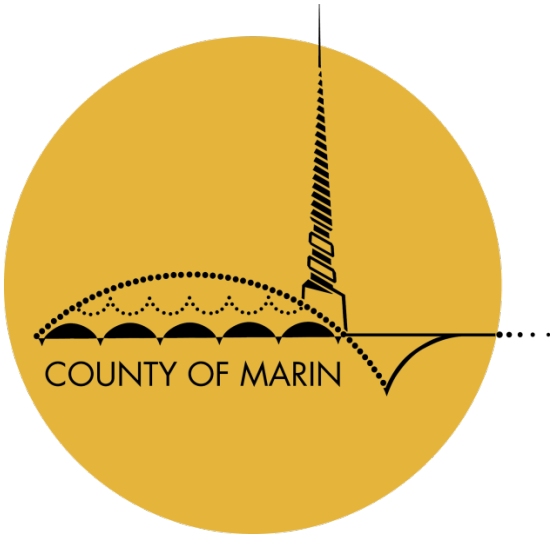

CLINICAL DOCUMENTATION GUIDE

September 2023

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

BEHAVIORAL HEALTH AND RECOVERY SERVICES

BHRS Documentation Manual v 9/21/2023

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APPENDICES

Chapter 1. INTRODUCTION/COMPLIANCE

1.1. WHY DO WE HAVE THIS MANUAL?

As a behavioral health system, The Marin Behavioral Health and Recovery Services (BHRS) is committed to delivering client and family driven care. It is important that our service providers understand and embrace this philosophy. Client centered care has been recognized as a best practice in behavioral health. **"All services and programs designed for persons with mental disabilities should be consumer centered, in recognition of varying individual goals, diverse needs, concerns, strengths, motivations, and disabilities."** Client centered care involves putting the consumer in the driver's seat of the care they are receiving.

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 that BHRS provides reflect the values stated above, good documentation practices need to be followed. This manual has been developed as a resource for providers of BHRS. It outlines documentation standards and practices required within the Children, Youth and Family System of Care, Adult/Older Adult System of Care, contract providers, and Substance Use Services. It serves to ensure that providers within BHRS meet regulatory and compliance standards of competency, accuracy, and integrity in the provision and documentation of their services.

While this manual is not specific to any particular electronic medical record system, there are many specific items that refer to SmartCare. Where this is the case, it is usually stated as "In SmartCare…"

As with any manual that incorporates policies and regulations, updates will need to be made as these policies and regulations change. When updates are distributed, please be sure to replace copies or sections that have been downloaded or printed.

1.1.1. CalAIM

Beginning July 2022, as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, there were significant changes to the documentation standards and requirements. These changes can be found throughout this Manual. The reasons for these changes are to streamline and standardize clinical documentation requirements across systems, and to better align with Centers for Medicare and Medicaid Services' national coding standards and with physical health care documentation practices. The Clinical Documentation Guide published by the California Mental Health Services Authority (CalMHSA) describes these changes in depth and is the source for significant parts of the changes set forth in this guide. The CalMHSA Documentation Guides can be found here.

Effective July 1, 2023, the payment reform aspects of CalAIM went into effect. This transition is largely "behind the scenes" and relates to how billing and payment are processed. However, because of the shift to CPT billing, some of the service choices and definitions have been changed. These changes are reflected throughout this guide.

Please note that this is primarily a **clinical** documentation guide, i.e., the main focus through this manual is the clinical documentation in the medical record. There are other required documents which are more administrative. These are included in Appendix E.

Sources of Information

This Clinical Documentation Guide is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements. This manual includes information based on the following sources: Code of Federal Regulations (CFR) 45 and 42, the California Code of Regulations (CCR) Title 9, the California Department of Health Care Services' (DHCS) Letters and Information Notices, California Mental Health Services Authority (CalMHSA), American Health Information Management Association (AHIMA), California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Marin County Behavioral Health and Recovery Services (BHRS) policies & procedures, directives, and memos; and the Quality Improvement Program's interpretation and determination of documentation standards.

Suggestions and Feedback

Suggestions and feedback for enhancements, improvements, or clarifications to this manual are welcome. Please send feedback to BHRSQM@marincounty.org.

1.2. COMPLIANCE

Marin County Behavioral Health and Recovery Services (BHRS) is a county behavioral health organization (also referred to as a Mental Health Plan) that provides services to the community and 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 guide. In general, good ethical standards meet nearly all of the requirements. At times, there is a need to provide some guidance and clarity so staff can efficiently and effectively document for the services they provide.

BHRS has adopted a Compliance Program based on guidance and standards established by the Office of Inspector General (OIG), U.S. Department of Health and Human Services, (HHS). The OIG is primarily responsible for Medicare and Medicaid fraud investigations and provides support to the US 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 many of those counties either severe consequences known as Corporate Integrity Agreements have been imposed or fraud charges have been brought, or both. The intent of the Compliance Program is to prevent fraud and abuse at all levels through auditing and monitoring. These auditing and monitoring activities support the integrity of all health data submissions, as evidenced by accuracy, reliability, validity, and timeliness. It is the responsibility of every provider to submit a complete and accurate record of the services that they provide and to document those services in keeping with all applicable laws and regulations.

This guide serves as the basis for all documentation and claiming by BHRS, regardless of payer source. All staff in County programs, 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 and coding, and documentation.
- Participation by all providers in proactive training and quality improvement processes.
- Providers working within their professional scope of practice.
- Having a Compliance Plan to ensure there is accountability for all BHRS, Community Programs activities and functions. This includes the accuracy of progress note documentation by defined practitioners who will select correct procedures and service location to support the documentation of services provided.
- Utilization Review disallowances are now focused on Fraud, Waste, and Abuse instead of compliance with documentation standards.

Chapter 2. GENERAL PRINCIPLES OF DOCUMENTATION AND CLINICAL WORKFLOW

2.1. General Principles of Documentation

1. All Providers must refer and adhere to BHRS-25, Documentation Requirements for All Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

2. Until SmartCare is fully implemented and becomes a completely electronic EHR, BHRS will temporarily maintain a hybrid health record system, which includes both paper-based and electronic documents. For new client admission and re-admission in SmartCare, the hybrid health record continues to include chart forms that require client's signature until signature pads and/or scanning capabilities become available system wide.

3. All Providers must use BHRS approved forms or an approved electronic health record system for documentation. BHRS Contract Providers must incorporate all BHRS required documentation elements as referenced in this Manual and BHRS 25 policy.

4. Required documents include an accurate Assessment, Problem List and Ongoing Care Notes (Progress Notes). Remember that the medical records, both electronic and paper, are legal documents.

5. All services shall be provided by staff within the scope of practice of the individual delivering service. Clinicians will follow specific scope of practice requirements determined by regulations, including those of the governing boards of the applicable licenses.

6. Progress notes should provide enough detail so that auditors and other service providers can easily ascertain the client's status and needs and understand why the service was provided without having to refer to previous progress notes. Remember the Golden Thread when writing notes. This is the consistent presentation of relevant clinical information throughout all documentation for a client. Each note should lead into the next, creating a comprehensive story of the client's progress through treatment.

7. It is crucial that the staff providing the service records the correct procedure for the service provided and that the documentation supports and substantiates this service. In order for Marin County to receive the correct reimbursement for services provided, clinicians must ensure that they choose the correct procedure for the correct Program and for the correct client.

8. Under CalAIM Payment Reform, only face-to-face time is billable, based on type of procedure provided. However, recording documentation and travel time is still necessary, as it is used to help set reimbursement rates for the face to face service for the following fiscal year.

9. Timeliness of Service Documentation. Each Service contact is documented in a progress note and documentation must be completed in a timely manner per the following guidelines.
   - A progress note is completed for each service contact. (Except for Crisis Stabilization Unit (CSU) and Crisis Residential services which have daily note requirements).
   - For group notes billing, staff must detail the purpose of the group and individualize the note for each client in the group which documents how the client participated in and benefited from the group as well as their individual response to the interventions provided during the group.
   - Every effort should be made to complete progress notes on the same day as the service.
   - Individual and Group Notes must be completed within 72 hours or 3 business days from the date of the delivery of the service, except as follows:

- Notes requiring co-signatures must be submitted to a supervisor within 3 business days for review and authorized by the supervisor as soon as possible. Upon authorization, the staff requiring co-signature must then finalize the note so that the service can be claimed. If the supervisor is not available, the providing staff must coordinate with the program director or other designated supervisors for reviewing notes and other clinical documents for co-signature.
- If notes are not finalized within 3 (or 10) days, the clinician must write "late entry" in the "Notes" section of the progress note. Late entry services should include documentation time when claiming.
- Crisis intervention services must be finalized within 24 hours.

10. Documentation must be readable and legible. Ensure that the spell check function is turned on. In SmartCare, the "Spell Checker" button is located in the toolbar, at the top right of most pages. Spell Checker can also be located by clicking "Select Action" button also found in toolbar. Always spell check prior to finalizing a document.

11. The use of abbreviations in clinical documentation must be consistent with approved BHRS abbreviations. (See Appendix F for a list of approved abbreviations.)

12. Restriction of Client Information: APS/CPS Reports, Serious Incident Reports, Grievances, Utilization Review Committee recommendations or forms and audit worksheets should never be scanned into the electronic health record or filed within the paper record or billed. Questions regarding other forms (not already listed) and their inclusion into the medical record should be directed to QM staff.

13. Confidentiality: Do not write another client's name in client's chart. If another client must be identified in the record do not identify that individual as a behavioral health client unless necessary. Names of family members/support persons should be recorded only when needed to complete intake registration and financial documents. Otherwise, refer to the relationship - mother, husband, friend, but do not use names. May use first name or initials of another person when needed for clarification.

14. Copy and Paste: Do not copy and paste notes into a client's medical record. Each note needs to be specific to the service provided. Progress notes that are submitted which appear to be worded exactly like, or too similar to, previous entries may be assumed to be pasted, i.e., containing inaccurate, outdated, or false information, therefore claiming associated with these notes could be considered fraudulent.

2.2. SIGNATURES:

Clinician 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.

- Your signature must be on file in order to use the Electronic Health Record (EHR). SmartCare maintains a file of clinician unique identifiers/signatures.
- Authentication – BHRS maintains a signed Electronic Signature Agreement for the terms of use of an electronic signature signed by both the individual requesting electronic signature authorization and the BHRS Director or designee. Electronic signatures based on login name and passwords are valid for six (6) months. Renewal of the password renews the electronic signature agreement.
- Agencies wanting to use their own electronic signatures must provide BHRS with policies and procedures on electronic signatures.

Each clinician signature must include a license or designation (e.g., ASW, MD, AMFT, LCSW, MFT, MHRS, PhD waivered, etc.). Staff without a license or discipline must include a job title (e.g. Resource Counselor)

2.2.1. Co-Signatures

Co-signatures for staff may be required on documents for several reasons. The State Department of Health Care Services (DHCS) requires that some documents be approved by a Licensed, Registered, or Waivered clinician.

Additionally, County policy requires that some documents be reviewed and co-signed by a supervisor as part of the authorization process. Also, some staff are required to have progress notes co-signed for specific or indefinite periods. For example, new and reassigned staff are required to have co-signed notes for three months. Other co-signature requirements may be assigned for purposes of quality assurance and/or compliance. Staff should consult with their supervisor for additional specifics. SmartCare enforces the requirement for Co-Signature.

2.3. CLINICAL WORKFLOW

The following are the steps for admitting a client, providing and documenting services, through discharge.

Please note: there are additional non-clinical requirements such as the Financial Responsibility Form, the Notice of Privacy Practices and others.

