MENTAL HEALTH & AOD DOCUMENTATION MANUAL

SEPTEMBER 2017 SAN MATEO COUNTY

BEHAVIORAL HEALTH SYSTEM OF CARE

This manual provides documentation standards for SUD and the Drug Medi-Cal Organized Delivery System (DMC- ODS), and outpatient mental health services provided by or contracted for BHRS. The manual provides a general description of services and service definitions and is a day -to-day resource for both clinical and administrative support staff. Additional resources include the Management Information System (MIS) Coding Manual, and State and Federal regulatory documents.

BHRS documentation standards were established to fulfill a core value of our system—the commitment to clinical and service excellence. Furthermore, accurate and complete documentation protects us from risk in legal proceedings, helps us to comply with regulatory requirements when we submit claims for services, and enables professionals to discharge their legal and ethical duties.

All of our services are documented using Medi-Cal and Medicare documentation standards, regardless of funding source. Services for clients with co-occurring mental health and substance use disorders are documented using the rules presented in this manual.

HOW TO GET HELP

This manual is BHRS policy and is the resource for all documentation issues. The Quality Management intranet site provides links to other resources as well as trainings, guides and other helpful documents. The QM Team offers basic documentation training here, www.smchealth.org/bhrs/providers/ontrain.

Got a question?
Send QM an email at
HS_BHRS_QM@smcgov.org

Visit us on the web at
www.smchealth.org/bhrs/qm

See our online documentation training at
www.smchealth.org/bhrs/providers/ontrain

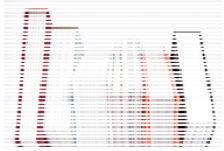
Check out our policies and see additional resources at
www.smchealth.org/behavioral-health-staff-documentation-forms-policies

View our Compliance Program
http://www.smchealth.org/bhrs-compliance-program

Table of Contents

Page 2 - Compliance
Page 3-4 - Medical Necessity*
Page 5-Documentation Requirements
Page 6 - Diagnosis & MSE
Page 7-9 - MH Assessment
Page 10 - Co-Occurring
Page 11-16 Client Plan
Page 17-20 Progress Notes
Page 21-Non-Reimbursable services
Page 22-Lockout and Non-Billable Codes
Page 23-24-Location Codes
Page 25-40 MH Billing/Services
Page 41- Alerts/ Incident Reports Breaches
Page 42-44 MH Scope of Practice
Pages 45-62 AOD Services

Page 4 - Link to List of Included Diagnoses for Mental Health & SUD/ODS



COMPLIANCE ISSUES

BHRS Policy 91-05, *Compliance with Documentation Standards,* is the source for documentation policy in this manual.

BHRS has adopted a Compliance Plan to express our commitment to providing high-quality health care services in accordance with all applicable federal, state and local rules and regulations. A key component of the Compliance Plan is the assurance that all services submitted for reimbursement are based on accurate, complete and timely documentation. Read more about the BHRS Compliance Program here: http://www.smchealth.org/bhrs-compliance-program. It is the personal responsibility of all providers to submit a complete and accurate record of the services they provide, and to document in compliance with applicable laws and regulations. The QM program strives to support the provider network in the provision of quality care, and to maintain programmatic, clinical and fiscal integrity.

Every service entry shall:

- Be legible
- Accurately reflect the activity, location, and duration of each service
- Use Service Code 55 for services that are not claimable (see "Non-Reimbursable Activities.)
- Be signed legibly with your discipline, or signed in the electronic medical record.

NOTES MUST BE ACCURATE AND FACTUAL. It is critically important for staff to be aware of their essential role in ensuring the compliance of our services with all pertinent laws. The progress note is used to record services that produce claims. **Please keep in mind that when you write a billable progress note, you are submitting a bill to the State.** Notes must be accurate and factual. Errors in documentation (e.g., using incorrect locations or service charge codes) directly affect our ability to submit true and accurate claims. For this reason, compliance is the personal responsibility of all clinical and administrative staff at BHRS.

To ensure compliance, documentation for all services provided must observe the following overarching rules:

Services must be documented in a timely manner. **Progress notes are due within 3 working days of the date of service.** Progress notes completed more than 30 days (for MH) or 7 days (for AOD) after the service date are considered excessively late and must be coded as non-billable unless otherwise approved by BHRS Quality Management.

The date of a ***late entry*** must be clearly identified in the documentation.

Notes must be signed legibly, including your discipline, or signed in the electronic medical record based on your password.

All services will be based on a current assessment updated every 3 years (for MH). For AOD, assessments must be done at every intake, and updated at least annually. All charts must contain an admission assessment and, as indicated, a current updated reassessment. Services provided without a current assessment may not be submitted for reimbursement.

All services must be based on a current client treatment plan that is updated at least annually for MH (see Client Treatment and Recovery Plan.) For AOD, treatment plans must be updated at least every 90 days, or every time there is a significant event or change.

Services provided after the expiration of the client's treatment plan will not be submitted for reimbursement to the State.

Services must be provided within the staff person's scope of practice, as indicated in this manual.

Contractors that submit billing or invoices are required to *attest* that all billing is correct. Contractors that submit bills for services that were not provided are subject to fines and/or loss of their contract with San Mateo County.

Please remember that when you write a billable progress note, you are submitting a bill to the State.

All services shall be documented as described in this Documentation Manual, and in accordance with any amending or procedural bulletins, memos, alerts or policies issued prior to or following its adoption.

MH & AOD MEDICAL NECESSITY

MH: Medical Necessity is established by adherence to **three primary tests or criteria:**

1. An **Eligible Diagnosis** that is supported by the client's symptoms, impairments and/or behaviors as documented on the most current Assessment.

2. One or more **Significant Impairments** present (or expected if untreated) that are the direct result of the eligible diagnosis.

3. Interventions proposed (on the *Client Plan*) and **actual** (documented in a *Progress Note*) that address the goals and objectives of the Client Plan. The Interventions must be linked to the symptoms/impairments of the client's diagnosis.

DOCUMENTATION OF MEDICAL NECESSITY:
The following section applies generally to MH and AOD; however, there are some additional requirements for SUD ODS medical necessity. Those requirements will be outlined in later sections of this manual that are dedicated to the ODS.

Every billed service (other than services solely for the purpose of assessment or crisis intervention) must meet the test of Medical Necessity. Medical Necessity means 1) the service is directed towards reducing the effect of symptoms/behaviors of an included diagnosis and its resultant functional impairments or, 2) the service is rendered to prevent an increase in those symptoms/behaviors or functional impairments (prevent deterioration), or to maintain the current level of functioning.

Documentation must support ongoing Medical Necessity to ensure that all provided services are Medi-Cal reimbursable. To be reimbursable, all services claimed to Medi-Cal, except for assessment or crisis intervention, **MUST** fit into the "Clinical Loop" and support Medical Necessity. The "Clinical Loop" is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are Medi-Cal reimbursable.

The sequence of documentation on which Medical Necessity requirements converge is as follows:

The Assessment - The completion of an Assessment establishes the foundation for an included diagnosis and the resulting impairments in life functioning.

The Client Treatment & Recovery Plan - The demonstration of Medical Necessity is carried forward into the Client Treatment & Recovery Plan, where the diagnosis and impairments are used to establish treatment goals/objectives and the proposed clinical interventions that will address the identified objectives.

The Progress Note - Progress Notes document delivered services that are linked to an intervention identified on the Client Treatment & Recovery Plan. Progress Notes document progress the client is making toward their objectives. The Clinical Loop is not a one-time activity. The Clinical Loop occurs throughout the client's treatment and should be reviewed and updated on a regular basis to ensure that interventions are consistent with current symptoms/impairments and behaviors documented in the Clinical Record. ***Document all elements of Medical Necessity in the Progress Note.*** There should be sufficient documentation in the Clinical Record to support the interventions recorded in the Progress Note.

MEDICAL NECESSITY

Outpatient/Specialty Mental Health Services and SUD/ODS Services must meet all 3 of the following criteria for Medical Necessity (diagnostic, impairment & intervention-related) to be Medi-Cal reimbursable.

A. DIAGNOSTIC CRITERIA: The focus of the service should be directed to the client's functional impairments and related to an Included Diagnosis.

The primary diagnosis must be an included one (*See link below). When a mental health diagnosis *and* a substance use/abuse diagnosis are both present, the mental health diagnosis must be the primary diagnosis. *A primary provisional, deferred or rule-out diagnosis must be confirmed or changed within two (2) months of opening the case.*

B. IMPAIRMENT CRITERIA: The client must have at least one (1) of the following as a result of mental health disorder(s) or emotional disorder identified in the diagnostic (A) criteria:

1. A significant impairment in an important area of life functioning, or
2. The probability of significant deterioration in an important area of life functioning, or
3. Children qualify if there is a probability the child will not progress developmentally as individually appropriate, or
4. For full scope MC clients under the age of 21, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate.

