatric Technician; PA = Physician Assistant

This cheat sheet is not comprehensive.

APPENDIX H: LOCKOUT GRID CHEAT SHEET

LOCKOUTS – WHAT, WHEN, WHY?
LOCKOUT means a situation or circumstance where Medi-Cal cannot be billed for specific mental health services (*Title 9 §1840.100(d)*). The following table summarizes when TCM, MH Services (**+**), and Crisis Intervention (**++**) can be billed based on facility type; when a service is locked out, the corresponding non-billable "Y Code" must be used in the Progress Note.
Important: "On the day of admission & discharge" means the service can be billed prior to the client being admitted and post-discharge, but the service is locked out ("Y Code" needed) while the client is in the actual facility (see TCM exceptions below)

FACILITY	AGE	WHAT CAN I BILL AND WHEN?
Institution for Mental Disease (IMD)+++ **Short Doyle Medi-Cal (SD/MC)** **Psychiatric Inpatient Hospital** **-Sutter Center for Psychiatry** **-Sierra Vista Hospital** **-Heritage Oaks Hospital** **-Adventist Health Vallejo** **Mental Health Rehabilitation Center (MHRC)** **-Crestwood (San Jose, Sacramento)** **-Canyon Manor** **Psychiatric Skilled Nursing Facility** **-Vista Pacifica Center (Riverside)** **-Crestwood (Redding)**	Age 0-21, 65+ *only* *(age 22-64 use Y codes only)*	• **TCM**: On the day of admission & discharge, & for discharge planning for placement purposes during the 30 calendar days prior to discharge, and within two additional non-consecutive 30-day periods if the client remains in the same facility before being discharged • **MH Services & Crisis Intervention**: On the day of admission & discharge *Title 9 §1840.215(c); §1840.374; §1840.312(g)* *CFR 42 §435.1009*
Fee for Service (FFS) Psychiatric Inpatient Hospital **-Woodland Memorial Catholic Healthcare West / Dignity Health 3BN** **-Adventist Health (St. Helena)**	Any age	• **TCM**: On day of admission & day of discharge, & for discharge planning for placement purposes during the 30 calendar days prior to discharge, and within two additional non-consecutive 30-day periods if the client remains in the same facility before being discharged • **MH Services & Crisis Intervention**: On the day of admission & discharge *Title 9 §1840.215; §1840.374*
Psychiatric Health Facility (PHF, <17 beds) **-North Valley Behavioral Health**	Age 18+	• **TCM**: On day of admission & day of discharge, & for discharge planning for placement purposes during the 30 calendar days prior to discharge, and within two additional non-consecutive 30-day periods if the client remains in the same facility before being discharged • **MH Services & Crisis Intervention**: On the day of admission & discharge *Title 9 §1840.374; 1840.370*
Crisis Residential Treatment Facility **-Safe Harbor Crisis House**	Age 18+	• **TCM**: At any point during facility stay • **MH Services & Crisis Intervention**: On the day of admission & discharge *Title 9 §1840.364*
Detention Facility **-Jail, Prison**	Age 18+	• **TCM & MH Services & Crisis Intervention**: On the day of admission & discharge, & if client has confirmed active Medi-Cal *Title 22 § 50273*

+ MH Services include: Assessment, Psychotherapy, Plan Development, Collateral, Rehabilitation

++ Across all facilities, Crisis Intervention services are allowed maximum 8 hrs in 24-hour period (Locked out > 8 hrs)

+++ *Title 9 §1810.222.1*; DHCS IMD List, updated annually: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx

This cheat sheet is not comprehensive.