1. See if the potential client is in the system – Inquiries (My Office)
2. Admit the client to the program – Client Programs (Client)
3. Screen Client – Adult or Youth Screening Tool (Client)
4. Complete Consents: Coordinated Care, Email communication, Telehealth, Text communication, Treat (Client)
5. Conduct Assessment – Mental Status Exam, Assessment (Client)*
6. Establish Diagnosis – Diagnosis Document (Client)*
7. Complete Required State Forms – CSI, CANS (up to 20 YO), PSC (under 18) (Client)
8. Schedule Service – Staff Calendar (My Office)
9. Provide Service – check each problem from Problem List
10. Write a note – New Service Note – Document new needs in Problem List and problems assessed during service
11. Discharge – Client Programs (Client), CSI Update/Discharge (Client)

* Within Scope of Practice

2.4. ASSUMING RESPONSIBILITY OF A HEALTH RECORD

- When new to an ongoing client, assume responsibility for the Mental Health Record.
- Confirm that the client has a finalized Assessment with all required elements.
- Confirm that the client has a problem list.
- Confirm the client record has all compliance items: Consent to Treatment, HIPAA Notification, and ROI (if needed).

Chapter 3. ACCESS CRITERIA AND MEDICAL NECESSITY

3.1. ASSESSMENT

Assessment is the process of gathering and documenting information about the status of the individual's mental, emotional, or behavioral health. It can include mental status exam, establishing a diagnosis, appraisal of the individual's functioning in the community such as living situation, daily activities, social support systems, relevant cultural issues and history, and health history and status. Assessment includes screening for substance use/abuse and may include the use of testing procedures. The diagnosis, MSE, medication history, and assessment of relevant conditions and psychosocial factors are assessment activities which must be provided by a licensed and/or licensed waived practitioner consistent with their scope of practice. However, other qualified providers may provide assessment activities such as gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

Completing the assessment is an important first step to get a clear account of the current problems. 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 in seeking help. 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.

Standardized Assessment Requirements (Including Timeliness)

a. BHRS requires providers to use the CalAIM assessment with uniform domains as identified below. For beneficiaries under the age of 21, the required Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

b. The time period for providers to complete an initial assessment and subsequent assessments is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.

d. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Electronic signatures done SmartCare are sufficient if the provider's credentials and license are included.

e. The assessment shall include the provider's recommendation – and determination of medical necessity for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider,

operating in 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.

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

The Assessment Domain Requirements:

The Assessment is comprised of 7 domains:

- Presenting Problem
- Trauma
- Behavioral Health History
- Medical History
- Psychosocial Factors
- Strengths/Risks
- Clinical Summary

Key elements and information to consider under each domain:

Presenting Problem/Chief Complaint (1)

This domain focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint.

· Presenting Problem (Current and History of) –The person's and collateral sources' descriptions of problem(s), history of the presenting problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.

· Current Mental Status Exam – The person's mental state at the time of the assessment.

· Impairments in Functioning - The person and collateral sources identify the impact/ impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning.

Trauma (2)

This domain involves information on traumatic incidents, the person in care's reactions to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care — it is not necessary in every setting to document the details of traumatic incidents in depth.

· Trauma Exposures – A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.)

· Trauma Reactions – The person's reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.

· Trauma Screening- The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}), indicating elevated risk for development of a mental health condition.

· Systems Involvement – The person's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.

Behavioral Health History (3)

This domain focuses on history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/ abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

· Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.

· Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.

· Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addiction Treatment [MAT]), length of treatment, and efficacy/ response to interventions.

Medical History and Medications (4)

In this domain, medical and medication items are integrated into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides important context for understanding the needs of the people we serve.

· Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.

· Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.

· Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger)

Psychosocial Factors (5)

This domain supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

· Family - Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)
· Social and Life Circumstances – Current living situation, daily activities, social supports/ networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community

· Cultural Considerations – Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) and/or Black, Indigenous and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practice

Strengths, Risk and Protective Factors (6)

This domain explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing.

· Strengths and Protective Factors – personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships

· Risk Factors and Behaviors – behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/ planning/intent, aggression, inability to care for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used

· Safety Planning –specific safety plans to be used should risk behaviors arise, including actions to take and trusted individuals to call during crisis.

Clinical Summary, Treatment Recommendations and Level of Care determination (7)

The clinical summary domain provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

· Clinical Impression – summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below)

· Diagnostic Impression – clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified)

· Treatment Recommendations – recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care.

While each of the domains are required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the person's current and historical need is accurately documented. Include the perspective of the person in care and, whenever possible, use their quotes within the document.

Also, It is considered a "best practice" to note the name of the Primary Care Physician (PCP) on the assessment.

The CalAIM Assessment Clinical Assessment found in SmartCare is compliant with all State and Federal Regulations. However, the service provider (author) must ensure that all sections of the Clinical Assessment are filled out.

3.2. ACCESS CRITERIA for Specialty Mental Health Services (SMHS)

DHCS has issued the following age specific descriptions of Access Criteria for Specialty Mental Health Services (SMHS)

3.2.1. Criteria for Beneficiaries 21+

Beneficiary meets both of the following criteria, (1) and (2) below:

1. The beneficiary has one or both of the following:
   a. •Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

   b. A reasonable probability of significant deterioration in an important area of life functioning AND
2. The condition is due to either of the following:
   a. •A diagnosed mental health disorder, according to the criteria of the DSM and the ICD.

   Or

   b. •A suspected mental disorder not yet diagnosed.

3.2.2. Access Assurances for Beneficiaries under 21

For enrolled beneficiaries under 21 years of age, BHRS shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code.

Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2)

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

Or

(2) The beneficiary meets **both** of the following requirements in a) and b), below

a) The beneficiary has **at least one** of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

And

b) The beneficiary's condition as described above is due to **one of the following**:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems

ii. A suspected mental health disorder that has not yet been diagnosed

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria for SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

Definitions: Involvement in Child Welfare

The beneficiary has an open child welfare services case, which means that the child welfare agency has opened a child welfare or prevention services case with the family to monitor and provide services.

A child has an open child welfare or prevention services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance and/or prevention services case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement.

A child can have involvement in child welfare whether the child remains in the home or is placed out of the home. Involvement in child welfare also includes a child whose adoption occurred through the child welfare system.

Definitions: Homelessness

The federal Department of Housing and Urban Development's most recent definition of homelessness includes four categories:

1. Literally homeless
2. Imminent risk of homelessness
3. Homeless under other Federal statutes
4. Fleeing/attempting to flee domestic violence

Definitions: Juvenile Justice Involvement

The beneficiary: has ever been detained or committed to a juvenile justice facility or is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency.

Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition.

Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

The assessment is critical for establishing the diagnosis and identifying problems or illnesses to be included in the problem list. The problem list takes the information gathered during the assessment process and directs the focus of services. The problem list also links the interventions to specific problems. The Progress Notes describe the specific service provided and establish that the service is meant to address a problem on the problem list.

3.3. Medical Necessity in Context of Access Criteria.

The California Advancing and Innovating Medi-Cal (CalAIM) initiative aims to improve health outcomes by ensuring that beneficiaries have access to the right care in the right place at the right time. A part of improving this access is by redesigning the medical necessity criteria for Specialty Mental Health Services for children and adults. These changes supersede the previous medical necessity criteria described in Title 9 that are based on

ameliorating symptoms and functional impairments brought about by an included diagnosis and are aimed at lessening the burden on beneficiaries to get through the door for treatment.

All Medi-Cal services provided to persons in care continue to need to meet the standard of being "medically necessary". However, under the CalAIM revision, medical necessity criteria will now be more closely aligned with W&I Code definitions for adults[1], and Title 42[2] for children.

> For persons 21 years of age or older, a service is generally "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. This is in addition to the following criteria.
>
> - The person has a significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in an important area of life functioning
> - AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.
>
> For individuals under 21 years of age a service is "medically necessary" if needed to correct and ameliorate a mental illness or condition. This would include services that sustain, support, improve, or make more tolerable a mental health condition. This is in addition to the following criteria.
>
> - The person is experiencing homelessness, and/or is interacting with the child welfare or criminal justice system
> - OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder.
> - OR, the person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment
> - AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

This deemphasis on diagnosis to establish medical necessity is meant to allow more flexibility in the provision of services but is not meant to eliminate diagnoses in clinical practice as a focus for treatment.

Note: Although W & I and CFR sections state that a mental health diagnosis is not a prerequisite for access to covered SMHS, this does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted previously, there are applicable ICD-10 codes. These include "Other specified" and "Unspecified" disorders. Additionally, Z-codes for "Factors influencing health status and contact with health services" and DHCS' established list of priority Social Determinants of Health (SDOH) should be used where appropriate.

[1] Welfare and Institutions Code section 14184.402(a)

[2] Section 1396d(r)(5) of Title 42 of the United States Code

3.4. When Access Criteria are Not Met.

It is possible that some clients will not meet the Access Criteria for Specialty Mental Health Services. It may be determined at screening that a referral to the Managed Care Plan (MCP) for non-Specialty Mental Health care is appropriate. Screening may indicate that an assessment for Specialty Mental Health Services is indicated. However, the assessment then may determine that the Access Criteria listed above are not met and that the client should be seen by the MCP. In this case, the Access Team should complete a Notice of Adverse Benefit Determination (NOABD). A NOABD is a written notice that gives Medi-Cal Beneficiaries an explanation when a denial or only a limited authorization is made in response to a request for services. NOABDs can also be notifications of the reduction, suspension or termination of a previously authorized service; denial of payment for a service rendered by a provider, etc., depending on the situation.

NOABDs should include the effective dates of coverage and the changes made to the level of benefits/services received. NOABD Forms will also include a "Your Rights" document about appeals, expedited appeals, timeframes, etc. should the client not agree with the decision made or determination made.

NOABD forms are found in SmartCare EHR, and should be completed in the EHR, then printed and mailed to client.

4.1. THE PROBLEM LIST

The use of the Problem List in behavioral health has largely replaced the use of treatment plans except where federal requirements mandate that treatment plans be maintained.

The Problem List is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the Problem List. The providers responsible for the client's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by non-LPHA staff.

4.1.1. Problem List Requirements

The Problem List needs to include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any. Include diagnostic specifiers from the DSM if applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the beneficiary and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Problem List Example

Number	Code	Description	Begin Date	End Date	Identified by	Provider Type
1	Z65.9	Problem related to Unspecified psychosocial circumstances	7/1/2023	7/19/2024	Name	MH Rehab Specialist
2	Z59.02	Unsheltered homelessness	7/1/2023	Current	Name	Peer Support Specialist
3	Z59.7	Insufficient insurance and social welfare support	7/1/2023	Current	Name	Peer Support Specialist
4	F33.3	Major Depressive Disorder recurrent, severe with psychotic features	7/19/2023	Current	Name	Psychiatrist
5	F10.99	9 Alcohol Use Disorder, unspecified	7/19/2023	Current	Name	Clinical Social Worker
6	I10	Hypertension	7/25/2023	Current	Name	Primary Care Physician
7	Z62.819	History of unspecified abuse in childhood	8/16/2023	Current	Name	Clinical Social Worker

Note that ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate.

4.1.2. Problem List Timelines

DHCS does not require the Problem List to be updated within a specific time frame or have a requirement about how frequently the Problem List should be updated after a problem has initially been added. However, providers should update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

Providers should add to or remove problems from the Problem List when there is a relevant change to a beneficiary's condition.

The basic requirement for the Problem List is that it should be updated on an ongoing basis to reflect the current presentation of the person in care.

4.2. Services Still Requiring a Treatment Plan.

4.2.1. Targeted Case Management (TCM)/Brokerage

Targeted Case Management 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 plan:

- 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 by the beneficiary;
- Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

A plan with these required elements must be provided in a narrative format in the care plan section a client's SmartCare progress note and do not require a client/caregiver signature. This plan should be included at the initiation of TCM/Brokerage services and updated as appropriate in the narrative of subsequent TCM/Brokerage services.