C. INTERVENTION RELATED CRITERIA: The proposed and actual intervention (s) will do at least one (1) of the following:

1. Significantly diminish the impairment
2. Prevent significant deterioration in an important area of life functioning.
3. Allow the child to progress developmentally as individually appropriate.
4. For full-scope MC clients under the age of 21, correct and ameliorate the condition.

AND The condition would not be responsive to physical health treatment.

MH Medi-Cal clients with an included diagnosis *and* a substance-related disorder may receive specialty mental health services directed at the substance abuse component. However, the intervention must be consistent with, and necessary to, the attainment of the specialty mental health treatment goals linked to the primary, included mental health diagnosis.

NOTE: If the client does *not* have an included mental health diagnosis, the program supervisor is required to inform BHRS Quality Management to block Medi-Cal billing.

(*) LIST OF INCLUDED DIAGNOSES for SUD/ODS and Mental Health:

www.dhcs.ca.gov/formsandpubs/Pages/2017-MHSUDS-Information-Notices.aspx

MH Documentation Requirements

REQUIREMENTS OVERVIEW

To avoid disallowance of a service, a chart must have all of the following items completed on time :

- **Most programs will complete assessment and treatment within the first few service appointments .** Planned services cannot be provided until an assessment and treatment plan are completed (*See pg. 28-29 for Planned Services).
- Initial Assessment completed within 60 days of the Intake Date.
- Initial Client Treatment and Recovery Plan completed within 60 days of the Intake Date.
- Re-Assessment completed every 3 years, or sooner if there is a significant change.
- Client Treatment and Recovery Plan updated annually by the due date.

Timelines are mandated and fixed for each client.

Assessments and Client Treatment & Recovery Plans may be amended with additional material added at any time. These subsequent changes do not alter the established timelines in Avatar.

ASSESSMENT SERVICE STRATEGIES - Broad categories describing an underlying concept or fundamental approach by a team or program. A service strategy will be checked as part of a client's Assessment when it is anticipated to be a part of the core services provided to the client.

Peer/Family Delivered – Services provided by clients and family members hired as program staff.

Psycho-Education – Services providing education regarding diagnosis, assessment, medication, supports, and treatments.

Family Support – Services provided to client's family members in support of the client.

Supportive Education – Services supporting a client to achieve educational goals with the aim of productive work and self-support.

Delivered in Partnership with Law Enforcement – Services integrated or coordinated with law enforcement, probation or courts (e.g., mental health court, diversion) to provide alternatives to incarceration.

Delivered in Partnership with Health Care – Services integrated or coordinated with physical health care, including co-location or collaboration with providers and sites offering physical health care.

Delivered in Partnership with Social Services – Services integrated or coordinated with social services, including co-location or collaboration with providers and sites offering social services.

Delivered in Partnership with Substance Abuse Services – Services integrated or coordinated with substance abuse services, including co-location or collaboration with providers and sites offering substance abuse services. Does not include substance abuse services provided by County staff.

Integrated Services for MH & Aging – Services integrated or coordinated with issues related to aging, including co-location or collaboration with providers and sites offering aging-related services.

Integrated Services for MH & Developmental Disability - Services integrated or coordinated with services for developmental disability, including co-location or collaboration with providers and sites offering services for clients with developmental disabilities.

Ethnic-Specific Service Strategy – Culturally appropriate services tailored to persons of diverse cultures. Can include ethnic-specific strategies and practices such as traditional practitioners, natural healing, and recognized community ceremonies.

Age-Specific Service Strategy – Age-appropriate services tailored to specific age groups. These services should promote a wellness philosophy including concepts of recovery and resiliency.

MH DIAGNOSIS AND MENTAL STATUS, CONTINUED ON NEXT PAGE

A diagnosis and mental status exam (MSE) can only be provided by a LMHP, or Licensed Mental Health Professional: a physician (MD), licensed/waivered Psychologist, licensed/registered Clinical Social Worker, licensed/registered Marriage and Family Therapist, licensed/registered Licensed Professional Clinical Counselor, a Registered Nurse with a Master's degree, and a Nurse Practitioner (NP) licensed in a mental health-related field. These clinicians will sign as the "assessor" on the signature page of assessment forms used by BHRS. Other staff may contribute to and conduct all other portions of the assessment and will sign the assessment form as "authorized clinical staff." At a minimum, the assessor is responsible for reviewing and agreeing with the completed assessment, conducting the mental status exam, and providing a clinical formulation and the diagnosis. Behavioral health trainees sign an assessment as "authorized clinical staff" and they may provide a diagnosis and mental status exam under the supervision of a licensed clinician in one of the disciplines noted above. The supervisor must then sign the assessment as the "assessor." All diagnoses—the primary diagnosis and any secondary diagnoses—must be included on the assessment form. The presence of a non-eligible diagnosis does not impact claims for services as long as there is a primary, eligible diagnosis that is the focus of treatment. ***BHRS requires that any substance use diagnosis found will also be listed.***

Formulation of a diagnosis requires a provider, working within his/her scope of practice, to be licensed, waivered and/or under the direction of a licensed provider in accordance with California State law. Diagnosis is the scope of practice for the following provider types: Physician, Psychologist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist, and Advanced Practice Nurses (in accordance with the Board of Registered Nursing.)

The diagnosis, mental status exam, 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 his/her scope of practice under California State law. The provider must be licensed, waivered, and/or under the direction of a licensed mental health professional. However, the MHP may designate certain other qualified providers to complete parts of an assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use and identifying strengths, risks and barriers to achieving goals.

CHANGE OF DIAGNOSIS

Assignment of a primary diagnosis may be deferred for a maximum of 60 days after case opening. A primary diagnosis listed as provisional or rule-out must be confirmed or changed within 60 days of case opening, or billing will be blocked. Diagnoses may be changed at any time during the course of treatment. No planned service can be provided without an included diagnosis.

DIAGNOSIS & TREATMENT WITHOUT MEDICAL NECESSITY

Occasionally, it may be appropriate to open and treat a client whose condition does not meet Medi-Cal Medical Necessity standards. The clinician must obtain supervisor approval to continue treating the client after the assessment period. **To block a chart please notify your supervisor and QM.**

Other Diagnosis-Related Issues

- "By History", "Rule out" and "Provisional" diagnoses are not included diagnoses and therefore do not meet Medical Necessity. However, a client may have one of the above diagnoses as an additional diagnosis *as long as the primary diagnosis is an included one.*

- An assessment, which includes a diagnosis, evaluates the *current status* of a client's mental, emotional or behavioral health. This status may change as a client transitions from inpatient to outpatient services. Therefore, providers should not rely on an inpatient diagnosis when conducting an assessment for outpatient services. However, the inpatient assessment documentation should be reviewed to inform the outpatient assessment process and to verify that the diagnosis reflects the client's current mental, emotional or behavioral health status.

- If there is a difference of opinion between providers regarding a client's diagnosis—e.g. between a physician and a non-physician clinician—it is best practice for the providers involved to consult and collaborate to determine the most accurate diagnosis.

- A client's diagnosis may be used by multiple providers if the diagnosis reflects the current status of the client's mental, emotional, or behavioral health. A Re-Assessment may be required when a client has experienced a significant medical or clinical change.

LOCUS & CALOCUS

BHRS uses the "Levels of Care Utilization System" (LOCUS) and "Child and Adolescent Levels of Care Utilization System" (CALOCUS) as treatment planning and utilization management tools. Scores on the CA/LOCUS are based on the clinical needs of the clients. They help ensure that clients receive the type and amount of service that corresponds to the clinical need. These tools are now an important part of our clinical and utilization management system and have been integrated into the timeline structure for all important clinical documents. In addition, the CA/LOCUS are useful in identifying the need for day treatment services.

WHO COMPLETES THE CA/LOCUS? The CA/LOCUS should be completed by clinicians who have been trained in its use. To ensure inter-rater reliability, clinicians are urged to complete the form using the scoring grid developed by BHRS or the scoring criteria developed by the authors of the tool.
The initial CA/LOCUS is a component of the Admission Assessment. Subsequently, the form should be completed every three years by the clinic or team assigned as the care coordinator for the client.

The CA/LOCUS may be completed at other times by other clinicians as an aid to treatment or as a component of a utilization management process.

TIMELINES For new clients, the team has 60 days to complete the initial CA/LOCUS. For clients continuing in care, the CA/LOCUS must be completed at the time of assessment. This means the CA/LOCUS is completed on the same schedule as the Assessment.

MH ASSESSMENT COMPONENTS

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

- **Presenting Problem(s) -** The client's chief complaint, history of the presenting problem(s), including current family history and current family information.