APPENDIX I: YOLO COUNTY MHP – APPROVED ABBREVIATIONS

Revised November 15, 2019

ABBREVIATION	DEFINITION
SYMBOLS	**SHORTCUT KEYS**
1:1	one to one 1 (Alt+058)1
5150	WIC 72-hour hold for mental health evaluation
5250	WIC 14-day hold
5585	WIC 72-hour hold for mental health evaluation of a minor
-	Minus, negative, no Alt+0150
ᾱ	Before Insert>Symbol>Unicode(hex)>Character Code:1FB1
#	Number Alt+35
%	Percent Alt+37
&	And Alt+38
?	Unknown Alt+63
@	At Alt+64
‘	Feet Alt+39
”	Inches Alt+34
+	Plus, positive, yes Alt+43
=	Equal Alt+61
↑	Increase Alt+24
↓	Decrease Alt+25
♀	Female Alt+12
♂	Male Alt+11
1°	Primary 1 (Alt+0176)
2°	Due to; Secondary to 2 (Alt+0176)
24/7	24 Hours A Day/Seven Days A Week 24(Alt+047)7
3BN	Woodland Memorial Hospital Psychiatric Inpatient Unit
5 HT	Serotonin
5HT2	Serotonin 2 Receptor

ABBREVIATION	DEFINITION
Ψ	Psychiatric/Psychiatrist/Psychology Insert>Symbol>Unicode(hex)>Character Code:03A8
A	
A/H	Auditory Hallucinations
A/O	Alert & Oriented
A/OA	Adult/Older Adult Services
A/P	Assessment / Plan
A&A	Adult and Aging
AA	Alcoholics Anonymous
ac	Before Meals
ACT	Assertive Community Treatment Team
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHC	Adult Day Health Care
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
ADM	Admission
ADMH	Alcohol, Drug and Mental Health
ADMIN	Administrative
ADOL	Adolescent
ADP	California State Office of Alcohol and Drug Programs
ADV DIR	Advance Directive
AIDS	Acquired Immune Deficiency Syndrome
AKA	Also Known As
ALOC	Altered Level Of Consciousness
AM	Morning
AMA	Against Medical Advice or American Medical Association
AMFT	Associate Marriage and Family Therapist
AMPHET	Amphetamines
AMS	Acute Mental Status (on emergency room records) or Altered Mental Status

ABBREVIATION	DEFINITION
AMT	Amount
ANS	Autonomic Nervous System
ANSA	Adult Needs and Strength Assessment
AOD	Alcohol and Other Drugs
AOT	Assisted Outpatient Treatment
APA	American Psychiatric Association
APAP	Tylenol (acetaminophen)
APCC	Associate Professional Clinical Counselor
APPROP	Appropriate(ly)
APPT	Appointment
APROX	Approximate(ly)
APS	Adult Protective Service
APT	Apartment
ARF	Acute Renal Failure / Adult Residential Facility
ASA	Aspirin
ASAM	American Society of Addiction Medicine
ASAP	As Soon As Possible
ASI	Addiction Severity Index
ASSESS	Assessment
ASW	Associate Clinical Social Worker (registered with California BBS)
ATTN	Attention:
AUX	Auxiliary
AVG	Average
AWOL	Absence With Out Leave
B	
B&B	Bowel & Bladder
B&C	Board & Care
BA	Bachelor of Arts
BAC	Blood Alcohol Content

ABBREVIATION	DEFINITION
BAD	Bipolar Affective Disorder
BBS	Board of Behavioral Sciences, California
BDI	Beck Depression Inventory
BDZ/benzo	Benzodiazepine
BEH	Behavior
BF	Boyfriend
BIB	Brought in by
BIBA	Brought in by Ambulance
BIBLE	Brought in by Law Enforcement
BID	Twice a day
BILAT	Bilateral
BIPOLAR	Bipolar Affective Disorder
BM	Bowel Movement
BP	Blood Pressure
BPD	Borderline Personality Disorder
BRO	Brother
BTWN	Between
BX	Behavior
C	
c̄	With
C/B	Complicated By
C/O	Complains of
Ca or Ca++	Calcium
CA	Cancer
CAADAC	California Association of Alcoholism and Drug Abuse Counselors
CAD	Coronary Artery Disease
CADC I / II	Certified Alcohol and Drug Counselor
CADE	Certified Alcohol and Drug Educator
CAFAS	Child and Adolescent Functional Assessment Scale