4.2.2. Peer Support Services (PSS)

Peer Support Services (PSS) must be based on approved plan of care.

The plan of care shall be documented within the progress notes in the beneficiary's clinical record and must be based on a plan of care approved by any treating provider who can render reimbursable Medi-Cal Services. A specific care plan is based on the information collected throughout the assessment and the care plan:

- 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 by the person in care;
- Includes activities such as ensuring the active participation of the person in care, and working with the person (or the person's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the person in care;
- Includes development of a transition plan when a person in care has achieved the goals of the care plan.

These required elements shall be provided in the plan section of the SmartCare progress note in the person's progress notes.

4.2.3. Other Service types: ICC, IHBS, TFC, TBS

These service types require a separate care plan with specified goals and **do require** client/caregiver signature. This care plan is in addition to the Problem List. See service description for additional information.

Intensive Care Coordination (ICC)

Intensive Home Based Services (IHBS)

Therapeutic Foster Care (TFC)

Therapeutic Behavioral Services (TBS)

Chapter 5. PROGRESS NOTES

The progress note is used to record the services that result in claims (billing). Please remember that when a clinician writes a billable progress note a bill to the state is being submitted, therefore, all progress notes must be accurate and factual. Errors in documentation (e.g., using an incorrect location or procedure) directly affect BHRS' ability to submit true and accurate claims. This is an aspect of compliance, and compliance is the personal responsibility of all clinical and administrative staff.

What makes a good progress note? A good progress note accurately represents the service provided. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment.

Good progress notes should be:

Clear,
Consistent,
Descriptive,
Reliable,
Accurate/Precise
Timely

Progress notes are also used to inform other clinical staff about the client's treatment, to document and claim for services, and to provide a legal record. Progress notes may be read by clients/family members. Use your judgment about what to include. Aim for clarity and brevity when writing notes. Lengthy narrative notes are discouraged.

Who are we writing the note for?

Progress notes should be written as if an attorney and/or the client/family will read the document. You should be able to explain or defend every statement that is made in the progress note. Use quotes when stating what other people said.

Clear and concise documentation is crucial to client care. Progress notes are used not only to claim for services, but to document the client/family's course and progress in treatment. Progress notes are also used to communicate

with other care providers. Progress notes should clearly indicate the type of service provided and how the service is necessary to address an identified problem.

In order to meet regulatory and compliance standards, Progress Notes must contain the following

- The date that the service was provided.
- Location of the beneficiary at the time of receiving the service.
- The type of service rendered
- Duration of the service, face to face time and travel and documentation time.
- Evidenced-Based practices used if applicable.
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (i.e., a problem from the problem list or the need to add a problem to the problem list.).
- The care plan which includes goals, treatment progress, and next steps, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.
- A typed or legibly printed name, signature of the service provider and date of signature: a signed service note in SmartCare imbeds staff credentials and date.

The following are also required to be incorporated within progress notes in order to meet regulatory requirements. However, they are provided "in the background" by the EHR system.

- ICD 10 code.
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

5.1. PROGRESS NOTE FORMAT

BHRS is not requiring that progress notes be written in a specific format. However, it may be helpful for providers to use a format that will make sure that the notes are readable, as well as make sure that the required elements listed above are included.

Purpose (not required)

The Purpose: In order to meet the requirement that the note describes how the service addresses the client's behavioral health need, (e.g., symptom, condition, diagnosis, risk factor), purpose of the intervention should be clear.

- Include keywords from the Problem List to clearly identify the issue(s) being addressed.
- Indicate the status of the problem – that it is still an active need.
- Be clear that the focus of the intervention is to address the identified problem.

Intervention (required)

The Intervention: Use descriptive sentence(s) about staff's interventions (what you did). Identify skills used to cope/adapt/respond/problem solve. Reinforce new behaviors, strengths. Identify specific skills that are taught/modeled/practiced.

The intervention elements of the progress note shall describe the following:

- Clinician's interventions: what did clinician do?
- Clinician's assessment, including risk assessment when applicable

- Document advice/recommendations given to client/family

Plan (required)

The Plan: The Plan component outlines clinical decisions regarding the client, collateral contact, referrals to be made, follow-up items, homework assignments, treatment meetings to be convened, etc. Any referrals to community resources and other agencies when appropriate, and any follow-up appointments may also be included. If this is a Brokerage or Peer Support service, the treatment plan could go here.

- Are there new problems for the problem list?
- Document that the problems on the problem list remain appropriate or revise as needed
- If lack of improvement, get consultation or consider change in treatment strategy
- Consider treatment titration and plan for discharge

5.2. TIMELINESS OF DOCUMENTATION OF SERVICES

All client-related services must be completed in the client electronic health records within 72-business hours or 3 business days from when the service was provided. Any other documents related to a client (i.e. discharge summaries, labs, etc.) must also be entered/scanned in the client's clinical record as soon as practical. State regulations drive timeliness standards, which are based on the idea that documentation completed in timely fashion has greater accuracy and makes needed clinical information available for best care of the client. State guidelines and auditors' practice established the 72-hour (or three business days) documentation time frame utilized in BHRS.

Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

The intent of the 72-hour/3 business day documentation policy is to establish a trend of timely documentation. Timely documentation is not only about compliance with State expectations, but it is also about insuring that clinically relevant and accurate information is available for the best care of the client.

However, perfection is not expected. QM recognizes that documentation cannot always be completed within 72-hours/3 business days. Situations may arise that prevent timely documentation, such as sickness, client crisis, or scheduling challenges. As with any trend's longevity, timely documentation is meant to be evaluated on a long-term basis.

There are often questions on how the timeline expectation applies to services that occur at the end of the business day on Fridays or the day before a holiday. Progress notes need to be completed within 72 hours-3 business days from when the service was provided. The same rules apply for staff working alternative or modified schedules, the 72-hour business hours includes all regular hours of BHRS operation (excluding weekends and holidays) even if it coincides with a regularly scheduled day off that falls on a BHRS business day. For example, staff working four 10-hour days with Fridays off must consider that their regularly scheduled Friday off is still part of the calculations for the 72-business hour documentation standards.

There are some staffing classifications, such as new employees or interns, who require a reviewer or clinical supervisor to review the progress notes prior to finalization. Even in these instances, the 72-business hour standards apply. Generally, the practitioner completes a progress note, selects the "co-signature" option, and finalizes the progress note. The reviewer then reviews the progress note and provides the practitioner with feedback, if any. The use of supervision to provide feedback on progress notes is always encouraged, however, the feedback may be provided by e-mail or telephone. Depending on the feedback, the practitioner has the option

to “amend” the progress note to include any necessary information regarding the service provided. If the progress requires more than the use of the amend option, please contact QM for support.

5.3. COMPLETING A PROGRESS NOTE

- When a practitioner signs the progress note in SmartCare, they are finalizing the note and stating that it is complete and accurate.
- Signing a progress note allows the documented service to the client to be billed.

Chapter 6. SPECIALTY MENTAL HEALTH SERVICES

Specialty Mental Health Services are comprised of a variety of treatment services provided to individuals, groups and/or families. Definitions of the primary service types are below.

6.1 Descriptions of Specific Treatment Services:

6.1.1. ASSESSMENT

A service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary’s clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnoses and the use of testing procedures. For more detail see Assessment section.

6.1.2. PLAN DEVELOPMENT

Service activity which consists of one or more of the following: development of client plans, approval of plans, and/or monitoring of a person in care’s progress.

It is used to document the development or revision of Problem Lists or, for those services that need them, treatment plans. Services whose plans are included in the narrative of the service, like TCM Linkage would not use Plan Development. Plan Development may be claimed by any practitioner. For example, when the client’s status changes (i.e., a new issue is identified there may be a need to update the problem list. Documentation of Plan Development should include a description of the revision, or update made to the problem list, or a statement that the Problem List was reviewed and found to remain appropriate in addressing client’s needs

6.1.3. REHABILITATION

This is a recovery or resiliency-focused service activity identified to address a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary’s functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the individual. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided in an individual or group format.

This procedure is used to document services that assist the client in improving a skill or the development of a new skill set.

6.1.4. THERAPY

A therapeutic intervention is one that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist an individual in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to an individual or a group of individuals or may include family therapy directed at improving the individual's functioning and at which the individual is present.

Progress notes need to adequately document the therapeutic intervention(s) or therapy activity that was provided.

Only Licensed/Registered/Waivered Staff and trainees who have the necessary training and experience can provide therapy.

Group Therapy - Services provided in a group format. These may be facilitated by multiple practitioners.

When a group service is rendered, a list of group participants needs to be maintained. Should more than one practitioner render a group service, one progress note may be completed for a group session and signed by one practitioner. While one progress note with one practitioner signature is acceptable for a group activity where multiple providers are involved, the progress note should clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity. Travel and documentation time should be captured separately.

Family Therapy

There are many times when family therapy is warranted in treatment, particularly in children's services in order to assist the client. Family Therapy involves the client and one or more family members for the purpose of addressing the client's behavioral health impairments through changes in family member interactions.

May include:

- ✓ support family members to understand client's mental health impairments
- ✓ the family member learning coping strategies to support the client
- ✓ improve family communication and resolve conflicts
- ✓ facilitate attachment between child and caregiver
- ✓ teach, model and reinforce parenting skills

6.1.5. COLLATERAL

This is described as a service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client plan goals.

Note: With the transition to CalAIM claiming on 7/1/2023, collateral services can no longer be claimed as a distinct stand-alone service.

However, the activity formerly known as a "collateral" service may be included as an aspect of all other claimable services except Therapy. Documentation of the collateral activity should be included the narrative of the claimable service.

Collateral activity may include the following:

consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services;

consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary;

family counseling with the significant support person(s) to improve the functioning of the beneficiary.

6.1.6. MEDICATION SUPPORT SERVICES

Services provided by medical staff which include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.

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 supports beneficiaries in taking an active role in making choices about their behavioral health care and helps them make specific, deliberate, and informed decisions about their treatment options.

TYPES OF MEDICATION SERVICES

- ASSESSMENT MD
  Initial Assessment including medical and psychiatric history, current medication, chart review. Observation of need for medication due to acuity. Consultation with clinician, M.D., or nurse regarding medication.
- MEDICATION SUPPORT – EXISTING CLIENT
  Prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, side effects and compliance to medication. Obtaining informed consent for medications.
- MEDICATION INJECTION
  Specifically for the injection and all that an injection entails under guidelines of administration/evaluation of medication.

6.1.7. TARGETED CASE MANAGEMENT (Case Management/Brokerage/Linkage)

Services that assist a person in care 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 access to service and the service delivery system; monitoring of individual progress.

Case management is identified in SmartCare as "Targeted Case Management" and used to be referred to as Brokerage.

When Targeted Case Management services are provided to support a client, they must have a TCM specific treatment plan, which should be imbedded within the narrative of the /service note.

Targeted Case Management 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.

Targeted Case Management services 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 brokerage is billable for clients in acute settings like the hospital (e.g. Marin General Inpatient Psychiatric Unit). For clients in these facilities, brokerage services are billable only for the following purpose:

- Use TCM when services are directly related to discharge planning for the purpose of coordinating placement of the client upon discharge. These services are limited to within 30 days of discharge from the acute setting.
- Use keywords like "Placement" or Discharge Planning" in the narrative.

6.1.8. PEER SUPPORT SERVICES

Peer support services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower individuals through strength-based coaching, support linkages to community resources, and to educate individuals and their families about their condition and the process of recovery. Peer support services may be provided face-to-face, by telephone or by telehealth with the individual or significant support person(s) and may be provided anywhere in the community.

Service types are Individual and Group Peer Services.