- **Relevant Conditions and Psychosocial Factors** affecting the client's physical and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;

- **Mental Health History** - Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records and relevant psychological testing or consultation reports;
- **Medical History** - Relevant physical health conditions reported by the client or significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
- **Medications** - Information about medications the client has received, or is receiving to treat mental health and medical conditions, including duration of treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
- **Substance Exposure/Use** - past and present use of tobacco/nicotine, alcohol, caffeine, complementary and alternative medications, over-the-counter, and illicit drugs.
- **Client Strengths -** documentation of the client's strengths in achieving treatment plan goals related to the client's mental health needs and functional impairments as a result of the mental health diagnosis;
- **Risks -** Situations that present a risk to the client/others. Examples of risks are: history of danger to self or others, previous inpatient hospitalizations, prior suicide attempts, lack of family or other support, arrest history, probation status, history of alcohol/drug use, history of trauma or victimization; physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the client vulnerable to others; psychological or intellectual vulnerabilities (e.g., low IQ, traumatic brain injury, dependent personality).
- **Diagnosis:** A DSM-5 diagnosis shall be documented, consistent with the presenting problems, history, mental status exam and/or other clinical data. (To bill Medi-Cal, **the primary diagnosis must be an included mental health diagnosis**. ***See Pg. 4 for List of included diagnoses)**
- **Clinical Formulation** based on presenting problems, history, MSE and/or other clinical data. This diagnostic hypothesis is a framework for developing the most suitable treatment plan with the client. It describes the client's overall condition and plan for wellness, recommends a plan for treatment that addresses the symptoms and impairments resulting from the diagnosis, and establishes Medical Necessity for mental health services.

- The assessment must include the date of service, signature and license/job title of provider, and date it was entered into the medical record.

ASSESSMENT TIMELINES

New Clients: Assessments for new clients who are not already open to any treatment program must be completed within 60 days of the episode opening. Use the Initial Assessment Form. **The assessment is expected to be done within the first few sessions. No planned services may be provided until the assessment and treatment plan are completed. (*See pgs. 26, 28-29 for planned services).**

If the client is already open to a treatment program, any additional program accepting a client is responsible for ensuring that there is a current and accurate Assessment in the Clinical Record.

When two or more treatment programs are treating the same client, the teams should coordinate care and determine which team will be the lead in developing and completing the assessment. However, it is every program's responsibility to ensure there is a complete and current assessment that meets medical necessity. No team may bill for services without a complete assessment that meets medical necessity. If the assessment is overdue, the receiving/treating program must complete an Initial Assessment if it has not been completed previously, or a Re-Assessment for continuing client.

Assessment Addendum: An addendum to the Assessment may be completed when additional information is gathered or a change occurs after the completion of the Initial Assessment, or between required Assessments. The addendum cannot be used to change or add a new diagnosis. **Diagnosis changes** are completed on the Re-Assessment form (Assessment Type: UPDATE).

When additional information is gathered, an Addendum to the Assessment is required. However, it does not restart the timeline. Each program is required to ensure that the assessment documents meet medical necessity for their care. To use the addendum there must be a pre-existing assessment less than 3 years old (if completed after January 1, 2016.) This does not count as a full assessment and does not restart the timeline.

Quality Management may approve alternate assessment forms for use in certain situations.

Re-Assessments: Re-Assessment for continuous clients with ongoing services (no lapse of services over 180 days) must be completed at least **every 3 years** or when there is significant change in clinical condition. Use the Re-Assessment Form.

For clients returning to services after termination of all services for over 45 days but within one year, conduct an assessment using the Re-Assessment form within 60 days of re-admission. If the client returns to services beyond one year, a new Initial Assessment is required.

Clients without billable services for over 180 days must have a completed Re-Assessment when the client re-engages with services. Use the Re-Assessment form.

Any program treating a client continuously is responsible for ensuring that there is an assessment in the clinical record with all required sections completed. **It is not sufficient to state "no change", "see progress notes" or "see previous assessment." All treatment programs are responsible for a complete assessment meeting all requirements even if the program is not considered the lead/care coordinating team/episode.**

An assessment is completed on the date the LPHA signs and submits it as final. Assessment Addendums do not count as the Re-Assessment and draft documents do not count as completed.

Re-Assessment Diagnosis Update: To update the diagnosis between assessments, complete the Re-Assessment Form, select Assessment Type: UPDATE. You may then complete only the diagnosis tab. This will not reset the assessment timelines.

Clients may present in any behavioral health setting with any combination of mental health and substance use symptoms or disorders. Mental health disorders may or may not be substance-induced, and the mental health and substance use conditions may be active or in remission. For individuals and families with co-occurring conditions and other complex needs, the provision of integrated services matched to the multiple needs of the individual and/or family is an evidence-based practice.

San Mateo County Behavioral Health and Recovery Services (BHRS) assesses and treats co-occurring disorders including substance abuse/dependency, trauma related, and developmental disorders. In this section, we will focus on substance use disorders. *The presence of a co-occurring substance abuse/dependence disorder will not, in and of itself, trigger disallowance of specialty mental health Medi-Cal billing*. All diagnoses for mental illness and substance abuse/dependence shall be documented in the BHRS chart when criteria are present.

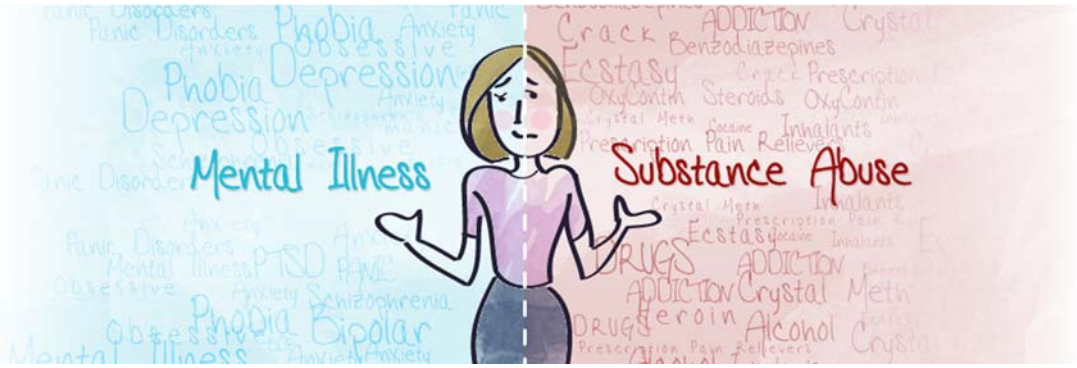
Substance use, including nicotine/tobacco and caffeine, will be explored with all clients and caretakers as part of routine screening at the point of first contact with our system, during the admission assessment, and periodically during the course of ongoing treatment.

TREATMENT PLANNING/SERVICE DELIVERY

Treatment and Recovery Plans for clients and families with children with co-occurring disorders must address both mental health and substance use issues. The goals for each will be tailored to the client's readiness to address an issue, with the understanding that the client and family members may have different levels of readiness to address each issue.

PROGRESS NOTES

Mental health progress notes will document ongoing assessment and monitoring of co-occurring substance use issues. These notes will focus on how substance use may be exacerbating mental health issues or impeding recovery from a mental illness, and how integrated interventions will promote mental health recovery.



DEFINITIONS

Co-occurring Disorder: Youths, adults and older adults are considered to have a co-occurring disorder when they exhibit the co-occurrence of mental health and substance use/abuse problems, whether or not they have already been diagnosed. Co-occurring disorders vary according to severity, duration, recurrence, and degree of impairment in functioning. The significant co-morbidity of SUDs and mental illness (typically reported as 40 percent to 80 percent depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Co-occurring Families are families in which the identified child has an emotional disturbance and a significant family member or caregiver has a substance use issue. Note: Integrated services and documentation apply to co-occurring families as well as to co-occurring individuals receiving adult or child mental health services funding. However, clinicians need to use care when documenting these issues in the child's chart.

CLIENT TREATMENT & RECOVERY PLAN

The Client Treatment & Recovery Plan is a primary way of involving clients in their own care. The development of the Client Plan is an interactive process between the client and the treatment team. It is designed to establish the client's treatment goals, develop a set of objectives to help realize these goals, and reach agreement on the services we will provide. Program goals should be consistent with the client's/family's goals as well as the diagnosis and assessment. The client plan must include documentation of the client's participation in the development of and agreement with the client plan.

CLIENT PARTICIPATION

Client participation in the formulation of the treatment plan is documented by obtaining the signature of the client/parent/guardian, providing a copy of the plan to the client/family member, OR by documenting in a progress note how the client/parent/guardian participated in developing and approving the treatment plan.

It is not sufficient to write on the plan or in a progress note that the client missed the Plan Development appointment or could not be reached; this does not describe the client's participation.

It must be documented that a copy of the plan was offered to the client and if the client accepted or declined the copy. Offering a copy of the plan to the client/family member is an important acknowledgment of the client's involvement in the development of the client plan, and demonstrates the clinician's commitment to involving clients/families as full participants in their own recovery process.

The 10 elements required by the current MHP & SUD/ODS Contract with DHCS:

1. Statement of the problem to be addressed;
2. An expected frequency for each proposed intervention;
3. An expected duration for each proposed intervention and target dates;
4. Adequate documentation that the beneficiary was offered a copy of the Plan;
5. Observable and measureable goals and objectives; SMART (*See pg. 15)
6. Provider's signature with Degree/ License or job title on the Plan;
7. Specific behavioral interventions (description) for each proposed service;
8. All interventions that were actually delivered to the beneficiary;
9. Timely completion according to the MHP's or SUD provider's own documentation standards;
10. Documentation that the beneficiary participated in and agreed to the Plan;
    a. Date of the Provider's signature on the Plan (i.e., date completed).

