SECTION 5, CHAPTER 7, POLICY 010
OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES
CLINICAL DOCUMENTATION

POLICY NUMBER:	5-7-010
SYSTEM OF CARE:	MENTAL HEALTH
FINALIZED DATE:	12/22/2023
EFFECTIVE:	1/1/2024
SUPERSEDES # :	Supersedes Policy #'s: 5-7-001 Clinical Assessments 5-7-002 Client Treatment Plans 5-7-006 Progress Notes

A. PURPOSE: To establish revised clinical documentation standards for Yolo County Health and Human Services Agency (HHSA) and Network Providers outpatient (i.e., non-hospital) Specialty Mental Health Services (SMHS) per the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

B. RELATED DOCUMENTS:

1. Attachment 1a: Care Planning Requirements That Remain in Effect
2. Attachment 1b: Other Data and Documentation Requirements that Remain in Effect
3. Attachment 2: Superseded Regulations

C. DEFINITIONS:

1. **Assessment:** A service activity designed to evaluate the current status of a member's mental, emotional, or behavioral health, documentation of which shall address the seven (7) uniform assessment domains as specified by the CalAIM initiative.

2. **Diagnostic and Statistical Manual of Mental Disorders (DSM)**: Handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders.

3. **Direct Patient Care**: Includes time spent directly with the member as well as time spent with caregivers, significant support persons, and other professionals. Documentation should clearly indicate if member is/is not present and what other persons participated in the service. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a visit.

4. **Full-Service Partnership (FSP) Programs:** FSP programs are Mental Health Services Act (MHSA) funded, team-based, and recovery-focused services, typically based on intensive case management or assertive community treatment (ACT) models of service. These services are targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement and repeat hospitalizations.

5. **Medical Necessity:** Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

   For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.

6. **Medi-Cal Member:** Also referred to as "member", replaces the term "beneficiary". This is a Medi-Cal recipient who is currently receiving services from the Mental Health Plan.

7. **Mental Health Plan (MHP)**: Yolo County HHSA Behavioral Health and network providers of SMHS.

8. **Network Provider**: Any provider, group of providers, or entity that has a network provider agreement with Yolo County HHSA BH and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract (Title 42 Code of Federal Regulations [42 CFR] § 438.2)

9. **Problem List:** A list which may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

10. **Scope of Practice:** The extent and limits of the interventions that a provider may perform based on their credentials and/or classification. Refer to appropriate licensing boards for specific information about scope of practice; as we as any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations.

11. **Specialty Mental Health Services (SMHS)**: As defined by the MHP Contract between HHSA and the California Department of Health Care Services (DHCS).

D. POLICY: SMHS shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency. Documentation of Non-hospital SMHS will include the following:

1. **Assessment**
   a. Providers are required to use uniform assessment domains as described below. For members under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool continues to be required and may be utilized to help inform the assessment domain requirements.

   b. Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to determination of a diagnosis, during the assessment, or prior to

determination of whether SMHS access criteria are met, even if the assessment ultimately indicates the member does not meet criteria for SMHS.

c. Crisis assessments completed during the provision of SMH crisis intervention or stabilization, or a SMH Mobile Crisis Services encounter, need not meet the comprehensive assessment requirements outlined in this policy; however, crisis assessments are not a replacement for a comprehensive assessment. When a member who has received a crisis assessment subsequently receives other SMHS, an assessment shall be completed in accordance with the requirements in this policy.

d. The MHP may designate certain other qualified providers to contribute to the assessment, including gathering the member's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

e. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

2. **Problem List**
   a. The provider(s) responsible for the member's care shall create and maintain a problem list

   b. A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.

3. **Treatment Plans**
   a. In addition to the problem list, the following services require a Plan (i.e., Care Plan, Treatment Plan, etc.) as specified in this policy's referenced regulations:
      i. Targeted Case Management.
      ii. Intensive Care Coordination (ICC)
      iii. Intensive Home-Based Services (IHBS) and Therapeutic Foster Care (TFC) services.
      iv. Therapeutic Behavioral Services (TBS).
      v. Services provided in Short-Term Residential Therapeutic Programs (STRTPs).
      vi. Peer support services, which are based on an approved plan of care.

   b. Furthermore, some grant and/or other non-Medi-Cal funding sources (e.g., Mental Health Services Act) may require client treatment plans. Providers shall ensure compliance with regulations specific to the funding their program utilizes.