Activities can include:

- encouragement and support for individuals to participate in behavioral health treatment
- supporting beneficiaries in their transitions between levels of care
- supporting beneficiaries in developing their own recovery goals and processes
- Provide a supportive environment in which individuals and their families can learn coping mechanisms and problem-solving skills

Peer support services may be provided by a Peer Support Specialist.

These services must be based on a plan of care that should be documented within the progress notes and is approved by any treating provider.

6.1.9. CRISIS INTERVENTION

Service, lasting less than 24 hours, for a condition which requires more timely response than a regularly scheduled visit. Crisis intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Crisis intervention may be provided face-to-face, by telephone or by telemedicine with the beneficiary and/or significant support persons and may be provided in a clinic setting or anywhere in the community. Service activities may include but are not limited to assessment, collateral, and therapy. Note that billing for crisis intervention services is limited to 8 hours per instance

Examples of Crisis Intervention 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.

Crisis Assessment 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

Providers are required to complete progress notes for crisis services within 24 hours.

6.1.10. INTENSIVE CARE COORDINATION (ICC)

ICC is a targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems**.**

ICC requires a separate Care Plan.

6.1.11. INTENSIVE HOME BASED SERVICES (IHBS)

IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the Child and Family Team (CFT) in coordination with the family's overall service plan. They may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria

6.1.12. THERAPEUTIC BEHAVIORAL SERVICES (TBS)

TBS is a specialty mental health services covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. TBS are intensive, one-to-one, short-term outpatient services for beneficiaries up to age 21 designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish specified outcomes

TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility, or to enable a transition from any of those levels to a lower level of residential care.

Therapeutic behavioral services are intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or planned transition to a to a lower level of placement. The purpose of providing TBS is to further the child/youth's overall treatment goals by providing additional TBS during a short-term period.

TBS Services may be provided to children and youth under the age of 21 who, in addition to having full cope Medi-Cal meet TBS class criteria under any of the following:

- Child/Youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs.
- Child/Youth is being considered by the county for placement in a facility described above.
- Child/Youth has undergone at least one emergency psychiatric hospitalization related to current presenting mental health diagnosis within the preceding 24 months.
- Child/Youth has previously received TBS while a member of the certified class.
- Child/Youth is at risk of psychiatric hospitalization.

6.2. NON-BILLABLE SERVICES

Some services are not claimable to Medi-Cal, even though they may be useful to the client, or are important to document in the record. In this case, select Client Non-Billable Srvc as the service type. In the event of a cancellation or no show, select Cancelled or No Show.

The following services are not Medi-Cal claimable:

1. Purely clerical activities (faxing, copying, emailing, texting, leaving a voicemail, scheduling an appointment between the client and yourself, etc.)
2. Supervision. This applies to both the provision of supervision to clinical staff as well as receiving supervision from or consulting with a supervisor.
3. Traveling to a site when no service is provided due to a "no show". Leaving a note on the door of a client or leaving a message on voicemail.
4. No service provided: Missed visit. Waiting for a "no show" or documenting that a client missed an appointment.
5. Providing transportation ONLY
   - NOTE: "Travel" is not "Transportation."
   - Travel involves the provider going from their "home office," to the location where a service will be provided.
   - Transportation involves the provider taking the client/family from one location to another.

- If a claimable service is provided while a provider is transporting a client/family, then the service, not the "transportation", can be claimed. The documentation should reflect the service provided.

6. Preparing documents for court testimony for the purpose of fulfilling a requirement; whereas when the preparation of documents is directly related and reflects how the intervention impacts the client's behavioral health treatment and/or progress in treatment, then the service may be billable.
7. Completing the reports for mandated reporting such as a CPS or APS.
8. Academic/Educational services, i.e., actually teaching math or reading, etc.
9. Vocational services which have, as a purpose, actual work or work training.
10. Recreation or general play.
11. Socialization-generalized social activities which do not provide individualized feedback.
12. Personal care services provided to individuals including grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals.
13. Childcare/babysitting.
14. Case Conference attendance by non-involved/contributing staff. Only practitioners directly contributing (involved) in the client's care may claim for their services. See also Case Conferences
15. Utilization management, peer review, or other quality improvement activities.
16. Interpretation/Translation; however, an *intervention* in another language may be claimed.
17. Any service after the client is deceased. Includes "collateral" services to family members of deceased.

6.3. LOCKOUTS AND LIMITATIONS

Lockouts and limitations refer to specific billing or claiming rules that either prohibit or limit claiming. The rules are specific to different situations. Services may be provided and should be documented, but care needs to be taken regarding how the services are entered so that no prohibited claiming takes place.

LOCKOUTS exist when, due to a client staying in a specific type of facility, some or all of the usual outpatient services may not be claimed. Lockouts vary depending on the type of facility. Additional details and a list of specific facilities in the different categories can be found in the Facility Lockout Assistant.

IMDs (Institutions for Mental Disease)**, MHRCs** (Mental Health Rehabilitation Centers), **SNF** (Skilled Nursing Facility) with **STP** (Special Treatment Program): All Medi-Cal Claimable services are locked out. Use only Non-Billable service types.

Jail and Juvenile Hall: All Medi-Cal Claimable services are locked out. Use "Jail" or "Juvenile Hall" as the service location for any service if that is where the client is when providing the service. SmartCare will automatically block inappropriate claiming by using this location. Use any procedure code within scope of practice, as long as the service location is Jail or Juvenile Hall. Juvenile Hall lockout exceptions (services are billable only if):

- A dependent minor in Juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary is medi-cal eligible, or
- After adjudication for release into the community.

In these instances, choose location of "other location" and clearly document the above reasons and that minor is in Juvenile Hall in body of note

Acute psychiatric inpatient: Partial Lockout. May use TCM if service activity is documented as relating to placement or discharge planning. Additional restriction is that TCM must be within 30 days of discharge, up to 3 non-consecutive 30-day periods. Medication related services, if within scope, provided while consumer is hospitalized, use Non-Billable Medication. Other services, use the non-billable form of the service.

All services provided on day of admission, but before admission are allowed. All services allowed on day of discharge.

Crisis Residential: Partial Lockout TCM services allowed. Medication services are allowed if within scope of practice. Mental Health Services, i.e., Assessment, Plan Development, Individual, Group, Rehab, Crisis Intervention are not allowed. May use., Non-billable Chart Note.

Crisis Stabilization (CSU). Partial Lockout TCM services only allowed after admission. Other services allowed same day but prior to admission.

Medical Skilled Nursing Facilities (SNF): without Special Treatment Program (**STP**): has no Medi-Cal lockout.

Other residential treatment - Residential treatment other than Crisis Residential, such as SUS residential has no Medi-Cal lockout.

Other Acute Inpatient – Medical (non-psychiatric) Inpatient services do not have a Medi-Cal lockout.

LIMITATIONS refer to either a maximum number of hours per day that a specific type of service can be claimed for a client, or to the types of service that are allowed before the completion of a client plan, or during lapses in client plans.

Limits for Medication Support Services - The maximum amount claimable for Medication Support Services for a client in a 24-hour period is 4 hours. Is client specific and based on staff time, i.e., staff and co-staff providing a 2-hour service to a client would equal 4 hours. Note that these maximums are based on total staff time and are not program specific. For example, if an MD and an RN are co-staffing a med service that takes two hours, the claimed time is 4 hours. Also, if an MD from one program is providing a med service in the morning and an RN from another program is providing a med service in the afternoon, the time for both will count toward the daily maximum.

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 program specific, as described for medication support services.

6.4 COMBINING MULTIPLE SERVICE TYPES

Sometimes during a single session with a client, two distinct types of service get provided. While it's ok to write two separate notes for the different services, it's also acceptable to combine the services into one note. When deciding which type of service to select for claiming, staff should use the "**preponderance rule**", i.e., choose the service type that took the most time or has the most information in the note. Documentation of the preponderant service should be at the beginning of the note.

6.5 CASE CONFERENCES

A "case conference" is not a specific service type. It refers to a discussion between direct service providers that are involved in the care of the client. There are multiple options for providing and documenting this type of activity in SmartCare EHR.

Chapter 7. SCOPE OF PRACTICE/COMPETENCE/WORK

Staff must only provide services that are within their scope of practice and scope of competency. Scope of practice refers to how the law defines what members of a licensed profession may do in their licensed practice. It applies to the profession as a whole. Scope of competence refers to those practices for which an individual member of the profession has been adequately trained. Scope of work refers to limitations imposed by BHRS to ensure optimal utilization of staff resources.

Some services are provided under the direction of another licensed practitioner. "Under the direction of" means that the individual directing service is acting as a Program Supervisor or manager, providing direct or functional supervision of service delivery, or review, approval and signing client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service provided. Services are provided under the direction of a physician, a psychologist, a waivered psychologist, a licensed clinical social worker, a registered associate clinical social worker, a marriage and family therapist, a registered associate marriage and family therapist, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).

Note that with the advent of CalAIM, the use of ICD-10 diagnosis codes for “Persons with potential health hazards related to socioeconomic and psychosocial circumstances” is considered within the scope of practice for both licensed and non-licensed staff. These codes are Z55 through Z65. The complete list can be found here.

"Waivered Professional’ is defined as: A psychologist candidate, an individual employed or under contract to provide services as a psychologist who is gaining the experience required for licensure and who has been granted a professional licensing waiver to the extent authorized under State law.

Prior to providing services, “waivered” clinicians must provide the following to Marin BHRS Credentialing at: BHRSCredentialingPub@marincounty.org

- State Waiver Form
- School Transcript
- Resume

Waiver packet will be reviewed and sent to the State Compliance for processing. Waiver is good for six (6) years.

“Registered” Professional (Associate MFT*, ASW, Associate PCC*) is defined as: A marriage and family therapist candidate, a clinical social worker candidate, or a professional clinical counselor candidate, respectively, 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 or clinical social worker or professional clinical counselor licensure, to the extent authorized under state law.

Prior to providing services, “registered” clinicians must provide the following to the BHRSCredentialingPublic <BHRSCredentialingPub@marincounty.org>

- Copy of Certificate Board Issued Associate/Intern Registration

* Effective January 1, 2018, the titles for marriage and family therapist interns and professional clinical counselor interns are changed to Associate Marriage and Family Therapist or Associate Professional Clinical Counselor.

7.1. Scope of Practice Matrix

	Physician	Licensed or Waivered Psychologist (post doctorate)	Licensed, Registered or Waivered staff: ACSW/ LCSW, AMFT/ LMFT, APCC/ LPCC (post MA/MS)	RN with Masters in MH Nursing or related field	Psychiatric Nurse Practitioner	Registered Nurse	Licensed Vocation Nurse/ Licensed Psychiatric Technician	Mental Health Rehabilitation Specialist: BA/ BS in MH related field and 4 yrs. MH experience	Certified Peer Specialist+*	Other Qualified Staff approved by BH Director: typically, 18+, High School Equivalency, Driver' s License
Assessment: MH + medical history (hx), Substance use + exposure, strengths, risks, barriers to achieving goals	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	No	Yes*
Assessment: Diagnosis, MSE, medication hx, assessment of relevant conditions and psychosocial factors affecting the person's physical and MH	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes++	Yes++	Yes++	No	Yes*,++
Intensive Care Coordination (ICC)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	No	Yes*
Intensive Home-Based Services (IHBS)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	No	Yes*
Medication Support	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Medication Prescribing	Yes	No	No	No	Yes	No	No	No	No	No
Medication Administering	Yes	No	No	Yes	Yes	Yes	No	No	No	No
Medication Dispensing	Yes	No	No	Yes+	Yes	No	Yes	No	No	No
Psychological Testing	No	Yes	No	No	No	No	No	No	No	No
Psychotherapy	Yes	Yes	Yes	No	Yes	No	No	No	No	No
Rehabilitation Counseling	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	No	Yes*
Peer Support Services (Self Help/Peer Services; Behavioral Health Prevention Education Service)	No	No	No	No	No	No	No	No	Yes*	No
Targeted Case Management/	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes	No	Yes*
Therapeutic Behavioral Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	No	Yes*

*Under the direct supervision of an LPHA/LMHP

+ Training and certification requirement may apply

++ May require close supervision if issues of danger to self or others are present

+++ Typically limited to post-master's doctorate students

+* While other services may be technically allowable depending on an individual's classification, Certified Peer Specialists mainly utilize the Peer Support Service codes.