Treatment Plans must be written in the client's preferred language. If the preferred language is not English, the treatment plan must be translated into English as well.

Every individual receiving mental health services after the 60-day Intake Period must have a completed Client Treatment & Recovery Plan signed by the client and the clinician.

CLIENT PLAN TIMELINES

A client plan must be completed *prior to service delivery for all planned services.* The State Plan requires services to be provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to the State of California requirements. The client plan must be updated at least annually or when there are significant changes in the client's condition.

For MH, the initial Client Treatment & Recovery Plan is due by the end of the two-month (60-day) Intake Period. The plan for an additional provider/program is due two months (60 days) from the opening by that team.

For AOD, the initial client plan is due within 30 days of admission for OP or IOP, within 10 days for Residential programs, and within 28 days for NTP.

Please note: No Planned Services may be provided prior to the completion of the assessment and client plan (*See pgs. 26, 28-29 for planned services).

A client plan is required whether a client receives only one service modality or multiple service modalities. Specialty Mental Health Services are to be provided based on medical necessity criteria, in accordance with an individualized client plan.

For AOD, each Treatment Plan may be authorized for a maximum of 90 days. Each subsequent Treatment Plan shall be reviewed and modified prior to the 90- day period, or at each change event in the client's life.

For MH, each Client Plan may be authorized for a maximum of one year. The client plan shall be renewed— reviewed and modified—every 365 days from the start date of the previous client plan.

UPDATES TO CLIENT PLAN

The Client Treatment & Recovery Plan must be updated at least annually or when there is a significant change in the client's condition—e.g. major life change such as divorce, loss of job, death in family, change in living situation...etc.

There is no specific language in regulation that defines a "significant change" in a client's condition, but some factors that would warrant an updated Client Plan include:

A client's symptoms or behaviors change radically—e.g. a client who has never been suicidal makes a suicide attempt, there is a sudden increase in severity of symptoms, a client who has been attending therapy regularly suddenly stops coming to appointments...etc.

CLIENT PLAN SIGNATURES

The client's signature or the signature of the client's parent is required on the client plan when the client is expected to be in long-term treatment **and** when the plan indicates that the client will be receiving more than one Specialty Mental Health Service. The definition of "**Long-Term Treatment**" is a client that is seen for more than one treatment session. And a "**Long-Term Client**" is any client admitted to an outpatient treatment episode.)

REFUSAL TO SIGN OR UNAVAILABILITY TO SIGN

Whenever a client's signature or the signature of the client's legal representative is required on a client plan or updated client plan, and the client refuses to sign or is unavailable for a signature, the client plan (or updated plan) must include a written explanation of the refusal or unavailability. The written explanation may be on the plan itself or in a progress note. Although it is not required, it is best practice to make additional attempts to obtain the client's signature and document the attempts in the client's chart.

Minors Can Sign Their Own Client Plans

There is no minimum age for a minor to independently sign a treatment plan. The plan is a collaborative process between the client and the provider. The minor client should understand what they are signing is based on their participation in the process.

In order to update a plan without a client signature, the clinician must identify **client involvement in plan development**—e.g. a telephone discussion about the plan—and document this involvement by the client on the treatment plan or in a progress note. It is best practice to write a progress note that describes how the client participated in the formulation of the treatment plan.

STAFF THAT MUST SIGN THE CLIENT PLAN

A client plan must be signed (or electronic equivalent) and dated by either the person providing the services, a person representing a team or program providing the services, or a person representing BHRS who is providing the services. In addition to a signature by one of the forgoing staff, the plan must be co-signed by one of the following providers if the client plan indicates that some services will be provided by a staff member **under the direction** of one of the categories of staff listed below, and/or the person signing the client plan is not one of the categories of staff listed below:

- Physician
- Licensed/waivered Psychologist
  Licensed/registered/waivered Social Worker
- Licensed/registered/waivered Marriage & Family Therapist
- Licensed/registered/waivered Professional Clinical Counselor
- Registered Nurse, including but not limited to nurse practitioners (NPs) and clinical nurse specialists

A client plan is effective once it has been signed (and co-signed, if required) and dated by the required staff member(s). **Drafts are not considered to be complete.**

If the client is not available to participate in the review prior to the expiration of the 365-day period, the annual Client Plan shall be reviewed and updated with the client at the next contact prior to providing any additional treatment services. The review shall be documented in the progress note, including outcomes, progress (or lack thereof) on of the previous treatment plan's goals/objectives.

When the covered period passes and the next client plan is completed late, there will be unauthorized days that are not claimable (e.g., the renewal date was July 1 but the plan is completed on July 7, so July 1-6 would be unauthorized for all services during that time period.)

A *gap* between client plans results when a client plan has expired and there is an amount of time that passes before the updated client plan is in effect.

When there is a gap between client plans, those services that *can* be provided prior to a client plan being approved may be provided and are reimbursable. However, any services provided in the gap that are services that *cannot* be provided prior to a client plan being in effect, are not reimbursable and will be disallowed.

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

Before a Client Plan is approved and in place, ONLY the following services are reimbursable:

- Assessment
- Plan Development
- Crisis Intervention
- Crisis Stabilization
- Medication Support Services—for assessment, evaluation, or plan development; or *if there is an urgent need (which must be documented)*
- Targeted Case Management and Intensive Care Coordination (ICC)—for assessment, plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services

An approved Client Plan MUST be in place before the following services may be provided:

- Mental Health services (except assessment, client plan development)
- Intensive Home-Based Services (IHBS)
- Specific component of TCM and ICC: Monitoring and follow-up activities to ensure that the client plan is being implemented and that it adequately addresses the client's individual needs
- Therapeutic Behavioral Services (TBS)
- Day Treatment Intensive
- Day Rehabilitation
- Adult Residential treatment services
- Crisis Residential treatment services
- Medication Support (non-emergency)
- Psychiatric Health Facility services
- Psychiatric Inpatient services

INITIAL TREATMENT PLAN TO QUICKLY BEGIN SERVICES

A client treatment plan may be prepared shortly after the client comes into the system, prior to completion of a comprehensive plan, in order to quickly begin providing services that cannot be provided without a plan. However, all treatment plan requirements must be met. The plan is a dynamic, living document, and services can be added over time based on the client's needs.

At a minimum the treatment plan, (even if for just one service), must include:

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

For example, if a client is initially assessed to need services, the provider could prepare a treatment plan that includes those services only, as long as the other treatment plan requirements are met. As the assessment continues, and a comprehensive assessment of the client is completed, other services would be added to the treatment plan based on medical necessity and individual client needs.

TREATMENT PLAN ELEMENTS:

CLIENT'S OVERALL GOAL/DESIRED OUTCOME - The client's desired outcome from successful treatment.

This is the reason the client is seeking treatment. Overall goals are broad life goals, such as returning to work or graduating from high school, that reflect the client's intent and interests. The overall goal should be clear to the client and the treatment team, and it should reflect the client's preferences and strengths. These goals have a special place in a system committed to recovery – they should speak to the client's ability to manage or recover from his/her illness and to achieve major developmental milestones.

DIAGNOSIS/RECOVERY BARRIER/PROBLEM – *Primary Diagnosis' signs/symptoms/impairments, and other barriers/challenges/ problems.* Describes the behavioral health symptoms and impairments that are the focus of treatment.

GOAL –The removal or reduction of the problem.

The goal addresses the problem. The goal is the development of new skills/behaviors and the reduction, stabilization or removal of the barrier/problem. Individual goals address the barriers that prevent clients from reaching overall goals. They are generally related to important areas of functioning that are affected by the client's mental health condition such as daily activities, school, work, social support, legal issues, safety, physical health, substance abuse and psychiatric symptoms. The treatment plan must clearly document how a goal reflects the client's mental health condition. Goals must relate to the diagnosis and case formulation.

OBJECTIVE(S) – What the client will do.

This is a breakdown of the goal. It may include specific skills the client will master and/or steps or tasks the client will complete to accomplish the goal. Objectives should be specific, observable or quantifiable, and related to the assessment and diagnosis. A simple mnemonic that may be helpful when working with the client to develop program objectives is SMART (Simple, Measurable, Accurate, Realistic, Time-bound).

Examples: Recovery Barrier/ Problems linked to Diagnosis

Auditory hallucinations leading to self-harm and hospitalization.

Exhibits angry behavior in class; refuses tasks and help; learning disabilities impede progress in school.

Examples of Goals

Reduce auditory hallucinations and improve symptom management.

Will get along better with others at school, without incidents of physical fighting.

Will participate in job placement activities through Vocational Rehab Services (VRS).

Examples of Objectives

Will talk about positive and negative things regarding medication (monthly, in meeting with MD).

Will identify at least 2 things to do that will help me not to listen to the voices.

Will immediately call case manager or PES if voices tell me to hurt myself or others.