ABBREVIATION	DEFINITION
CalOMS	California Outcome Measurement System
CANS	Children and Adolescent Needs and Strengths Assessment
CAP	Capsule
CAUC	Caucasian
CBC	Complete Blood Count
CBO	Community Based Organization
CBT	Cognitive Behavioral Therapy
CC	Chief Complaint
CD	Chemical Dependency
CCHC	Communicare Health Center
CDC	Center for Disease Control
CERT	Certification
CHEM 7	Blood test
CHEMO	Chemotherapy
CHF	Congestive Heart Failure
CIGS	Cigarettes
CIP	Community Intervention Program
CIT	Crisis Intervention Training
CKD	Chronic Kidney Disease
CLT	Client
CM or cmgr	Case management / manager
CMP	Comprehensive Metabolic Panel
CMS	Center for Medicare & Medicaid Services
CNS	Central Nervous System
CO	County
COD	Co-Occurring Disorders
COLL	Collateral
CON REP	Conditional Release Program
CONC	Concentrate

ABBREVIATION	DEFINITION
CONS or c'ship	Conserved / Conservatorship
CONT	Continue / continuously
COORD	Coordinate
COPD	Chronic Obstructive Pulmonary Disease
CP	Client Plan
CPAP	Continuous Positive Airway Pressure or Machine Used
CPR	Cardiopulmonary Resuscitation
CPS	Child Protective Services
CPT	Current Procedural Terminology Code (billing)
CQI	Continuous Quality Improvement
CRD	Chronic Renal Disease
CRF	Chronic Renal Failure
Crisis Res.	Crisis Residential
CRT	Crisis Residential Treatment
CSI	Client Services Information
CSOC	Children's System of Care
CSU	Crisis Stabilization Unit
CT or CAT	Computerized (Axial) Tomography
CVA	Cerebrovascular Accident
CWS	Child Welfare Services
CWW	Child Welfare Worker
CXR	Chest X-Ray
CYF	Child, Youth, and Family
CYF-MH	Child, Youth, and Family – Mental Health
D	
D/C	Discharge or Discontinue
DA	Dopamine
DAW	Dispense As Written
DAY TX	Day Treatment

ABBREVIATION	DEFINITION
DBT	Dialectical Behavior Therapy
DC	Discontinue
DD	Developmental Disability
DDx	Dual Diagnosis
dec	Decanoate
DEC	Decrease
DEF	Defer
DEL	Delusions
DESS	Department of Employment and Social Services
DETOX	Detoxification
DHCS	Department of Health Care Services
DIFF	Differential
DIR	Director
DISPO	Disposition
DIV	Divorce
DM	Diabetes Mellitus
DMC	Drug Medi-Cal
DME	Durable Medical Equipment
DMH	Department Of Mental Health
DMV	Department of Motor Vehicles
DNR	Do Not Resuscitate
D.O.	Doctor of Osteopathic Medicine/Physician
DOA	Date of Admission
DOB	Date of Birth
DOE	Date of Entry
DOS	Date of Service
DPH	Department of Public Health
Dr.	Doctor
DSM	Diagnostic & Statistical Manual

ABBREVIATION	DEFINITION
DT's	Delirium Tremens
DTO	Danger to Others
DTR	Daughter
DTS	Danger to Self
DTSO	Danger to Self and Others
DUI	Driving Under the Influence
DV	Domestic Violence
DX	Diagnosis
E	
e.g.	(L. exempli gratia) for example
EAP	Employee Assistance Program
ECG/EKG	Electrocardiogram
ECT	Electro Convulsive Therapy
ED	Emergency Department
EDUC	Educate / Education
EEG	Electroencephalogram
EENT	Eyes, ears, nose, and throat
EHR	Electronic Health Record
ELOS	Estimated Length of Stay
EMDR	Eye Movement Desensitization Reintegration
EMT	Emergency Medical Technician
EPS	Extrapyramidal Side Effects/Symptomatology
EPSDT	Early & Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
ESP	Especially
ETA	Estimated Time of Arrival
ETOH	Alcohol
EVAL	Evaluation