4. **Progress Notes:**
   a. Providers shall create progress notes for the provision of all SMHS. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

5. **Additional Documentation Requirements**
   a. Telehealth Consent

i. Providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services and must explain the following to members:
    a. The member has a right to access covered services in person

    b. Use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the member without affecting their ability to access Medi-Cal covered services in the future

    c. Non-medical transportation benefits are available for in-person visits

    d. Any potential limitations or risks related to receiving covered services through telehealth as comparted to an in-person visit, if applicable

ii. Providers must also document the member's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The member's consent must be documented in their medical record and made available to DHCS upon request. A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement:
    a. Specifically mentions the use of telehealth delivery of covered services

    b. Includes the information described above

    c. Is completed prior to initial delivery of services, and

    d. Is included in the member record

6. **Recoupment**
    a. Recoupment shall be focused on fraud, waste, and abuse.

E. PROCEDURE:

1. **Assessment**
    a. To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.
        i. For members under the age of 21, an initial CANS shall be completed or an existing CANS shall be updated by a CANS certified provider.

    b. The assessment may be in any format so long as the assessment domains and components are included, and the assessment information is comprehensive, consolidated, and can be produced and shared as appropriate to support coordinated care, in accordance with applicable state and federal privacy laws.

    c. Assessments shall be updated as clinically appropriate, such as when the member's condition changes.

d. The assessment shall include the licensed provider's recommendations for medically necessary services and additional provider referrals, as clinically appropriate.

e. The diagnosis, current MSE, medication history, and assessment of relevant conditions and psychosocial factors affecting the member's physical and mental health must be completed by a provider, operating within their scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.

f. Both licensed and non-licensed providers, including those not qualified to diagnose a mental health condition, may contribute to the assessment consistent with their scopes of practice as defined in California State Plan, Sec. 3, Att. 3 1-A, Supp. 3.

g. The assessment shall include a typed or legibly printed name, signature of the service provider, and date of signature.

h. The SMHS assessment shall include the following seven required domains. To the extent the information is available, all components listed within each of the seven domains shall be included as part of a comprehensive assessment.
   i. Domain 1: Presenting problem(s), current Mental Status, history of presenting problem(s), member-identified impairment(s)
   ii. Domain 2: Trauma
   iii. Domain 3: Behavioral health history, co-occurring substance use
   iv. Domain 4: Medical History, current medications, co-occurring conditions (other than substance use)
   v. Domain 5: Social and life circumstances, culture/religion/spirituality
   vi. Domain 6: Strengths, risk behaviors, and protective factors
   vii. Domain 7: Clinical summary and recommendations, diagnostic impression, medical necessity determination/level of care/access criteria

i. Providers shall be monitored for timely completion of assessments to ensure appropriate access to, and utilization of, services.

j. Yolo County MHP shall not enforce standards for timely initial assessment, or subsequent assessments, in a manner that fails to permit adequate time to complete assessment when such time is necessary due to a member's individual clinical needs.

1. **Problem List**
   a. The problem list shall include, but is not limited to, the following:
      i. Diagnoses identified by a provider acting with their scope of practice if any
         a. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable

ii. Current International Classification of Diseases (ICD) Clinical Modification (CM) codes

iii. Problems identified by the provider acting with their scope of practice if any

iv. Problems identified by the member and/or significant support person if any
    a. The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.

b. A problem identified during a service encounter (e.g., crisis intervention encounter) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list

c. The problem list shall be updated on an ongoing basis to reflect the current presentation of the member. Providers, within their scopes of practice, shall add to, amend, or resolve problems from the problem list when there is a relevant change to a member's condition.
    i. DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice

2. **Care Planning**
    a. DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal SMHS. The intent of this change is to affirm that care planning is an ongoing, interactive component of service delivery rather than a one-time event.
        i. Yolo County MHP shall not enforce requirements for the location, format, or other specifications for documentation of the care plan that differ from those described within this policy and referenced in its Attachments.

    b. There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities (see Attachment 1a). For SMHS, programs, or facilities for which care plan requirements remain in effect:
        i. Providers must adhere to all relevant care planning requirements in state or federal law

        ii. The provider shall document the required elements of the care plan within the member record. For example, required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an electronic health record

        iii. For the purpose of care coordination, the provider shall be able to produce and communicate the content of the care plan to other providers, the member and