Will have at least one friendly talk with peers daily within 3 months and 2-3 times daily within 12 months (has none now).

Examples of Interventions

Provide monthly medication support services to assess and monitor medication compliance, client's response and side effects.

Provide rehabilitation services weekly to assist client in performing ADLs and reducing anxiety.

Provide targeted case management, every 3 months, to coordinate with VRS so client can reduce depression and achieve employment goals.

INTERVENTION(S) – The specific services that staff will provide.

These are all of the service types that will be utilized in treatment (e.g., Medication Support, Case Management, Individual Therapy, Group Therapy...etc.) List all that apply.

A *proposed intervention* is the service that the provider anticipates delivering to the client when formulating the client plan with the client. It is the proposed type of intervention/modality—e.g., "DBT-based individual therapy to reduce client's self-harming/cutting behaviors." There may be several of these on the plan, depending on the scope of services to be provided.

The *actual intervention* is the specific intervention utilized during the mental health service; each actual intervention is documented, along with the client's response, in a progress note.

Interventions describe specific, diagnosis-driven actions to be taken by BHRS providers —for each service type— to assist clients in achieving their program goals. **Do not merely list "Mental Health Services" or "Targeted Case Management" as the planned/proposed intervention.**

Examples of specific, diagnosis-related interventions:

1. Clinician will provide Individual Therapy 1x per week, for 6 months, utilizing Cognitive-Behavioral techniques, to assist client to reduce his anxiety.
2. (AOD) Case Management to be provided twice monthly, for 1 year, to ensure that client is utilizing support/resources to maintain sobriety.
3. Medication Management 1x per month to monitor/stabilize client's psychotic Sx.

Every proposed intervention for each service type—such as Individual Therapy, Medication Support and/or Targeted Case Management—must be listed and described in detail. Any intervention added during the course of treatment (e.g., TBS) must be written and dated on the plan.

DURATION OF INTERVENTION - Usually this will be 12 months, but it may be 3, 6, or 9 months, if appropriate. This time frame is a prediction of how long the intervention will be needed; it is the total expected timespan of the service. (E.g., "Client will attend two individual therapy sessions per week for **6 months**.")

A Client Plan in which all interventions have a duration of *less than one year* must be updated on time (before they expire), prior to the annual due date.

FREQUENCY OF INTERVENTION

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

Client plans must include the date of service, and the date the documentation was entered into the medical record.

MH & AOD PROGRESS NOTES

There must be a brief written description—a progress note—in the client record each time a service is provided. Progress notes provide the ongoing record of the client's condition, clinical interventions attempted, the client's response to the interventions and care provided, and the progress the client is making toward their goals and objectives. Progress notes also facilitate coordination of care and communication between team members. Funding sources verify that progress notes record a service for every billing, show evidence of collaboration with community resources including primary care, are legible and signed appropriately by a clinician, demonstrate ongoing medical necessity, and establish that time billed seems accurate for the service provided. Use the BIRP Format (Behavior, Intervention, Response, Plan)

THE FOLLOWING RULES APPLY TO SERVICES BASED ON STAFF TIME: In no case shall more than 60 minutes be reported or claimed for any one staff person during a one-hour period. Also, in no case shall the sum of the minutes reported or claimed for any one staff member exceed the hours worked in a given day.

When a staff member provides service to, or on behalf of, more than one individual at the same time, the staff member's time must be prorated to each client. When more than one staff person provides a service, the time utilized by all involved staff members shall be added together to yield the total billable services. The total time claimed shall not exceed the actual staff time utilized for billable services. (See the discussion of Group Documentation).

TIMELINESS OF DOCUMENTATION OF SERVICES

To ensure compliance and thorough documentation, progress notes must be completed in a timely manner, i.e. as soon as possible after the service has occurred. **Progress notes are due within 3 working days of the date of service.** Progress notes completed more than 30 days after the service date are considered late and must be coded as non-billable unless otherwise approved by a supervisor/manager. In the rare situation when a personal or clinical emergency prevents timely recording of services, the service shall be entered as soon as possible and clearly identified as a "late entry" if not electronically time stamped.

PROGRESS NOTE CONTENT

Progress notes record the date, location, duration and service provided, and include a brief narrative. The narrative describes the client's presentation in session, symptoms/behaviors, strengths, the provider's interventions and client's responses to those interventions, a plan for subsequent services, progress toward goals or objectives, and a description of significant changes in the client's status.

Medication progress notes should document the client's response to medications, side effects, compliance and/or a plan to maintain or change the medication regimen, as well as the impact of any medical symptoms or conditions affecting the client's mental health.

The electronic signature of the person providing the service, including professional degree or licensure or job title, completed when filing the progress note as "FINAL." This is your legal signature.

Documentation of all referrals to community resources and other agencies.

Documentation of any changes to the Treatment & Recovery Plan, program goals and interventions. Changes to the plan should also be recorded on the electronic Client Treatment and Recovery Plan.

Date of follow-up care, next appointment, or discharge summary

PROGRESS NOTE REQUIREMENTS/ MEDICAL NECESSITY

Progress notes describe how services provided reduced the impairment(s), restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the treatment plan. **Progress notes must include the following elements:**

- Timely documentation of relevant aspects of client care, including documentation of medical necessity;
- Documentation of client encounters, including relevant clinical decisions, and alternative approaches for future interventions;
- Interventions applied; client's response to the interventions, and the location of the interventions;
- The date the services were provided;
- Documentation of referrals to community resources and other agencies, when appropriate;
- Documentation of follow-up care, or as appropriate, a discharge summary;
- The amount of time taken to provide the services; and
- The signature of the person providing the service (or electronic equivalent), and their professional degree, licensure, or job title.

While not all components of medical necessity must be documented in a progress note, the **progress notes must clearly link the intervention to the identified functional impairment(s), resulting from the client's identified mental health diagnosis.**

Interventions should be described in such a way that a reviewer reading the note would be able to determine whether the interventions were clinically appropriate to the impairments, restore functioning, prevent deterioration, or allow developmental progress, as appropriate.

Progress notes **documenting the use of evidence-based practices, such as motivational interviewing, and techniques such as unconditional positive regard and empathic listening,** should describe how the technique used during the intervention assisted to reduce impairment, restore functioning, prevent deterioration, allow developmental progress as appropriate, and the client's response to the intervention.

Claiming for travel time : The time required for travel is reimbursable when it is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity, as follows: 1)Travel time from a provider site to an off-site location where MediCal SMHS services are delivered is claimable. The travel time must be directly linked to the services which should be clearly documented in the progress note. The amounts of travel time and service time should each be reflected in the progress note. 2) Travel time between provider sites or from a staff member's residence to a provider site **may not be claimed.** 3) Travel time between a staff member's home and a client's home may be claimed as long as San Mateo County travel guidelines are followed.

TIPS FOR WRITING PROGRESS NOTES

Progress notes are used to inform the on-duty clinician and other clinicians 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 and should be written in a manner that supports client-centered, recovery-based and culturally competent services. Aim for clarity and brevity when writing notes; lengthy narrative notes are discouraged when recording ongoing services.

PROGRESS NOTES ADDRESS GOALS, BEHAVIOR, INTERVENTIONS, RESPONSES, AND PLAN. ***The chart should document facts, staff interventions, and the client's response in BIRP Format: Behavior, Intervention, Response & Plan.***

PROGRESS NOTES DESCRIBE the client's **BEHAVIOR and the GOAL ADDRESSED.** Include your observations, the client's self-report and reports from others. Document the reports made by others involved in the client's care—e.g. document if the report was offered by a parent or if the client reported it. *Remember that* ***if it is not written, it did not happen****.* You may be asked to describe behaviors or reports from others at a later date.

Always document your **INTERVENTIONS**. This is how you show that you addressed a client's need with the standard of care. Include the **PURPOSE** of the intervention, linking it to an identified functional impairment resulting from the client's mental health diagnosis. This establishes medical necessity for the service provided.

Describe the client's **RESPONSE** to the intervention or the outcome or result of the service. Also, include a **PLAN** if needed. The Plan addresses any immediate needs that must be addressed prior to or in the next session. This is a good way to communicate with other providers involved in the case. It is helpful to know the necessary next steps. An example is, "will refer the client to an AOD group."

CONFIDENTIALITY

Because we protect client confidentiality, and because the medical record is a legal document that may be subpoenaed by a court, please observe the following standards in completing progress notes:

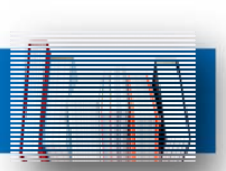
- Do not write another client's name (e.g. classmate or peer) in any other client's chart.
- In the unusual circumstance that another client must be identified in the record (for example, when the other client received a Tarasoff warning), do not identify that individual as a BHRS client.
- Names of family members/support persons should be recorded only to complete intake registration and financial documents.
- On progress notes and most assessments, refer to the relationship - mother, husband or friend, but *do not use names.*
- Use a first name or initials of another person only when needed for clarification.
- Be judicious in entering a mental health diagnosis reported by a parent/spouse/other about themselves or family members/support persons. (Indicate the entry: "as reported by...").