ABBREVIATION	DEFINITION
F	
F/U	Follow Up
Fa	Father
Fam Hx/FHx	Family History
FAS	Fetal Alcohol Syndrome
FBS	Fasting Blood Sugar
Fe	Iron
FFP	Federal Financial Participation
FG	Fasting Glucose
FH	Farmhouse
FL	Fluid
FNP	Family Nurse Practitioner
FOI	Flight of Ideas
FQHC	Federally Qualified Health Center
FRC	Family Resource Center, Yolo
FREQ	Frequent
FSA	Family Service Agency
Fx	Fracture
FY	Fiscal Year
G	
GA	General Assistance
GABA	Gamma Aminobutyric Acid
GAD	General Anxiety Disorder
GAF	Global Assessment of Functioning
GD	Gravely Disabled
GERD	Gastro Esophageal Reflux Disease
GF	Girlfriend
Gfa / Gpa	Grandfather / Grandpa
GHB	Gamma Hydroxybutyrate

ABBREVIATION	DEFINITION
GI	Gastrointestinal
GLBTQQ	Gay, Lesbian, Bisexual, Transgendered, Queer, Questioning
gm	Gram
Gmo / GM	Grandmother
GP	General Practitioner
Gr	Grains
Group Tx	Group Therapy
GRP(s)	Group(s)
GU	Genitourinary
GSW	Gunshot Wound
H	
H&H	Hemoglobin and Hematocrit
H&P	History and Physical
HR	Heart Rate
H/I	Homicidal Ideation
H2O	Water
HA	Headache
Hal / Halluc	Hallucinations
HAS	Human Services Agency
HBP	High Blood Pressure
Hct	Hematocrit
HEENT	Head, ears, eyes, nose & throat
Hep	Hepatitis
Hep A, B, C	Hepatitis A, B, C
Hgb	Hemoglobin
HHSA	Health and Human Services Agency
HI or H/I	Homicidal Ideation
HIE	Health Information Exchange
HIPAA	Health Insurance Portability & Accountability Act

ABBREVIATION	DEFINITION
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
hoh	Hard of Hearing
HOH	Heritage Oaks Hospital
Hosp	Hospital / Hospitalized
HPI	History of Present Illness
HPV	Human Papilloma Virus
HR	Human Resources
hr.	Hour
HRSA	Health Resources and Services Administration
hs	Hour of sleep (bedtime)
ht.	Height
HTN	Hypertension
HUH	Housing Urban Health
HUSB	Husband
HV	Home Visit
HX / H/O	History / History of
I	
I & O	Intake and Output
IBS	Irritable Bowel Syndrome
ICD	International Classification of Disease
ICU	Intensive Care Unit
ID	Identification
IDDM	Insulin Dependent Diabetes Mellitus
IEP	Individual Education Plan
IHSS	In Home Support Services
IM	Intramuscular
IMD	Institute of Mental Disease
Inc	Increase

ABBREVIATION	DEFINITION
Incont.	Incontinent
Inj	Injection
INPT	Inpatient
IOR	Ideas of Reference
IOP	Intensive Outpatient Program
IPO	Internally Preoccupied
IQ	Intelligence Quotient
IS	Information Systems
IST	Incompetent to Stand Trial
IT	Information Technology
ITWS	Information Technology and Web Services
IV	Intravenous
J	
JC	Junior College
JDF or JDC	Juvenile Detention Facility/Center
JHJ	John H. Jones facility
JUV	Juvenile
K	
K+	Potassium
Kcal	Kilo Calorie
Kg.	Kilogram
L	
L/R/W	Licensed/Registered/Waivered
LAB	Laboratory
LANG	Language
LB or lb.	Pound
LCSW	Licensed Clinical Social Worker
LD	Left Deltoid
LFU	Legal Entity File Update