7.2. UTILIZATION REVIEW

State regulations and BHRS policies specify that all beneficiary health records, regardless of format (electronic or print) go through the Utilization Review (UR) process. This process is meant to ensure that all planned clinical services are appropriate to address the client's behavioral health needs. It is also meant to make sure that the records comply with all State and Federal regulations as well as BHRS Policies. Utilization Review includes the evaluation and improvement of services through the following practices:

- Medication Monitoring
- Outpatient Programs Utilization Review
- Contract Provider Utilization Review
- Inpatient Utilization Review

The role of the Utilization Reviewers is critical as they provide clinical oversight and function as a "check and balance" system. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote quality and compliance. The reviewers are license-eligible, licensed, and/or waivered BHRS staff. Utilizing a UR tool, the reviewers provide feedback to the Quality Improvement Coordinator who is responsible for tracking any findings and following up on any quality issues and identify items that may indicate Fraud, Waste, or Abuse.

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse within the service provision and claiming system. Disallowances in audits will only occur when there is evidence of fraud, waste, and abuse. These are generally defined as follows:

Waste is an unintentional overutilization, under utilization, or misuse of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Programs and individuals may receive information regarding quality improvement items identified through the UR process. Notification is through the UR Report and these items will require a Plan of Correction. Information on trends will also be used when considering the training needs of individual staff and the organization.

Prospective clients should be given the necessary information about the range of services to be provided prior to admission so that the proposed services are clearly understood. This enables the client the opportunity to exercise control about health care decisions that affect them.

Adults, including those receiving behavioral health treatments, have by law the right to give or refuse consent to medical diagnostic or treatment procedures. Generally, minors need the consent of their parents to receive mental health services unless the minor has the right to consent to care under minor consent laws, discussed in the Minor consent section below.

Information about the consents in SmartCare can be found in the Privacy and Consents section of CalMHSA's 2023 Clinical Documentation.

An important part of informed consent is the person's capacity to consent. A person is deemed to have legal capacity to consent to treatment if he/she has the ability to understand the nature and consequences of the proposed health care, including its significant benefits, risks and alternatives (including doing nothing), and can make and communicate a health care decision. A person's lack of mental capacity to consent to medical care may be temporary or it may be permanent, and the provider should determine capacity on a case-by-case basis whenever consent is sought. For example, a client who is clearly under the influence of drugs or alcohol may lack capacity temporarily, but could provide consent at a later time, when not so impaired. If you have any questions regarding a beneficiary's ability to consent, please consult with your supervisor and Quality Improvement.

Telehealth

Telehealth Consent: Providers must also inform the client about the use of telehealth and obtain verbal or written consent from the client for the use of telehealth as an acceptable mode of delivering services at least once prior to initiating services via telehealth. Also, it must be explained that clients have the right to access services that may be delivered via telehealth through an in-person, face-to-face visit. Telehealth Consent form is in SmartCare.

8.1. MINOR CONSENT

This section provides guidance regarding consent for health care services for minors receiving services from BHRS. The terms *health care* and *medical care* include Assessment, care, services or referral for treatment for general medical conditions, mental health issues, and alcohol and other drug treatment. As with adult clients consenting for their own services, parents or minors who can consent for their own services have the fundamental right to consent to or refuse medical treatment.

Generally speaking, minors need the consent of their parents to receive mental health services unless the minor has the right to consent to care under minor consent laws (see Circumstances That Allow for Minor to Consent to Their Own Services). Only one parent is necessary to provide consent unless we are aware of evidence that the other parent has objected. Adoptive parents have the same rights to consent as natural parents.

In the case of divorced parents, the right to consent rests with the parent who has legal custody. If the parents have "joint legal custody" usually either parent can consent to the treatment unless the court has required both parents to consent. In most situations, we can presume that either parent can consent unless there is evidence to contrary. Some teams prefer to obtain consent from both parents. This is not a legal requirement, but this is acceptable within BHRS as long as it does not pose a significant detriment or cause harmful delay to the treatment of the client.

A parent or guardian who has the legal authority to consent to care for the minor child has the right to delegate this authority to other third parties (aged 18 and older); for example, the parent may delegate authority to consent to medical care to the school, to a coach, to a step-parent, or to a baby-sitter who is temporarily caring for the child while the parent is away or at work. A copy of the written delegation of authority should be scanned into the electronic health records.

In some cases, a “surrogate parent” is raising a minor child. If this adult is a *qualified relative* (often the grandparent, or an aunt or uncle, or older sibling) who has stepped into the role of parent because the biological parents are no longer willing or able to care for the child, he or she should fill out the ***Caregiver's Affidavit*** form which is used widely throughout California.

These so-called Caregivers who have "unofficially" undertaken the care of the child are authorized by law to consent to most medical and mental health care and to enroll these children in school. Once they have completed the ***Caregiver's Affidavit*** form (which is then scanned into the electronic health records) they may consent to medical or mental health care for the minor child; however, if the parent(s) returns, the "caregiver's" authority is ended, and once again the parent has authority to consent to or refuse care for the child. A Caregiver’s Affidavit does not have to be “renewed” and can remain in effect until the parent returns, or until the child turns 18.
The court has the power to authorize medical and mental health treatment for abandoned minors and for minors who are dependents or wards of the court (for example, youth in foster care or juvenile hall). Furthermore, the court may order that other individuals be given the power to authorize such medical and mental health treatment as may appear necessary, if the parents are unable or unwilling to consent. In some circumstances a court order is not necessary. For example, under certain circumstances, a police officer can consent to medically necessary care for a minor who is in "temporary custody."

In situations where some adult other than the parent or guardian is providing consent, (unless it is an emergency) care must be taken to establish a non-parent's legal authority to consent to care before treatment begins. Often this requires identification of the child's status as well as the ability or inclination of the natural parents to provide consent. A copy of the Court Order delegating this authority (to a Foster Parent, for example) should be scanned into the electronic health records before care is provided. For those treatments for which a minor can legally provide his or her own consent, no court order or other authorization is necessary when treating a dependent or ward.

In rare situations a court may summarily grant consent to medical or mental health treatment upon verified application of a minor aged 16 or older who resides in California if consent for medical care would ordinarily be required of the parent or guardian, but the minor has no parent or guardian available to give the consent. A copy of the court order should be obtained and scanned in the minor’s electronic health record before treatment is provided pursuant to the order.

Consent from the parent is not required if the minor is involuntarily held for 72-hour Assessment and treatment pursuant to Welfare and Institutions Code 5585.2 or 5150 et seq.

Circumstances that Allow for Minor to Consent to Their Own Services.
Minors generally need a parent to consent to healthcare services because minors suffer automatic legal incapacity due to their young age. However, there are certain minors who can consent for their own services.

These minors are:

A. Minors who are treated as "adults" under the law for purposes of medical consent. These are:
    - Emancipated minors
    - Self-sufficient minors

B. Minors seeking *sensitive services*

These minors do not suffer automatic legal incapacity due to their young age but must still display legal capacity. As with adults, legal capacity to consent to services indicate an ability to understand the nature and consequences

of the proposed health care, including its significant benefits, risks, and alternatives; make a health care decision; and communicate this health care decision.

Emancipated Minors include:

- Minors 14 and older who have been emancipated by court order.
- Minors who are serving in the active US military forces; and
- Minors who married or who have been married

Before providing services to these minors, we should obtain a copy of their emancipation card or court order, a copy of their military ID card, or a copy of their wedding certificate and scan these documents into their electronic health records.

Self-sufficient minors are defined by law as minors aged 15 and older who are living separate and apart from their parents and who are also managing their own financial affairs regardless of their source of income. Even though self-sufficient minors can consent to outpatient mental health services such as therapy, rehabilitative counseling, and brokerage, the law is not clear whether or not self-sufficient minors can consent to psychotropic medication treatment. Please consult with your supervisor and Quality Improvement if psychotropic medication treatment is part of the services being sought by a self-sufficient minor.

Minors seeking certain sensitive services may be legally authorized to provide their own consent to those services. The minor also controls whether or not the parent will have access to records generated as a result of receiving those services. When minor consent applies, sensitive services should not be provided over the minor's objection; in other words, ***even if the parent provides consent, non-consent by the qualified minor presents ethical issues and provision of care should be delayed until consultation using the chain of command can be obtained on a case-by-case basis.***

Minors 12 or older may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem; since the law deems such minors to be legally competent to consent to such care, parents or guardians have no legal authority to demand drug testing of their minor children who are 12 or older. The law requires providers to involve the patient or legal guardian in the care, unless to do so would be inappropriate. The decision and reasons to involve, or not involve, the parent/legal guardian needs to be recorded in the electronic health records, as well as staff efforts to involve them.

There are two separate California laws that permit minors 12 and older to consent to outpatient mental health counseling services. The first is Family Code 6924(b). It states that minors 12 and older may consent to mental health treatment or counseling on an outpatient basis (and also, to residential shelter services), if both of the following requirements are satisfied:

1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services, **and**

2) The minor would either present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services or is the alleged victim of incest or child abuse.

The second, more recent law is found at Health and Safety Code section 124260. It removes the requirement that the provider must first determine that the minor 12 and older be “at risk” before services can be provided. Instead, the provider need only determine that the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient mental health services. The attending professional person should clearly chart that any required “qualifying” criteria have been met if services are provided pursuant to either of these provisions of the law.

When outpatient mental health care or residential shelter services are provided, the laws state that it shall include the involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person must state in the

electronic health record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian. (Note: If outpatient mental health services are provided pursuant to Health and Safety Code 124260, the law states that the decision to involve, or not involve, the parents shall be made in collaboration with the minor patient.).

It needs to be reiterated that even though a minor 12 or over can provide their own consent for sensitive services related to substance abuse and mental health, mental capacity to provide consent and informed consent is still required. If a minor who otherwise qualifies for minor consent lacks mental capacity, and insists that there not be parental involvement, staff should consult with their supervisor and Quality Improvement so that appropriate steps may be taken.

Note: Psychotropic medication treatment is not one of the sensitive services that a minor can consent for. Parent/guardian consent is required if psychotropic medications are prescribed. Parent/guardian consent is also needed if voluntary inpatient mental health facility services are provided. Further, the minor consent laws do not authorize a minor to consent to convulsive therapy or psychosurgery.

See also http://www.calhospital.org/sites/main/files/file-attachments/qrg_medical_treatment_of_minors.pdf
http://www.teenhealthlaw.org/

8.2. MEDICATION CONSENT

A Medication Consent form must be obtained and retained at the time of initiating an antipsychotic medication. Notation within the progress notes will suffice that informed consent was obtained and patient states understanding for other psychotropic medications. Requirements for REMS drugs (e.g. Clozaril) are separate and may still require written consent. It is good practice to document a discussion about risks of not taking as prescribed, what side effects for client to be aware of, and other education about risks and benefits of taking or not taking the recommended medication. The MD/NP is also responsible for providing information to client about the specific medication, preferably in written form, at minimum verbally. This provision of information should be documented in the note.