Always keep in mind that you are documenting in the client's chart, not in a family member's chart. Discretion regarding the inclusion of family members' or others' personal information is important:

1. Protect the privacy of those connected to the client in treatment
2. Maintain professional ethical standards
3. Prevent potential liability resulting from inappropriate documentation practices

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

MH & AOD PROGRESS NOTE DETAILS



PROGRESS NOTE FIELDS

PROGRESS NOTE FOR: Select New Service.

DATE OF SERVICE: Record the date the service was provided.

LOCATION: Record where the service took place.

SERVICE CHARGE CODE: Record the type of service by selecting a code.

PROGRESS NOTE TYPE: Choose New Service.

SERVICE DURATION (in minutes): Record the amount of time spent for this service in minutes. Include time spent in travel, providing the service and documenting the service. Give actual time ***to the minute***; do **not** uniformly record 5, 10 or 15-minute time periods.

LANGUAGE INFORMATION FOR CONTACT: When you provide services in a language other than English, document this in the progress note.

NOTE: Write a summary of the service that you provided.

Frequency of Progress Notes

Progress notes must record every service contact for the following services:

- All AOD Outpatient services
- Assessment
- Individual and Family Therapy
- Group Services
- Collateral
- Rehabilitation or Intensive Home Based Services ("Katie A" services, *See pg. 31)
- Medication Support Services
- Crisis Intervention
- Plan Development
- Case Management or Intensive Care Coordination ("Katie A" services, *See pg. 31)
- Crisis Residential (Daily)
- Crisis Stabilization
- Therapeutic Behavioral Services
- Day Treatment Intensive (Daily Note)

Weekly summaries must be completed for the following services:

- Day Treatment Intensive & Day Rehabilitation
- Adult Residential (Transitional)
- All AOD Intensive Outpatient and Residential services

SIGNATURE

In Avatar, your signature will attach to the note when you submit the progress note as **final**. As needed, obtain co-signature. See "Scope of Practice" (Pg. 42-44) for more information.

For hard copy notes (rarely used), sign each note with your first initial, last name, and license/job title. The signature must be dated when using hard copy notes.

CO-PROVIDED SERVICES

When services are co-provided by two clinicians, one individual may write the note. The content of the note must indicate the specific and unique contributions of each clinician who participated in the provision of the service, and document why both providers were necessary.

Both co-providers must have scope of practice eligibility to claim the service. For example, only another medical clinician may be a co-provider on a Medication Support (15) note. Both co-providers must sign the progress note.

In addition to documenting the time and contribution of a co-provider, the clinician will add names, professional identification and contributions of any other providers of the service. This is required even though **services will be claimed by no more than two providers.**

DOCUMENTING A SERVICE INVOLVING TWO OR MORE PEOPLE

Define the Role of Others Involved in the Service - for example, the client's mother participated in the session.

When the Service Involves Another Professional - Use the name and role of the professional; for example, Sally Jones, Probation Officer.

When the Service Involves Another Client - Do not write a client's name in another client's chart.

When the Service Involves a Family Member or Support Persons - If needed, you may use a first name or initials of another family member. Limit what you say about family members. It is not their chart.

When the Service Involves Two or more Clients Who Are also Family Members - Write a note for each and split the time accordingly.

NON-REIMBURSABLE SERVICES

All staff must understand how services are claimed, and know that some services are not claimable/reimbursable.

SERVICES THAT ARE NOT BILLABLE

The following are examples of activities that are not claimable for reimbursement (do not claim if these are documented; use one of the non-reimbursable codes.)

- Reviewing chart for **assignment of therapist,** to **close a chart (discharge note)** or for **release of information**
- Any documentation after **client is deceased**
- Preparing documents for **court/testifying/waiting in court**
- Listening to or leaving **voicemail or email message**
- Mandated reporting such as **CPS/APS/Tarasoff reports**
- **No service provided: missed visit.** Traveling to a site/waiting for a **"no show".** Documenting that a client **missed an appointment**. Leaving a note on a door, or a message on an answering machine or with another individual about the missed visit.
- **Personal Care** services provided to individuals including grooming, personal hygiene, assisting with self-administration of medication and the preparation of meals
- Purely **clerical** activities (faxing, copying, filing, mailing...etc.)
- **Scheduling**/re-scheduling appointments
- **Recreation** or general play
- **Socialization:** generalized social activities which do not provide individualized feedback
- **Academic/Educational** services: teaching math or reading, etc.
- **Vocational** services for the purpose actual work or work training. (Exception: VRS services clearly linked to mental health Dx)
- **Multiple Staff in Case Conference:** Only staff directly involved in the client's care may claim for services, and each staff member's unique contribution to the meeting must be clearly noted
- **Supervision:** Supervision of clinical staff or trainees **is not** reimbursable. Reviewing and amending/updating the treatment plan with a supervisor **is** reimbursable.
- **Utilization management, peer review, or other quality improvement activities**
- **Interpretation/Translation** only
- **Transportation of a client**
- **Preparation for a service—**e.g. set up for group therapy
- **SSI paperwork with no client present**
- **Services provided out of the scope of practice of the provider**

Reimbursable services may be delivered at work, academic or recreational sites as long as the focus of the service meets medical necessity criteria.

Academic/Educational Situations:

Sitting with the client in a community college class to help reduce the client's anxiety and then debriefing the experience afterward **is** reimbursable.

Assisting the client with his/her homework **is not** reimbursable.

Teaching a typing class at an adult residential treatment program **is not** reimbursable.

Recreational Situations:

Introducing a client to a Friendship Center and debriefing about the visit **is** reimbursable.

Teaching the individual how to lift weights **is not** reimbursable.

Vocational Situations:

Visiting the client's job site to teach them how to cook hamburgers **is not** reimbursable.

Responding to the employer's call for assistance when a client is in tears at work because they are having trouble learning to use a new cash register **is** reimbursable **if** the focus of the intervention is assisting the individual to decrease their anxiety enough to concentrate on the task of learning the new skill.

Teaching a client how to use a cash register **is not** reimbursable.

MH LOCKOUT AND NON-BILLABLE CODES

BLOCK BILLING WITH LOCATION CODES AND NON-BILLABLE SERVICE CODES

All staff must understand how services are claimed and know that some services are not claimable. Non-reimbursable codes and certain location codes block the service from being billed. Progress notes entered into the medical record result in claims for service unless one of the following codes is selected.

NON-BILLABLE SERVICE CHARGE CODES

DIRECT CLIENT CARE UNCLAIMABLE (55) is the code used for services provided to clients and their families that are not claimable to Medi-Cal. These services are meant to include the wide variety of services deemed to be necessary for recovery and resiliency, but not reimbursable as Mental Health or other claimable clinical services. This category is intended to permit flexibility in treatment planning on the part of clinical teams and to promote the adoption of recovery-based services to individual clients. These services may be documented by all members of the clinical teams working with clients. Unclaimable services include:

- Transportation of client
- Leaving or listening to voicemail messages and sending/receiving faxes or emails
- Scheduling appointments
- Interpretation/Translation only (without a service)
- Assistance provided to family members seeking needed services for him/herself
- Ongoing Rep-Payee functions such as requesting checks
- Letter excusing client from jury duty/testifying, waiting in court
- Closing a chart (transfer of case could be Case Management or Plan Development)
- Writing a discharge note
- Reviewing and preparing records for an authorized release

Please review a more comprehensive list of non-billable services/activities on p. 17 of this manual.

LOCATION LOCKOUTS

The setting in which an individual resides may make services non-reimbursable. Once the location is entered, our information system will "lock out" the claim from billing. The following locations are blocked from billing:

26.5 OUT-OF-STATE (Client's location)

IMD (Client's location)

JAIL/YOUTH SERVICES CENTER (Client's location)

MISSED VISIT (No Show/Client not at home)

PSYCHIATRIC HOSPITAL (Client's location - billing blocked unless Case Management for placement/discharge planning)

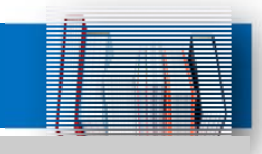
REDWOOD HOUSE (Client's location - billing blocked unless Medication Support or Case Management)

SKILLED NURSING FACILITY –PSYCH (Client's location)

When determining which location type to code: (*See pg. 23 for examples)

- first consider where the client is located,
- then consider your location.