Medi-Cal behavioral health delivery system, in accordance with applicable state and federal privacy laws

c. Targeted Case Management (TCM) services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan:
   i. Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational, and other services needed for the member

   ii. Includes activities such as ensuring the active participation of the member, and working with the member (or the member's authorized health care decision maker) and others to develop those goals

   iii. Identifies a course of action to respond to the assessed needs of the member, and,

   iv. Includes development of a transition plan when a member has achieved the goals of the care plan

d. Peer Support Services (PSS) must be based on an approved plan of care.
   i. The plan of care includes specific individualized goals developed through use of a person-centered planning process to help promote participant ownership of the plan of care.

e. Full-Service Partnership (FSP) services must include the collaborative development of an Individualized Services and Supports Plan (ISSP) between the member and the provider and may include the Full Spectrum of Community Services necessary to attain the goals identified in that plan.
   i. The services to be provided may also include services the County, in collaboration with the member, and when appropriate the member's family, believe are necessary to address unforeseen circumstances in the member's life that could be, but have not yet been included in the ISSP.

f. Additional Treatment and Care Plan Requirements for other service types are found in Attachment 1a.

3. <u>Progress Notes</u>
   a. Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by a least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service.

   b. Progress notes for all non-group services shall include:
      i. The type of service rendered

      ii. The date that the service was provided to the member

      iii. Duration of direct patient care for the service

iv. Location/place of service member

v. A typed or legibly printed name, signature of the service provider and date of signature

vi. A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors)
    a. For example, as clinically indicated the brief description may include activities or interventions that occurred during the service event, issues discussed, and progress toward treatment goals or other treatment outcomes

vii. A brief summary of next steps
    a. For example, as clinically indicated next steps may include planned action steps by the provider or the member, collaboration with the member, collaboration with other providers, goals, and actions to address health, social, educational, and other services needed by the member, referrals, and discharge and continuing care planning

c. For group services:
    i. When a group service is rendered, a list of participants is required to be documented and maintained by the provider

        a. Due to confidentiality standards, the full list of group participants must not be kept in any single participant's personal heal records; instead, the MHP must maintain the full participant list outside of any participant's health record.

    ii. Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in (b)(i-vii), above.

    iii. The progress note for the group service encounter shall also include a brief description of the member's response to the service
        a. For example, as clinically indicated the individual note for a group service may address the effectiveness of the intervention, progress or problems noted, group dynamics, or other information relevant to the member's participation, comments, or reactions during the treatment session.

d. Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described in (b) or (c), above, but the nature and extend of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others
    i. For example, a group note for a participant that chose not to speak during the group service may not include the same level of detail as a note for a group participant who engaged more actively, or a not for an individual counseling or therapy session).

e. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note.

f. Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).

g. Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled services), such as Crisis Residential Treatment, Adult Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation.)
    i. If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.

h. For valid Medi-Cal claims, appropriate ICD-CM diagnostic codes, as well as HCPCS/CPT codes must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note. However, current ICD-CM codes and HCPCS/CPT codes are not required to be included in the progress note narrative.

4. Contract requirements: Network providers shall consult their executed contracts with Yolo County HHSA for any clinical documentation requirements that may remain in effect in addition to those listed in this policy as required by federal and state law.

F. REFERENCES:

1. DHCS BHIN 21-073
2. DHCS BHIN 23-018
3. DHCS BHIN 23-068

Approved by:

Karleen Jakowski _____ 12/27/23

Karleen Jakowski, Mental Health Director **Date**
Yolo County Health and Human Services Agency

Attachment 1a: Care Planning Requirements That Remain in Effect

Attachment 1b: Other Data and Documentation Requirements that Remain in Effect

Attachment 2: Superseded Regulations

Attachment 1a: Care Planning Requirements that Remain in Effect

This Attachment provides guidance to Medi-Cal behavioral health delivery systems on specific standards for care planning that remain in effect under state or federal law (including secondary guidance like policy or practice manuals). It may not be an exhaustive list of all relevant state or federal requirements, and the guidance it cites may be subject to changes. Member records for programs, services, and facilities that are subject to care planning requirements cited in this Attachment must comply with all applicable care planning requirements.