Chapter 9. DOCUMENTATION REQUIREMENTS FOR SPECIFIC PROGRAM TYPES

9.1. FULL-SERVICE PARTNERSHIP (FSP)

Mental Health Service Act funds programs including Full-Service Partnerships (FSP) The intent of these programs is that mental health service providers work in partnership with clients, their family, caregivers, other providers, and community to provide a full range of services. These services include planning, policy development, service delivery and evaluation in areas such as drop-in centers, peer support centers, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services while taking into consideration the individual's goals, strengths, needs, race, culture, concerns, and motivations.

Each FSP site is responsible for maintaining outcome measurements and data collection based on the four age-groupings as specified in the Community Services and Supports (CSS) Plans:

- Youth (ages 0-15)
- Transitional Age Youth (ages 16-25)
- Adults (ages 26-59)
- Older Adults (ages 60+)

The following forms are required for this program:

- Outcome Measurements Application Baseline (Partnership Assessment Form - PAF)
- KET (Key Event Tracking)
- 3M forms (Quarterly Assessment)

Outcome Measurements Application Baseline (Partnership Assessment Form- PAF):
A baseline Assessment should be completed within the first 30 days after starting the FSP. The PAF to establish baseline is done at time of entry into an FSP program. A PAF is valid until the consumer has been disenrolled from a program **AND** a lapse of 365 days has occurred since the PAF was discharged. If the program receives a consumer with an existing PAF, meaning that no lapse of 365 or greater has occurred between events, then the program must enter a KET for admission into the program.

Key Event Tracking Changes (KET):

This form is used to enter key events. A program only needs to complete the section of the KET for which a change is being reported, with three exceptions: disenrolling a client, transferring a client, or receiving a transferred client.

When a consumer changes from one program to another, the **Referring** program must complete a KET document indicated the transfer. The **Receiving** program must immediately complete a KET document to complete the transfer process.

If a program opens a consumer for FSP services after the consumer has been closed to another FSP program, but less than 365 days have lapsed since the discharge from the previous FSP program, the new program must complete a KET document—a PAF should not be completed, unless more than 365-day lapse has occurred.
Note: The changing of an apartment but staying within the same complex does not constitute a need to complete a new form.

3M Forms:

The three-month Assessment (3M) is due on every three-month anniversary of the start date [Baseline Partnership Date – the date FSP services were first provided, not outreach and engagement; there must be an episode opening in the Integrated System (IS)]. There is a 15-day window prior to the three-month anniversary and 30 days after to complete it.

10.1. EXAMPLES OF STRENGTHS

Strengths refer to individual and environmental factors that increase the likelihood of success. Therefore, it is not only important to recognize individual and family strengths, but to *use* these strengths to help them reach their full potential and life goals.

- Motivated to change
- Has a support system –friends, family, etc.
- Employed/does volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Has insight into symptoms/impairments
- Sees value in taking medications
- Has a spiritual program/connected to church
- Good physical health
- Adaptive coping skills
- Capable of independent living
- Interested in restoring relationships

10.2. EXAMPLES OF INTERVENTION WORDS

Assess
Refer
Explore
Identify
Clarify
List
Discuss
Reinforce
Evaluate
Utilize
Encourage
Support
Arrange
Analyze
Develop
Interpret
Reframe
Facilitate
Practice
Connect
Educate

10.3. EXAMPLES OF INTERVENTIONS PHRASES FOR SPECIFIC PSYCHIATRIC SYMPTOMS, CONDITIONS.

ANXIETY

- Assess reasons for symptoms of anxiety
- Explore triggers/situations
- Refer for medication evaluation to address
- Encourage reading on subject of anxiety
- Discuss how medication is helping
- Explore benefits/changes in symptoms
- Teach relaxation skills
- Utilize relaxation homework to reinforced skills learned
- Analyze fears, in logical manner
- Develop insight into worry/avoidance
- Identify source of distorted thoughts
- Encourage use of self-talk exercises
- Teach thought stopping techniques
- Identify situations that are anxiety provoking
- Teach/practice problem-solving strategies
- Encourage routine use of strategies
- Identify coping skills that have helped in the past
- Validate/reinforce use of coping skills
- Identify unresolved conflicts and how they play out

BORDERLINE PERSONALITY

- Assess behaviors and thoughts
- Explore interpersonal skills
- Explore trauma/abuse
- Validate distress and difficulties
- Explore how DBT may be helpful
- Encourage outside reading on BPD
- Explore risky behaviors
- Explore self-injurious behaviors
- Improve insight into self-injurious behaviors
- Assess suicidal behaviors
- Encourage and practice use of coping skills
- Identify and work through therapy interfering behaviors
- Discuss benefits/effectiveness of medication
- Educate on skills training
- Encourage use of skills training skills
- Explore all self-talk
- Reinforce use of positive self-talk
- Explore and identify triggers
- Review homework
- Review Diary Card
- Reinforce completion of homework/diary card
- Reinforce use of DBT skills
- Encourage/reinforce trust in own responses

SUBSTANCE USE/ABUSE (within practitioner's scope of practice)

- Explore drug/alcohol history
- Refer for physical exam to primary care physician
- Encourage follow up with physician
- Support and encourage evaluation for psychotropic medication
- Discuss benefits/effectiveness of medication
- Encourage participation in appointments with psychiatrist
- List/identify negative consequences of substance use/abuse
- Educate on consequences of substance use on mental health
- Encourage to remain open to discussion around denial/acceptance
- Encourage participation in AA/NA
- Support participation of AA/NA
- Refer to inpatient/outpatient program
- Support/reinforce client's participation in substance abuse treatment
- Facilitate/explore understanding of risk factors
- List positive aspects of sobriety
- Reinforce development of substance free relationships
- Review effects of negative peer influences
- Encourage exercise and social activities that do not include substances
- Encourage positive change in living situation
- Identify positive aspects of sobriety on family unit/social support system
- Reinforce working on sobriety
- Explore effects of self-talk
- Reframe negative self-talk
- Assess stress management skills
- Teach stress management skills
- Reinforce use of stress management skills
- Explore effective after-Client Plan

TRAUMA

- Work together on building trust
- Explore issues around trust
- Teach/explore trust in others
- Research family dynamics and how they play out
- Explore effects of childhood experiences
- Encourage healthy expression of feelings
- Encourage use of journaling
- Encourage outside reading on trauma
- Explore how trauma impacts parenting patterns
- Educate on dissociation as a coping response
- Explore history of dissociative experiences
- Support confronting of perpetrator
- Utilize empty-chair exercise to work through trauma
- Explore/identify benefits of forgiveness
- Explore roles of victim and survivor and how they are playing out

DEPENDENCY

- Explore history of dependency on others
- Identify how fear of disappointing others affects functioning

- List positive aspects of self
- Assign positive affirmations
- Identify how distorted thoughts affect understanding
- Explore fears of independence
- Identify ways to increase independence
- Teach and reinforce positive self-talk
- Explore effects of sensitivity to criticism
- Educate on co-dependency
- Explore issues around co-dependency
- Educate on benefits of assertiveness skills
- Teach/practice assertiveness skills
- Reinforce/encourage assertiveness
- Encourage use of “No”
- Identify and list steps toward independence
- Identify ways of giving without receiving
- Teach about healthy boundaries
- Practice/reinforce/model use of healthy boundaries
- Encourage decision making

DEPRESSION

- Assess history of depressed mood
- Identify symptoms of depression
- Identify what behaviors associated with depression
- Explore/assess level of risk
- Assess/monitor suicide potential and risk
- Teach and identify coping skills to decrease suicide risks
- Identify patterns of depression
- Encourage journaling feelings as coping skill
- Identify support system
- Develop WRAP plan
- Encourage use of WRAP plan
- Encourage/reinforce positive self-talk
- Explore issues of unresolved grief/loss
- Teach/identify coping skills to manage interpersonal problems
- Reinforce/recommend physical activity
- Monitor and encourage self-care (hygiene/grooming)
- Normalize feelings of sadness and responses
- Explore potential reasons for sadness/pain
- Connect anger/guilt with depression

FAMILY CONFLICT

- Explore patterns of conflict within the family
- Teach conflict resolution
- Explore familial communication patterns
- Facilitate family communication
- Identify how family patterns of conflict and communication are played out
- Facilitate healthy expression of feelings/concerns
- Reinforce use of healthy expression of feelings
- Identify/reinforce family strengths
- List ways family may participate in healthy activities in community
- Define roles in the family

- Identify areas of strength that may be used to parent
- Teach/practice/model parenting techniques
- Identify patterns of dependency on family members
- Identify feelings of fear/guilt/disappointment
- Explore/identify patterns of dependency within family unit

BIPOLAR DISORDER

- Explore symptoms concerning bipolar disorder
- Educate on mania and depression
- Use reflection to identify mania/depression behaviors
- Educate on risky behaviors associated with mania
- Explore behaviors associated with mania
- Identify coping skills
- Identify early warning signs and energy levels
- Explore grandiosity
- Encourage/discuss effectiveness of medication
- Encourage participation in appointments with psychiatrist
- Identify effects of tress on psychiatric symptoms
- Identify/discuss issues of impulsivity
- Discuss consequences of impulsivity
- Model/reinforce effective communication
- Utilize cognitive reframe
- Encourage education on bipolar disorder

MEDICAL ISSUES

- Gather information regarding medical history
- Identify who is primary care physician
- Encourage follow through with medical recommendations
- Identify/explore negative consequences of no following through
- Educate on grief/loss issues and impact on openness to medical treatment
- Explore denial around recommended medical treatment/follow up
- Process feelings of fear/ambivalence/anxiety
- Normalize feelings of fear/ambivalence/anxiety
- Teach relaxation exercises
- Monitor/encourage compliance with medical recommendations
- Reinforce use of coping skills during medical appointments
- Reinforce communication skills to ask for clarity
- Reinforce assertiveness skills
- Encourage use of social support system

10.4. Sample Progress Note Narratives

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Assessment:
Met with client for clinical interview to inform the initial intake assessment. Information gathered included the reason(s) for seeking treatment, current mental state, history of the presenting problem, and impairments caused by the problem. Assessed the client's experience of trauma, behavioral health history, substance use disorders, medical history, current medications, and how their culture, religion, and spirituality influence their beliefs about mental health. Based on the information gathered, a diagnosis of schizoaffective disorder has been documented. These symptoms impair the person's ability to perform daily activities, maintain social relationships, and hold steady employment. A clinical summary and treatment recommendations were also documented in the assessment. Next steps include scheduling weekly Individual Therapy sessions with the client and collaborating with treatment team to determine the most appropriate interventions to assist with addressing the client's symptoms of schizoaffective disorder.

Assessment:
Reviewed information gathered from various sources (including x, y, z) to inform the 7 domains of the client's initial assessment and established a preliminary diagnosis of Major Depressive Disorder, Recurrent, Severe. Client exhibits and reports symptoms of depression, suicidal and self-injurious behavior, aggression toward others, and running away. The client's last substance use occurred a month ago, and there was no current suicidal ideation. The clinician plans to meet with the person in care, family, and Child and Family Team to update the problem list and formulate a plan for ongoing care.

Therapy:
Checked-in with person in care using scaling question to determine the person's current level of anxiety on a scale from 0-10 with 0 being none and 10 being most ever. Clinician explored what would make person's anxiety rating a point higher and a point lower. Clinician asked exception-seeking questions to explore times in which person in care has experienced lower ratings of anxiety and explored what was different about those situations. Clinician asked how they would know if their anxiety was completely gone and what would be different. Clinician plans to continue to meet with person in care weekly to work toward achieving person in care's therapy goals which include x, y, z.

Rehabilitation: This writer facilitated mindfulness-based breathing exercise to assist client with strengthening stress management skills, which directly impacts their experience of depression symptoms. This writer revisited body scan exercise introduced in the previous rehabilitation session to continue building self-awareness and manage physical symptoms of sadness. To assist with managing sadness, writer facilitated behavioral activation (outdoors) activity enjoyed by person in care, to build consistency and routine. Writer encouraged person in care to continue practicing skills to manage symptoms of depression that include sadness until the next rehabilitation session.