ABBREVIATION	DEFINITION
LG	Large
LiCo3/Li	Lithium Carbonate
liq	Liquid
LLE	Left Lower Extremity
LLQ or LLL	Left Lower Quadrant or Left Lower Lobe
LMFT	Licensed Marriage and Family Therapist
LMP	Last Menstrual Period
LOA	Leave of Absence
LOC	Loss of Consciousness
LOCUS	Level of Care Utilization System
LPCC	Licensed Professional Clinical Counselor
LOS	Length of Stay
LPS	Lanterman-Petris-Short
LPT	Licensed Psychiatric Technician
LSD	Lysergic Acid Diethylamide
LTC	Long Term Care
LUE	Left Upper Extremity
LUQ or LUL	Left Upper Quadrant or Left Upper Lobe
LVN	Licensed Vocational Nurse
M	
M	Male
MS	Master of Science Degree
MA	Master of Arts Degree / Medical Assistant
MAOI	Monoamine Oxidase Inhibitors
Marital Status	S Single
Marital Status	D Divorced
Marital Status	M Married

ABBREVIATION	DEFINITION
Marital Status	W Widowed
MAX	Maximum
MCAH	Maternal Child Adolescent Health
Mcg	Microgram
M.D.	Medical Doctor/Physician
MDART	Multi-Disciplinary Assessment and Referral Team
MDD	Major Depressive Disorder
MDMA	Methylenedioxymethamphetamine (Ecstasy)
MDO	Mentally Disordered Offender
MDT	Multidisciplinary Team
MED HX	Medical History
MEDI-MEDI	Medi-Cal and Medicare
Meds	Medications
Meth	Methamphetamine
MFT	Marriage & Family Therapist
mg	Milligram
MH	Mental Health
MHP	Mental Health Plan
MHRC	Mental Health Rehabilitation Center
MHRS	Mental Health Rehab Specialist
MHS	Mental Health Services
MHSA	Mental Health Services Act or Prop 63
MHSIP	Mental Health Statistics Improvement Program
MHW	Mental Health Worker
MI	Myocardial Infarction or Motivational Interviewing
MIN	Minutes
MJ	Marijuana
mL	Milliliter
MMPI	Minnesota Multiphasic Personality Inventory

ABBREVIATION	DEFINITION
MMSE	Mini-Mental State Exam
mo	Month
Mo	Mother
MOM	Milk of Magnesia
Mos	Months
MRI	Magnetic Resonance Imaging
MSE	Mental Status Exam
Msg	Message
MST	Multisystemic Therapy
MSW	Medically Supervised Withdrawal (detox) or Medical Social Worker
MSW	Master of Social Work
MTG	Meeting
MVA	Motor Vehicle Accident
N	
N/A	Not Applicable
N/V	Nausea & Vomiting
NA	Narcotics Anonymous
Na+	Sodium
NAD	No Acute Distress or No Active Disease
NAMI	National Alliance for the Mentally Ill
NARC	Narcotic
NASW	National Association of Social Workers
NCADA	National Council on Alcoholism and Drug Addiction
NEG	Negative
NEURO	Neurological
NGRI	Not Guilty by Reason of Insanity
NIAAA	National Institute of Alcoholism and Alcohol Abuse
NIDA	National Institute of Drug Abuse
NIDDM	Non-Insulin Dependent Diabetes Mellitus