While DHCS does not require a specific format or location for care plan information, to support delivery of coordinated care the provider shall be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws. Generally speaking, documentation shall comply with both Attachment 1a requirements (which may be more specific than the requirements above in this policy) and the standards in this policy.

Program, Service, or Facility Type	**Authority/ Background**
Children's Crisis Residential Programs (CCRP)	Children's Crisis Residential Mental Health Program Interim Standards
Community Treatment Facilities (CTF)	9 CCR § 1927, subds. (a)(6), (e)
Mental Health Rehabilitation Centers (MHRC)	9 CCR § 786.15, subds. (a), (d), (e)
Mental Health Services Act Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP)	9 CCR § 3620
Peer Support Services	CMS Directors' Letter 07-011; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att. 3.1-B, Supps. 2, 3
Short-Term Residential Therapeutic Programs (STRTPs)	Interim STRTP Regulations Version II, Section 10
Social Rehabilitation Programs (SRPs). Includes programs certified by DHCS for: • Short-Term Crisis Residential Treatment; • Transitional Residential Treatment; and • Long Term Residential Treatment	9 CCR § 532.2, subds. (c), (d)
Targeted Case Management (TCM); Intensive Care Coordination (ICC)	42 CFR § 440.169(d)(2)

Therapeutic Behavioral Services (TBS)	DMH IN 08-38; *Emily Q. v. Bonta,* Nine-Point Plan (Appendix D).

Attachment 1b: Other Data and Documentation Requirements that Remain in Effect

This Attachment was developed to provide guidance to Medi-Cal behavioral health delivery systems on additional service delivery, data reporting, or documentation standards that remain in effect under state or federal law (including secondary guidance like policy or practice manuals). Unlike Attachment 1a, these requirements are not limited to care planning. This Attachment is not an exhaustive list of all relevant state or federal requirements, and the guidance it cites may be subject to changes.

Requirement	**Authority/ Background**
Child and Adolescent Needs and Strengths (CANS)	MHSUDS IN 17-052; MHSUDS IN 18-007
Children's Crisis Residential Programs (CCRP) • See standards for assessment and other service activities. Standards for CCRP care planning are addressed in Attachment 1a.	Children's Crisis Residential Mental Health Program Interim Standards
Client and Service Information (CSI)	MHSUDS IN 19-020
Community Treatment Facilities (CTF) • See standards for assessment and other service activities. Standards for CTF care planning are addressed in Attachment 1a.	9 CCR § 1927
Intensive Care Coordination (ICC), Intensive Home- Based Services (IHBS), Therapeutic Foster Care (TFC) • See general standards for service delivery. Care planning requirements specific to ICC are addressed in Attachment 1a. DHCS will not enforce the use of a care plan or specific care planning requirements for IHBS or	Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries

TFC.	
Mental Health Rehabilitation Centers (MHRC) • See standards related to assessment and other service activities. Standards for MHRC care planning are addressed in Attachment 1a.	9 CCR § 786.11, subd. (b) 9 CCR § 786.15
Pediatric Symptom Checklist (PSC)	MHSUDS IN 17-052
Short-Term Residential Therapeutic Programs (STRTPs) • See standards for assessment and other service activities. Standards for STRTP care planning are addressed in Attachment 1a.	Interim STRTP Regulations Version II, Section 10
Social Rehabilitation Programs (SRPs) • See standards related to assessment and other service activities. Standards for care planning for SRPs that hold DHCS certifications for short-term, transitional, or long-term residential treatment are addressed in Attachment 1a.	9 CCR § 532.2, subds. (b), (g)

Attachment 2: Superseded Regulations

Regulation Title and Section Number	**Superseded Part of Regulation**
Title 9 Section 1810.205.2 Client Plan.	Superseded entirely.
Title 9 Section 1810.206 Collateral.	Requirement that the needs of the member are understood "in terms of achieving the goals of the member's client plan" is superseded.
Title 9 Section 1810.232 Plan Development.	Superseded entirely.
Title 9 Section 1810.440 MHP Quality management Programs.	Subdivisions (c)(1)(A)-(C) and (c)(2)(A)-(B) are superseded.
Title 9 Section 1840.112 MHP Claims Certification and Program Integrity.	Subdivision (b)(5) is superseded.
Title 9 Section 1840.314 Claiming for Service Functions-General.	Subdivision (e)(2)'s requirements related to approval of client plans are superseded.