Case Management:
This staff contacted FSP and spoke with intake counselor to obtain information about the appropriateness of their program to meet client's needs. Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Program indicated client seemed appropriate for their services and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend this program.

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APPENDICES

GLOSSARY

ANSA-Adult Needs and Strengths Assessment (ANSA) is an instrument that may be used to help identify the client and family strengths and needs. The results are useful when identifying treatment goals.

CalAIM-California Advancing and Innovating Medi-Cal initiative is a population health approach that prioritizes prevention and whole person care. In Behavioral Health, it will promote better integration with physical health care. It will streamline policies to improve access to behavioral health services, simplify how these services are funded, and support administrative integration of mental illness and substance use disorder treatment.

CANS-Child and Adolescent Needs and Strengths (CANS) is an instrument used to help identify the client and family strengths and needs. These results are useful when identifying and addressing treatment goals.

HIPAA- Health Insurance Portability and Accountability Act: includes the protection of the privacy of individually identifiable health information. As part of this protection, release of information is required to share any information pertaining to client's care/services.

Interventions refer to what the practitioner will do in order to assist client with meeting their objective and life goals. These are what drive reimbursements.

Medi-Cal refers to Medicaid program in California from which reimbursements for medically necessary services are received.

Notice of Adverse Beneficiary Determination (NOABD) is a written notice that gives Medi-Cal Beneficiaries an explanation when a denial or only a limited authorization is made in response to a request for services.

Objectives refer to the smaller accomplishments/steps the *client* makes in order to achieve their life goals.

Practitioner-Licensed/Associate/Licensed-Waived/Trainee provider of MH services.

Problem List is a list of diagnoses, identified concerns, and issues to identify person's care needs.

PHI-Protected Health Information The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. The Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Authorization to Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information refers to a document signed by client and provider that permits specified information to be shared among designated persons and/or agencies regarding client's services and or treatment plan, for a designated period of time.

"Significant Support Person" means persons, in the opinion of the client or the person providing services, who have or could have a significant role in the successful outcome of treatment, includes parents, legal guardians, other family members, or other unrelated individuals, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client.

Stage of Change or Stage of Recovery refers to practitioner's impression of where the client is; Client's stage of readiness to make changes to improve their quality of life; stage of change will inform treatment plan goals and interventions.

Treatment Plan – requirement for some specific types of services. In some instances may be imbedded within a progress note. Specifics are noted in service description section.

Appendix B.

DHCS Priority Social Determinants of Health (SDOH) Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home

Z63.72 Alcoholism and drug addiction in family

Z65.1 Imprisonment and other incarceration

Z65.2 Problems related to release from prison

Z65.8 Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Appendix C.

Abbreviations, Acronyms, & Symbols

Abbreviations and Acronyms

A/O	Alert and oriented
AAOX 1-4	Alert and oriented times 1,2,3,4,
ACE	Adverse Childhood Experience
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL's	Activities of Daily Living
ADV. Dir.	Advanced Directive
AH	Auditory hallucinations
AIDS	Acquired Immune Deficiency Syndrome
AIMS	Abnormal Involuntary Muscle Scale
aka	also known as
AMA	Against Medical advice
AOD	Alcohol and other drugs
approx	approximately
Appt	Appointment
ARBD	Alcohol Related Birth Defects
ASAP	As soon as possible
ASPD	Anti-Social Personality Disorder
avg.	average
AVH	auditory or visual hallucinations
AWOL	absent without leave
B.A.L.	blood alcohol level
B.I.D.	2 times a day
b/c	because
b/f	boyfriend
BCP's	birth control pills
BDD	Body Dysmorphic Disorder
BHIN	Behavioral Health Information Notice
BHP	Behavioral Health Practitioner
BIB	Brought in by
bio	biological
BIPOC	Black, Indigenous and People of Color
BM	bowel movement
BMR	Basal metabolic rate
BO	body odor
BP	blood pressure
BPD	Borderline Personality Disorder
bro.	brother
BS	Blood Sugar
Btw	by the way
Bx	behavior

c/o	compliant of/complaining of
CA	Carcinoma or cancer
CalAIM	California Advancing and Innovating Medi-Cal
CANS	child adolescent needs and strengths
Cauc.	Caucasian
CBC	Complete blood count
CBT	Cognitive Behavioral Therapy
cc	cubic centimeter
CD	Chemical Dependency
CFS	Chronic Fatigue Syndrome
CFT	Child family Team
cigs	cigarettes
CISD	Critical Incident Stress Debriefing
clt.	Client
CMS	Centers for Medicare & Medicaid Services
CNS	Central nervous system
conc.	concentrate
cont.	continued
COPD	Chronic Obstructive Pulmonary Disease
CP	Client Plan
CPR	cardiopulmonary resuscitation
CPT	Current Procedural Terminology (billing codes)
CSU	Crisis Stabilization Unit
CVA	cerebrovascular accident
CVD	cardiovascular disease
CXR	chest x-ray
D/C or d/c	Discontinue
DBT	Dialectical Behavior Therapy
DD	Developmental Disability
DDNOS	Dissociative Disorder Not Otherwise Specified
Dec.	Decanoate
DHCS	Department of Health Care Services
disc w/	discussed with
div	divorced
DM	Diabetes Mellitus
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery Services
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DNR	Do not resuscitate
DOB	date of birth

DS	discharge summary
DSM IV TR	Diagnostic & Statistical Manual of Mental Disease, 4th Ed, Text Revision
DSM-5	Diagnostic & Statistical Manual of Mental Disease, Fifth Edition
DTO	danger to others
DTS	danger to self
DT's	Delirium Tremens
dui	driving under the influence (alcohol)
DV	Domestic Violence
dwi	driving while intoxicated
Dx	Diagnosis
e.g.	for example
ECG or EKG	electrocardiogram
ECT	Electroconvulsive Therapy
EEG	electro encephalogram
EMDR	Eye Movement Desensitization Reintegration
enc	encourage
EPS	Extrapyramidal Syndrome of Side Effects
EPSDT	Early & Periodic Screening, Diagnosis and Treatment
ER	emergency room
est	estimate
Et al.	An Others
EtOH	Ethyl Alcohol
eval	evaluation
F/T	full time
F/U or f/u	Follow up
Fa	Father
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
Fdbk	Feedback
FFP	Federal Financial Participation
FFS	Fee-for-Service
FM	Fibromyalgia
FMS	False Memory Syndrome
FSP	Full Service Partnership
FY	fiscal year
GAD	Generalized Anxiety Disorder
GAF	Global Assessment of Functioning Scale
GD	Gravely Disabled; Grave Disability
gf or g/f	girlfriend
GI	gastrointestinal
gm	gram
group tx	group therapy
H & P	History & Physical

H.S.	Hour of sleep or p.m.
H/O	history of
H_2O	water
HA	headache
halluc.	hallucination
HBP	High Blood Pressure
HCPCS	Healthcare Common Procedure Code System
Hct	hematocrit
HEP A, B, or C	Hepatitis A, B or C
Hep Lock	Heparin Lock
HI	Homicidal ideation
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HOH	Hard of Hearing
hosp	hospital
HPI	History of present illness
HTN	Hypertension
husb	husband
HV	home visit
Hx	History
I & O	intake and output
i.e.	In other words
IBS	Irritable Bowel Syndrome
ICD-10	International Classification of Diseases, Tenth revision
ICU	Intensive care unit
ID	identification
ID	Identification
IEP	Individualized Education Plan
IM	intramuscular
IMD	Institute of Mental Disease
inc.	increase
info.	information
inj.	injection
Inpt.	Inpatient
int	internal
IOR	ideas of reference
IP	Internal preoccupation
IQ	Intelligence Quotient
IV	intravenously
juv.	juvenile
Kg	Kilogram
LAI	Long acting injectable
LGBTQ+	: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and others

LOC	Level of Care
L.M.	Left message
lb	pound
LD	Learning Disabled
lg	large
LiCO3	Lithium Carbonate
LPHA	Licensed Practitioner of the Healing Arts
LPS	Lanterman, Petris, Short
m	male
M/C	Medi-Cal
MAOI	Mono-amine oxidase inhibitor (class of anti-depressants)
MAT	Medication for Addiction Treatment
max.	maximum
MCP	Managed Care Plans (Physical Health)
MCO	Managed Care Organization
MDO	Mentally Disordered Offender
med.	medicine
Med. Hx	Medical History
Meds	Medications
meth.	methamphetamines
mg.	milligram
Mgmt.	Management
mgs	message
MHP	Mental Health Pan
MI	Motivational Interviewing
min	minimum
MJ	marijuana
ml	milliliter
mm	millimeter
Mo	Mother
Mos.	Months
MRI	Magnetic Resonance Imaging
MSE	Mental Status Exam
MTBI	Mild Traumatic Brain Injury
MVA	motor vehicle accident
N/A	Not Applicable
N/V	nausea and/or vomiting
narc	narcotics
neg	negative
neuro	neurological
NKA	No Known Allergy
NKDA	No Known Drug Allergies
NLP	Neurolinguistic Programming
NOABD	Notice of Adverse Benefit Determination
NOA's	Notice of Action (ABCD & E) (Obsolete forms)

noc	night
NOPP	Notice of Privacy Practices
NOS	Not otherwise specified
NPO	nothing by mouth
NRR	Normal rate and rhythm
NS	No show
NSG	nursing
NTE	Not to exceed (usually given as part of PRN RX)
O/N	overnight
OCD	Obsessive-Compulsive Disorder
OD	overdose
ODD	Oppositional Defiant Disorder
OP	Outpatient
oriented X3	oriented in all spheres: person, place & date/time
OT	occupational therapy
OTC	over the counter
oz	ounce
P.C.	penal code
P.O.	By mouth
p.r.n.	Prescribed to be taken as needed or as required
P/T	part time
P/u	Pick up
PC	Phone call
PCP	Primary Care Physician
PDR	Physicians' Desk Reference
PE	physical examination
Per	In Accordance With
perp	Perpetrator
PERRLA	Pupils equal, round, reactive to light & accommodation
PHF	Psychiatric Health Facility
PI	present illness
PID	Pelvic inflammatory disease
PM	afternoon
PMS	Premenstrual Syndrome
pre	before
PSC-35	Pediatric Symptom Checklist
pt.	Patient
PTSD	Post-Traumatic Stress Disorder
Q 1 hr	every hour
Q NOC	every night
q.2 h	every second hour
Q.A.M.	Every morning
q.h.s.	At hour of sleep
q.i.d.	4 times a day

q.s.	as much as will suffice
qt	quart
R	Right
R	respiration
R X 1	repeat times one
R/O	rule out
R/S	reschedule
RE/ re:	Regarding or Concerning
reg	regular
ret'd	returned
ROI	Release of Information
ROM	range of motion
RTC	return to clinic
RTIS	responding to internal stimuli
RX	Prescription or written order by a doctor
S/R	Seclusion & Restraints
SA	substance abuse
SE	Side effects
SI	Suicidal ideation
SIB	Self-Injurious Behavior
SIP	Situation, Intervention, and Plan
SIRP	Situation, Intervention, Response, and Plan
sis	sister
SLE	Sober Living Environment
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOB	shortness of breath
SOC	Share of Cost/System of Care
SPMI	Seriously and Persistently Mentally Ill
SSDI	Social Security Disability Insurance
SSI	Symptom Severity Index/ Social Sec Insurance
SSRI	Selective Serotonin Reuptake Inhibitor
stat	immediately
STD	Sexually Transmitted Disease
Sub Q	subcutaneous
SUD	Substance Use disorder(s)
SW	Social Worker
SWF	single, white, female (marital status, race, gender)