ABBREVIATION	DEFINITION
NIH	National Institute of Health
NIMH	National Institute of Mental Health
NKA	No Known Allergies
NKDA	No Known Drug Allergies
NMS	Neuroleptic Malignant Syndrome
NOA	Notice of Action
NOABD	Notice of Adverse Benefit Determination
NOC	Night
NOS	Not Otherwise Specified
NPI	National Provider Identifier
NPO	Nothing by Mouth
NPPES	National Plan and Provider Enumeration System
NS	No Show
NSAID	Non-Steroidal Anti-Inflammatory Drugs
NSG	Nursing
NTE	Not to Exceed
NTP	Narcotic Treatment Program
O	
O/R	Own Recognizance
O2	Oxygen
OAS	Older Adult Services
OB	Obstetrics
OBS	Organic Brain Syndrome
OCD	Obsessive Compulsive Disorder
OD	Overdose
ODD	Oppositional Defiant disorder
OINT	Ointment
OP	Outpatient
OT	Occupational Therapy

ABBREVIATION	DEFINITION
OTC	Over the Counter
Outpt	Outpatient
Ox4	Oriented times 4
Oz	Ounce
P	
p̄	After
PRN	As Needed
P/C	Phone Call
P/T	Part Time
P/U	Pick Up
P=	Pulse is
pc	After Meals
PC	Penal Code
PCN	Penicillin
PCP	Phencyclidine
PCP/PMD	Primary Care Provider/Primary Medical Doctor
PD	Plan Development
PDD	Pervasive Developmental Disorder
PDR	Physician's Desk Reference
PEI	Prevention and Early Intervention
Per	By / Through
Perp	Perpetrator
PES	Psychiatric Emergency Services
PET	Positron Emission Tomography
PFU	Provider File Update
PG	Public Guardian
PhD	Doctor of Philosophy
PHF	Psychiatric Health Facility
PHI	Protected Health Information

ABBREVIATION	DEFINITION
PHN	Public Health Nurse
PHP	Partial Hospitalization Program
PIN	Provider Identification Number
PM	Program Manager
pm	Afternoon
PN	Progress Note
PNS	Peripheral Nervous System
PO	Probation Officer
po	By Mouth
POS	Point of Service
PPD	Purified Protein Derivative for Tuberculosis Test
PRE OP	Before Operation
PREG	Pregnant
PREP	Preparation
PROB	Problem
PROG	Progress
PsyD	Doctor of Psychology
pt	Patient
PT	Physical Therapy
PTG	Pine Tree Gardens
PTSD	Post Traumatic Stress Disorder
PVC's	Premature Ventricular Contractions
Q	
q	Every
q2h, q3h, etc	Every 2 hours, Every 3 hours, etc.
QA	Quality Assurance
qam	Every Morning
qh	Every Hour
qhs	Every Night at Bedtime

ABBREVIATION	DEFINITION
QI	Quality Improvement
QIC	Quality Improvement Coordinator/Committee
qid	Four Times a day
QM	Quality Management
qpm	Every Afternoon or Evening
qt	Quart
R	
R/O	Rule-Out
R=	Respirations Are
RBC	Red Blood Count
RD	Right Deltoid
RE	Regarding
REC	Recommend
REC'D	Received
REG	Regular
REHAB	Rehabilitation
REL	Relationship
REM	Rapid Eye Movement
RES TX CNTR	Residential Treatment Center
RESP	Respiratory
REV	Review
RFP	Request for Proposals
RFQ	Request for Qualifications
RIS/RTIS	Responding to Internal Stimuli
RLE	Right Lower Extremity
RLQ or RLL	Right Lower Quadrant or Right Lower Lobe
RN	Registered Nurse
ROI	Release of Information
ROM	Range of Motion