AOD & MH PROGRESS NOTE LOCATION CODES



LOCATION TYPES	EXAMPLES
26.5 Youth Out-of-State	
Age-Specific Community Center	Senior Center, Teen drop-in center.
Client's Job Site	VRS, Safeway, Longs
Faith-Based	Church, temple, mosque.
Field Location away from the clinician's usual place of business.	Coffee shop
Health Facility/PCP/SNF Primary care or general health care provider, including services to patients in a medical bed in a hospital, emergency room, and public health clinic	Fair Oaks Clinic, Edison Clinic, Daly City Clinic, Willow Clinic, ER
Home – Private residences, hotels	Belmont Studios, Industrial Hotel
Homeless Shelter - Services provided at the shelter	Spring Street Shelter, Maple St.
IMD/MHRC (Client's location)	Cordilleras, 3rd floor
Jail/Youth Services Center (Correctional Facilities – Client's location here supersedes clinician's location.) Exception: Clients on GPO (general placement order) are not counted as being in a "Correctional Facility." If client is on GPO (general placement order) use GPO - Jail/Youth Services Center.	Maguire Facility/ Jail, Youth Services Center (non-GPO), Camp Kemp
Missed Visit	All "No Shows" in all locations
Mobile Service	Mobile Clinic
Non-Traditional Location	Park bench, on street, under bridge,
Office - A clinician's assigned work site/clinic. Does not include phone.	All county clinics, TDS sites
Other Community Location - formalized community meeting areas	Friendship Center, Heart & Soul, Pyramid Alternatives
PES (Psychiatric Emergency Services)	Client's Location
Phone does not include video conferencing or voicemails (see below)	
Psychiatric Hospital Inpatient – (Client's location here supersedes clinician's location)	Client's Location 3AB, Mills-Peninsula, St. Mary's
Redwood House (Medsup/Casemgmt). This is billable.	Client's Location
Redwood House (Billing Blocked)	Client's Location
Residential Care- Adults/Licensed Community Care Facility	Redwood House, Cordilleras Suites, Hawthorne House, Wally's Place, WRA
Residential Care- Children/Residential Care Facility	COYC, Foster homes, Receiving Home
School Not TDS staff, TDS uses "Office"	K-12
Skilled Nursing Facility – Psych	Client's Location
Telehealth "Telemedicine"- Clinician and client are in two different locations	E.g. video conferencing
Voicemail/Fax/Email (Billing Blocked)	Receive or send voicemail, email or fax

MENTAL HEALTH BILLING LIMITATIONS BY LOCATION

LOCKOUTS, OVERRIDES, COMPUTER EDITS & OTHER LIMITATIONS

	MH	Med Sup*	Case Mgmt	Day Tx	TBS	Adult Res-idential	Crisis Resi-dential	Crisis Inter-vention **	Crisis Stab ER ***	Inpatient
Mental Health				T			A		L	A
Medication Sup*									L	A
Case Management or Intensive Care Coordi-nation ("Katie A" ser-vices)				I	I					I
Intensive Home-Based Services ("Katie A" Services)				I	I		A		L	A
Day Rehabilitation	T			L			A		L	A
Day Treatment	T			L			A		L	A
TBS						L	A			A
Adult Residential					L	L	L		L	A
Crisis Residential	A			A	A	L	L	A	L	A
Crisis Intervention**							A		L	A
Crisis Stabilization ER***	L	L		T		T	L	L	L	A
Inpatient	A	A	I	A	A	A	A	A	A	L

I **Institutional Limitations-Audit**
L **Lockout**
OR **Override**
A **Lockout except for day of admission**
T **This is only a Lockout for the same day treatment/day rehab staff during the day treatment/rehab programs hours of operation, not a computer edit. Day Treatment/Day Rehab staff may not bill for Mental Health Service at the same time they are staffing the day treatment or day rehab program- Other providers may bill with authorization.**
***** **Maximum of 4 hours per day.**
****** **Maximum per 24 hour period is 8 hours**
******* **Maximum per 24 hour period is 20 hours**
Providers may not allocate the same staff time under two cost centers for the same time period

TRANSFER/DISCHARGE REQUEST

Complete the Transfer/Discharge Request form when you discharge or transfer a client (applies to all teams). **If you are discharging a client from your program and all of BHRS:**

- Complete the Transfer/Discharge Request. Write a progress note about the discharge, adding any clinical information as needed.
- Use code 55 (unclaimable) for documenting the discharge.

If you are discharging a client from your program AND at the same time transferring him/her to another county program:

- Complete the Transfer/Discharge Request.

MENTAL HEALTH SERVICES

Services provided by Behavioral Health and Recovery Services (BHRS) are designed to improve behavioral health outcomes for clients and families with substance use disorders, mental illness and/or co-occurring disorders. These services are based on the needs, strengths and choices of the individual client/family, and involve clients and families in planning and implementing treatment. Services are based on the client's/family's recovery goals concerning their own life, functional impairment(s), symptoms, disabilities, strengths, life conditions, cultural background, spirituality and rehabilitation readiness. Services are focused on achieving specific objectives to support the individual in accomplishing their desired goals. The unique values and strengths of both Mental Health and Substance Use providers are honored while we work together to create maximum opportunities to combine best practices in prevention, assessment and treatment within our integrated system.

Mental Health Services are those individual, group, or family therapies and interventions that are designed to reduce mental disability and/or facilitate improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

Services are directed toward achieving the client's/family's goals and must be consistent with the current Client Treatment and Recovery Plan. In this context, Mental Health Services is a term that includes the following services:

- **Assessment & Assessment Group**
- **Plan Development**
- **Rehabilitation & Rehabilitation Group**
- **Therapy & Therapy Group**
- **Collateral & Collateral Group**
- **Family Therapy**

Mental Health Services and other service categories (e.g., Medication Support Services, Case Management, Therapeutic Behavioral Services, and Crisis Intervention) are claimed in minutes, based on actual staff time.

PLANNED SERVICES

Planned service may only be provided with an assessment and treatment plan in place. (*See pg. 28-29 for more information)

UNPLANNED SERVICES

May be provided as needed. (*See pg. 30 for more information)

Medi-Cal will reimburse an MHP for some services provided to a beneficiary before his or her client plan is approved.

Prior to the client plan being approved with the required staff signature(s) on the client plan, the following services are reimbursable:

a. Assessment (5)

b. Plan Development (6)

c. Crisis Intervention (2)

d. Crisis Stabilization (PES)

e. Medication Support Services (if there is an emergency or immediate need which must be documented)

f. *Some* Targeted Case Management (51) Services

(See 1-3 below)

Pursuant to the State Plan, "Targeted Case Management" includes the following services:

1. *Comprehensive assessment to determine whether a beneficiary needs targeted case management services to access medical, educational, social or other services.*

2. *Development of a client plan.*

3. *Referral and Related Activities to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services.*

4. Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's needs.

Medi-Cal will disallow payment for certain services if at the time the services were provided, the beneficiary being treated did not have an approved client plan. What are those services?

The following specialty mental health services cannot be billed to Medi-Cal unless the beneficiary receiving the services has an approved client plan:

a. Therapy, groups, family therapy, collateral, rehabilitation, medication support (except for emergency), case management not geared toward assessment/plan development.

b. Day treatment intensive (must have completed client plan within 5 days of admission).

c. Day rehabilitation (must have completed client plan within 5 days of admission).

d. Adult residential treatment services (must have completed client plan within 5 days of admission).

e. Crisis residential treatment services (except crisis intervention services, assessment and client plan development). Must have completed client plan within 5 days of admission.

Providers may elect to prepare an "initial client plan" for a beneficiary within a short period of time of the beneficiary coming into the system in order to quickly begin providing services to the beneficiary that cannot be provided without an approved client plan. For example, if a beneficiary is initially assessed to need medication support services the MHP or provider could prepare (and obtain the necessary signatures for) an initial client plan that includes medication support services only. Once the MHP or provider has completed a comprehensive assessment of the beneficiary, the initial client plan would be updated to be comprehensive. Note: the beneficiary's comprehensive client plan must be completed within the MHP's time line for completion of an initial client plan, and all other client plan requirements must be met.

ASSESSMENT (5)

This code is used to document a clinical analysis of the history and current status of an individual's mental, emotional, and behavioral condition. It includes an appraisal of the individual's functioning in the community—i.e. psychosocial factors such as living situation, daily activities, social support systems, and medical health history and status.

The assessment process explores and documents the presenting problems that bring the client to treatment, the client's mental health history, the client's and family's strengths, risk factors, and a complete developmental history (youth).

Assessment includes screening for substance use/abuse, establishing diagnoses and medical necessity, and determining the need for testing procedures. Although assessment services may be provided by any staff member, the mental status examination (MSE), diagnosis, psychological testing and clinical formulation must be completed by a clinician consistent with his/her scope of practice. (See "Admission Assessment" Pg. 7-9 and "Scope of Practice" Pg. 42-44)

- All mental health services provided for the purpose of gathering information and completing both the annual assessment and admission assessment should be coded as Assessment (5).
- All mental health services provided to assess a child/youth for eligibility for mental health treatment through an IEP process should be coded as Assessment. [See section "Children/Youth Assessment of Need (Pre-IEP) Special Documentation Issues".]

PLAN DEVELOPMENT (6)

This code is used to document the development of the client treatment plan in collaboration with the client, to obtain approval of client treatment plans, and to monitor the client's progress related to the client treatment plan. Plan Development may be claimed by any clinical staff person.