SX /sx	Symptom
T	temperature
T.I.D.	3 times a day
T.O.	telephone order
tab	tablet
TAR	Treatment Authorization Request
TAT	Thematic Apperception Test
TC	Telephone call
TCM	Targeted Case Management
T-Con	Temporary Conservatorship
temp	temperature
TIA	Transient Ischemic Attack
TIR	Traumatic Incident Reduction
TPC	Treatment planning conference
TPR	temperature, pulse, respiration
TRO	Temporary Restraining Order
Tx	Treatment/Therapy
UA	urinalysis
unk	unknown
V.O.	Verbal Order
V/S/ v.s.	vital signs
VD	Venereal disease
VH	Visual hallucinations
VKD	Visual Kinesthetic Dissociation
VM	Voicemail
Voc	Vocational Services/Vocation Rehabilitation
Vol.	voluntary
vs	Versus
w/	With
w/c	wheelchair
w/in	within
w/o	Without
WBC	White blood count
WCB	Will call back
wk	week
WNL	Within normal limits
wt	weight
X	Times (as in 2 times per week)

Roles and Positions			
ACM	Adult case Manager	MFT	Marriage and Family Therapist
Case Mgr.	Case manager	MHRS	Mental Health Rehab Specialist

CM	Case manager	PHD	Doctor of Philosophy (Psychologist)
CMHC	Community Mental Health Counselor	P. A.	Program Assistant
EMT	Emergency Medical Technician	PD	Police Department
FNP	Family Nurse Practitioner	PO	Probation Officer
Hse Mgr	House manager	PRT	Placement Return Team
Int.	Intern	QIC	Quality Improvement Coordinator, Quality Improvement Committee
LCSW	Licensed Clinical Social Worker	W	when used after a discipline = waivered
LPHA	Licensed Practitioner of the Healing Arts	Super	Supervisor
MD	Physician	Psy.D	Doctor of Psychology

Agencies and Organizations			
AA	Alcoholics Anonymous	MCS	Marin County Sheriff
ACA	Adult Children of Alcoholics	MCSD	Marin County Sheriff Dept.
AFDC	Aid to Families with Dependent Children	MGH	Marin General Hospital
APS	Adult Protective Service	MHA	Marin Housing Authority
ARF	Adult Residential Facility	MHB	Mental Health Board
BES	Buckelew Employment Services	MMHP	Marin Mental Health Plan
BHRS	Behavioral Health and Recovery Services	MSW	Marin Services for Women
CAM	Community Action Marin	MTC	Marin Treatment Center
CHP	California Highway Patrol	NA	Narcotics Anonymous
CIP	Center for Individual Psychotherapy	NAMI	National Alliance for Mentally Ill
CMHS	County Mental Health Services	NPD	Novato Police Department
CMSP	County Medical Service Program	OA	Overeaters Anonymous
CPMC	California Pacific Medical Center	PES	Psychiatric Emergency Services (CSU)
CPS	Child Protective Services	PGO	Public Guardian's Office
CSOC	Children's System of Care	PHF	Psychiatric Hospital Facility
DHCS	California Department of Healthcare Services	PSG	Personal Support Group
DOR	Department of Rehab	R to R	Road to Recovery
EAP	Employee Assistance Program	RSS	Residential Support Services
ERC	Enterprise Resource Center	SAPD	San Anselmo Police Department
FPD	Fairfax Police Dept.	Shelter +	Shelter Plus
FSA	Family Service Association	SNF	Skilled Nursing Facility
GEM	Growing Excellence in Marin	Sr. Acc.	Senior Access
GGRC	Golden Gate Regional Center	SRPD	San Rafael Police Dept
HHS	Health and Human Services	TBS	Therapeutic Behavioral Services
HICAP	Health Insurance Counseling Advocacy Program	TCPD	Twin Cities Police Dept.
HMO	Health Maintenance Organization	UCSF	University of Calif. San Francisco Medical Center
IMD	Institute for Mental Disease	Unit A	MGH inpatient psychiatric unit
JFCS	Jewish Family and Children Services	Unit B	CMHS CSU unit
LPPI	Langley Porter Psychiatric Institute	WMSC	West Marin Service Center
MW	MarinWorks	YES	Youth Empowerment Services
MAIL	Buckelew Marin Assisted Independent Living	YFS	Youth & Family Services
MCC	Marin Community Clinic		

Symbols			
@	At	Ⓜ	Mother
Δ	change	Ⓕ	Father
∴	therefore, consequently	Ⓑ	Brother
Ψ	Psychologist, Psychiatrist or psychotherapy	Ⓢ	Sister
↓	decrease	2^{o}	secondary to
↑	increase	1^{o}	primary
Ø	zero or no	~	about, approximately
c̄	with	>	greater than
s̄	without	<	less than
♂	male	☺	happy
♀	female		

Official Joint Commission "Do Not Use" List[1]		
Do Not Use	**Potential Problem**	**Use Instead**
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "every other day"
Trailing zero (X.0 mg)*	Decimal point is missed	Write X mg
Lack of leading zero (.X mg)	Decimal point is missed	Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate"
MSO4 and MgSO4	Confused for one another	Write "magnesium sulfate"

1 Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Appendix D.

Lockout Guidelines for Facilities where BHRS Clients are Frequently Located

Please Note: These are general guidelines for facility level lockouts. These **do not include** claiming lockouts associated with CalAIM Billing Reform.

I. Facilities <u>with</u> lockouts/restrictions- CCR Title 9, Chapter 11, § 1810.221.1

Type of facility: IMDs (Institution for Mental Disease) – MHRCs (Mental Health Rehabilitation Centers) and Skilled Nursing Facilities (SNF) with Special Treatment Program (STP)

All Services Locked-Out (Medi-Cal Mental Health (MH)/Case Management (CM) services not allowed):

California Psychiatric Transitions (CPT)
Canyon Manor Residential
Creekside Santa Rosa
Crestwood Idylwood Care Center (Helio's)
Crestwood Modesto
Crestwood Stockton
Crestwood Vallejo
Medical Hill Oakland
Merced Behavioral Health
Sequoia Treatment Center – Willow Glen
Telecare Garfield
Telecare Morton Baker

Psychiatric Healing Facility (PHF)

Crestwood Healing Center PHF Santa Rosa

Other Lockout Facilities – All Services Locked-Out*

Jail/Juvenile Hall

* Juvenile Hall lockout exceptions (services are billable only if):

A dependent minor in Juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary is medi-cal eligible, OR

After adjudication for release into the community.

In these instances, choose location of "other location" and clearly document above reasons and that minor is in Juvenile Hall in body of note

State Hospitals – Napa

II: Crisis Stabilization Unit (CSU, aka PES): Can provide: Case Management - Brokerage is after admission to CSU. No other specialty mental health service allowed <u>after</u> CSU Admission. Crisis Intervention and other Mental Health Services allowed on the same day as admission to CSU but only <u>prior</u> to admission, not to be used <u>after</u> admission.

III. Acute Psychiatric Inpatient Units (partial list)

<u>Can provide:</u>

<u>Case Management – Brokerage related to Discharge Planning and Placement only*,</u> or **<u>Medication Support Unbillable.</u>**

Marin General Hospital	Mills Peninsula Health Services
San Francisco General Hospital	John Muir Behavioral Health Center
St. Francis Hospital	Aurora Hospital

** Within 30 days of discharge for up to 3 non-consecutive 30-day periods.*

IV. Crisis Residential Facilities: <u>Brokerage services</u> allowed only. **<u>Medication Services</u>** are allowed if within scope of practice.

Casa Rene (Drake House)

V. Facilities <u>without</u> any lockouts/restrictions of Mental Health and Case Management/Brokerage services

Transitional Residential Facilities:

Crestwood Healing Ctr Transitional Residential Treatment Program (San Rafael)

Medical Skilled Nursing Facilities – <u>without</u> Special Treatment Program (STP)

<u>Can provide any Medi-Cal Mental Health Services</u>

Crestwood Idylwood ("The Gardens")
Kindred Nursing and Transitional Care (Greenbrae)
Northgate Post-Acute Care
Novato Healthcare Center
The Oaks-Petaluma
Pineridge Healthcare Center
Professional Post-Acute Center
Rafael Convalescent Hospital
San Rafael Healthcare & Wellness

Residential Care Facilities (aka RCF or Board & Care/B&C)

<u>Can provide any Medi-Cal Mental Health Services</u>

All Saints	Everwell (Delta at the Sherwoods)
Crestwood Our House (Vallejo)	St. Anne's
Crestwood American River	Psynergy
Good Shepard Vista (Assisted Living)	Ruby's Valley Care Home
Golden Home Extended Care	St. Michael's
Davis Guest Home	Willow Glen
Everwell (Enclave at the Delta)	

Appendix G.

Revision History

Changes in the September 2023 version

Revised service definitions and examples throughout in keeping with CalAIM Billing reform using CalMHSA language

Revised EHR specific language throughout to reflect change to SmartCare

Replaced documentation timelines with Clinical Workflow

Consolidated Assessment documentation and definition

Changed references Finalization to Completion

Clarified elimination of “Collateral” as a distinct billing type

Replaced Brokerage with Targeted Case Management (TCM) throughout

Condensed Non-Billable service section

Eliminated outdated Service Comparison section

Updated and condensed Scope of Practice section – eliminated staff class description and inserted CalMHSA’s Scope of Practice grid

Revised Consent section and aligned with SmartCare

Revised Medication Consent section

Revised Lockout section

Changes in the July 2022 version

Revised introduction to include CalAIM changes

Revised Assessment related section and language to reflect CalAIM Standardized domains

Provided link to CalAIM Clinical Documentation Manuals

Revised Medical Necessity section

Revised Scope of Practice section including table

Removed sections pertaining to Client Plan

Replaced references to Client Plan with Problem List

Removed section regarding Service Authorization Period

Added section pertaining to Problem List, with example

Included section pertaining to treatment plan for select services

Added section pertaining to Telehealth Consent

Updated language regarding required note format

Updated sections pertaining to time frames, timeliness and maximum time for documentation

Updated Utilization Review Section, including definitions of Fraud, Waste, and Abuse

Updated abbreviation and acronym list

Updated Lockout section

Added Appendix of SDOH ICD-10 codes

Added revised policy BHRS-25 to Appendix H

Changes in the January 2022 version

Added CalAIM as a source of information in the Introduction section

Updated General Principles of Documentation and Compliance sections

Removed or revised references to diagnosis related medical necessity throughout guide

Added CalAIM language throughout guide

Amended assessment requirements re: “not yet diagnosed” status and use of Z codes

Revised Medical Necessity section in keeping with CalAIM criteria changes, i.e., replaced Diagnostic, Impairment, and Intervention Title 9 language with CalAIM language

Revised Components of Medical Necessity section

Removed “included diagnosis” references in Client Plan section

Revised Progress Notes section to included expanded medical necessity description and to remove “covered diagnosis” language.

Removed “Planned vs Unplanned” reference from Lockouts and Limitations section

Removed Appendix listing “Covered Diagnoses”

Removed Appendix including BHRS 25 Documentation Standards Policy pending revisions

Reordered revision history

Renumbered Appendices

Changes in the May 2021 version

Clarified scope of practice for assessment service

Added statement of 15 minute maximum for documentation time for ongoing care notes

Added section on assuming the record of an ongoing client

Expanded Planned vs Unplanned services and added graphic

Removed Special Populations Chapter: Katie A Subclass section & Therapeutic Behavioral Services class section

Renumbered Chapters

Removed Katie A Service Procedures section

Moved ICC, IHBS, TBS from Katie A Services Procedures section to Descriptions of Specific Services chapter

Incorporated TBS Class requirement into TBS Service description

Expanded Medication Consent