ABBREVIATION	DEFINITION
ROS	Review of Systems
RRR	Regular Rate and Rhythm
rt	Right
RU#	Reporting Unit Number
RUE	Right Upper Extremity
RUQ or RUL	Right Upper Quadrant or Right Upper Lobe
Rx	Prescription
Rxn	Reaction
S	
s̄	Without
S&R	Seclusion & Restraint
S/A	Suicide Attempt
S/I	Suicide Ideation
S/O	Significant Other
S/P	Status Post
S/S or S/Sx	Signs and Symptoms
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIZ	Schizophrenia
SCP	Sutter Center for Psychiatry
SDH	Sutter Davis Hospital
SDI	State Disability Insurance
SDMC	Short-Doyle MediCal
SE	Side Effects
SED	Severely Emotionally Disturbed
SHCH	Safe Harbor Crisis House
sib	Sibling
SIB	Self Injurious Behavior(s)
sis	Sister

ABBREVIATION	DEFINITION
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SNRI	Selective Serotonin and Norepinephrine Reuptake Inhibitor
SOB	Shortness of Breath
SOC	System of Care
SOC Hx	Social History
SPYC	Suicide Prevention of Yolo County
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately
STD	Sexually Transmitted Disease
Strep	Streptococcus
SUBJ	Subject
SUBQ or SQ	Subcutaneous
SUD	Substance Use Disorder
SV	Sierra Vista
SVP	Sexually Violent Predator
SW	Social Worker
Sx	Symptoms
T	
T/C	Telephone Call
T/O	Telephone Order
T= or Temp	Temperature is
TA	Technical Assistance
Tab	Tablet
TANF	Temporary Assistance to Needy Families

ABBREVIATION	DEFINITION
TAR	Treatment Authorization Request
TAY	Transitional Age Youth
TB	Tuberculosis
TBI	Traumatic Brain Injury
TBS	Therapeutic Behavioral Services
Tbsp.	Tablespoon
TCA	Tri-Cyclic Antidepressants
TCM	Targeted Case Management
TCN	Tetracycline
TCON	Temporary Conservatorship
TD	Tardive Dyskinesia
THC	Tetrahydrocannabinol (active ingredient to Marijuana)
TI	Thought Insertion
TIA	Transient Ischemic Attack
tid	Three Times A Day
tr or tinct.	Tincture
tol	Tolerated
Tox	Toxicology
TPCP	Turning Point Community Programs
TPR	Temperature, Pulse, Respirations
TRH	Thyroid releasing hormone
TRO	Temporary Restraining Order
TSH	Thyroid-Stimulating Hormone
tsp.	Teaspoon
TV	Television
TW	Thought Withdrawal
Tx	Treatment
U	
UA	Urinalysis

ABBREVIATION	DEFINITION
UDS	Urine Drug Screen
UFC or UFCY	Unified Family Court (of Yolo)
UM	Utilization Management
UMDAP	Uniform Method for Determining Ability to Pay
UNK	Unknown
UOS	Unit of Service
UR	Utilization Review
UTI	Urinary Tract Infection
Utox	Urine Toxicology Screen
V	
V/H	Visual Hallucinations
V/O	Verbal Order
VA	Veterans Administration
VD	Venereal Disease
VM	Voice Mail/ Voice Message
VOC REHAB	Vocational Rehabilitation
Vol	Voluntary or Volume
VPA	Valproic Acid/Valproate
VS	Vital Signs
VSS	Vital Signs Stable
W	
W&I	California Welfare and Institutions Code
w/	With
W/C	Wheelchair
W/D	Withdrawal
w/o	Without
WBC	White Blood Cell Count
WD	Woodland
WDL	Within Defined Limits

ABBREVIATION	DEFINITION
Wdld	Woodland
WET	Workforce, Education and Training
WIA	Workforce Investment Act
WIC	Women's, Infants & Children
WK	Week
WMH	Woodland Memorial Hospital
WNL	Within Normal Limits
WPD	Woodland Police Department
WRAP	Wellness Recovery Action Plan
WS	West Sacramento
WSPD	West Sacramento Police Department
Wt.	Weight
X	
X	Multiplied by/times
Y	
Y/O	Years Old
YCCC	Yolo Community Care Continuum
YGC	Youth Guidance Center
YR	Year
Z	
Zn	Zinc