It is expected that Plan Development is provided during the development/approval of the initial treatment plan and subsequent treatment plans. However, Plan Development may be provided at other times, as clinically indicated. For example, when the client's status changes—i.e. significant improvement or deterioration—it will likely be necessary to update the treatment plan.

Plan Development (6) is reserved for clinical activities that directly address the Client Treatment and Recovery Plan, safety plan, or other treatment planning. Time spent developing *acute care* discharge plans, transportation plans or benefit plans should be claimed as Targeted Case Management/Brokerage (51).The MD involved in a case discussion provides medical information involving the treatment plan and should code the service as (17).

A PLAN DEVELOPMENT PROGRESS NOTE DESCRIBES:

Developing

Approving

Modifying

the client treatment plan

Clinicians/staff must accurately specify the activity or service provided in the service charge code field of the progress note. In addition, the content of the progress note must support the specific type of service.

PROGRESS NOTES DESCRIBE:

- The list of people involved in the service and their roles
- Goal/Objective/Behavior Addressed
- Client's presentation/behavior in session
- Clinical Interventions and Client's Responses
- Outcome of services and follow-up plan (if needed)

REHABILITATION (7)

This code is used to document the following services and can be delivered by any clinical staff member to an individual and/or family or to a group of clients. **Rehabilitation includes:**

- Assistance in improving, maintaining, or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication compliance.
- Counseling of the client and/or family including psychosocial education aimed at helping to achieve the individual's goals.
- Monitoring medication compliance by non-medical staff.

COLLATERAL (12)

This code is used to document contact with any significant support person in the life of the client (e.g., family member, roommate) but excludes contact with other professionals involved in the client's case. The intent of the contact is to improve or maintain the mental health of the beneficiary.

Collateral may include helping significant support persons understand and accept the client's mental health condition. This may involve consultation with and/or training of the significant support person.

Collateral may also be billed for consultation and training of the significant support person, to further better utilization of mental health services by the client. It may involve consultation with and training of a significant support person to support them in assisting with the planning and provision of the client's care.

A COLLATERAL PROGRESS NOTE DESCRIBES:

Helping the significant support persons understand and accept the client's mental health condition, and involving them in planning and provision of care. Include in Collateral progress notes:

- List people involved in the services and their role
- Training/counseling provided to the Significant Support Person regarding the client's diagnosis
- Describe how the Client's behavior/mental health goals were addressed
- Response to the mental health Interventions
- Follow-up Plan (if needed).

INDIVIDUAL THERAPY (9)

This code is used to document therapeutic interventions, consistent with the client's goals, which focus primarily on symptom reduction as a means to minimize functional impairments. This service activity is delivered to an individual client.

Therapy provided to the client with other members of the family present is coded Family Therapy (41).

FAMILY THERAPY (41)

This code is used to document therapy services focused on the care and management of the client's mental health condition within the family system. The client and one or more family/significant support persons must be present.

GROUP THERAPY (10)

This code is used to document therapeutic interventions in a group setting, consistent with the client's goals, which focus primarily on symptom reduction as a means to minimize functional impairments. The progress note must document the client's unique behavior, participation and responses to the group process.

SCOPE OF PRACTICE

Therapy services may only be provided by clinicians consistent with their scope of practice as follows: licensed psychiatrist, psychologist, LCSW, and MFT; registered MFT-INTERN or ASW; waivered psychologist; registered nurse with a Master's Degree in a mental health specialty; or trainees under the supervision of licensed clinicians. (See Scope of Practice Pg. 42-44)

THERAPY PROGRESS NOTES:

- List people involved in the services and their role
- Behavior/Mental Status/Presentation
- How the service assisted client in improving/maintaining functioning
- Describe the Mental Health Interventions utilized and Client's Responses
- Follow Up Plan (if needed):

CASE MANAGEMENT (CODE 51, VRS51)

Case Management (CM) is a set of services that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to services; monitoring of the client's progress once they receive access to services; and development of the plan for accessing services. When CM services are provided to support a client to reach program goals, they must be listed as an intervention on the treatment plan.

A CASE MANAGEMENT

PROGRESS NOTE DESCRIBES communication, coordination, and referral; monitoring service delivery to ensure client access to services and service delivery; and development of the plan for accessing services.

Every Case Management progress note, to be billable, must include content that links the CM service to the client's **included mental health diagnosis**—its symptoms and/or impairments addressed.

Linkage and Coordination The identification and pursuit of resources including, but not limited to, the following:

- Inter-and intra-agency communication, coordination and referral.
- Monitoring service delivery to ensure an individual's access to services and the service delivery system.
- Linkage, brokerage services focused on transportation, housing, or finances.

Placement Services Supportive assistance to the individual in the assessment, determination of need, and securing of adequate and appropriate living arrangements including, but not limited to:

- 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 when Case Management is billable for clients in Medi-Cal eligible acute psychiatric inpatient hospitals (e.g. SMCHC, Peninsula, St. Mary's).

For clients in these facilities, case management services are billable only for the following purpose:

- Placement services provided within thirty (30) calendar days immediately prior to the individual's discharge from the facility.
- The location code for these services is always the client's location, e.g., acute psychiatric hospital.

IN CASE MANAGEMENT NOTES:

- **List people involved in the services and their role**
- **Describe planning/ linking/coordinating activity as it relates to the client's diagnosis, its impairments, and treatment plan objectives**
- **Describe the client's response and the outcomes**
- **Follow Up Plan (if needed)**

No other services may be claimed for clients in an acute psychiatric facility.

CRISIS INTERVENTION (CODE 2)

Crisis Intervention is an immediate emergency response intended to help a client exhibiting acute psychiatric symptoms which, if untreated, present an *imminent threat* to the patient or others.

Crisis Intervention (2) is a service lasting less than 24 hours. 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.

Service activities may include, but are not limited to, assessment, collateral and therapy to address the immediate crisis. Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.

CRISIS INTERVENTION

PROGRESS NOTES DESCRIBE:

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

EXAMPLE OF CRISIS INTERVENTION ACTIVITIES:

- **Client in crisis** - assessed mental status and current needs related to immediate crisis.
- **Danger to self and others** – assessed/provided immediate therapeutic responses to stabilize crisis.
- **Gravely disabled client/current danger to self** - provided therapeutic responses to stabilize crisis.
- **Client was an imminent danger to self/others** - a severe reaction to current stressors.
- Provided counseling to the client's significant support person(s) involved in **crisis stabilization on how to follow the safety plan.**

A Crisis Intervention progress note documents a service to address an immediate mental health emergency and describes the nature of the crisis, the crisis stabilization interventions used, the client's response, and the overall outcome.

AN EXCELLENT CRISIS INTERVENTION PROGRESS NOTE documents a clear description of the crisis that ***distinguishes the situation from a routine event***, and describes the clinician's interventions to help stabilize the client.

The maximum amount of time claimable to Medi-Cal for a client in a 24-hour period is eight (8) hours per client.

Pathways to Mental Health Services– Core Practice Model (KATIE A SERVICES)

Under a settlement agreement within a Federal class -action lawsuit, Mental Health Plans are now obligated to provide two new services for those children/ youth identified as members of the Katie A. subclass. Members of the subclass must meet the following criteria:

- Full scope Medi-Cal
- Open Child Welfare Case
- Meet medical necessity criteria for Specialty Mental Health Services, and also meet one of the following conditions:

Currently in or being considered for Wraparound, therapeutic foster care or other intensive services, TBS, specialized care rate due to behavioral health needs, or crisis stabilization/intervention.

Currently in or being considered for placement in a group home at RCL 10 or above, a psychiatric hospital or 23-hour mental health treatment facility, or has experienced 3 or more placements within 24 months due to behavioral health needs.

INTENSIVE CARE COORDINATION (ICC-51)

This code is used to document ongoing assessment, care planning and coordination of services, including urgent services and transition planning. This includes both facilitation and provision of these services.

- ICC-51 is mandated for children/youth in the Katie A. subclass. All Case Management services provided to Katie A. subclass members in the System of Care are documented using code ICC-51.
- In addition, services provided to these children/ youth as part of the Child/Family Team process are documented using this code.

INTENSIVE HOME BASED SERVICES (IHBS-7)

This code is used to document intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons.

The services are designed to help the child/youth develop skills and achieve the goals and objectives of the behavioral plan.

ICC-51
Follows basic documentation rules for Case Management

CFT ICC
Document CFT meetings.

IHBS-7
Follows basic documentation rules for Rehabilitation

P

Pathways to Mental Health-Core Practice Model (Katie A) EXCLUSIONS

Intensive Home Based Services (IHBS-7, described on the next page) may not be provided at the same time as Day Treatment Rehabilitative or Day Treatment Intensive, Group Therapy and Therapeutic Behavioral Services (TBS).

In addition, IHBS may not be provided to children/ youth in Group Homes. IHBS may be provided outside a Group Home setting to children/youth who are transitioning to a permanent home environment to facilitate this transition, during single day and multiple days visits.

GROUP SERVICES

This code is based on the specific service being provided and is used for interventions offered to more than one client in a group setting. Mental Health services may be provided to more than one individual at the same time. One or more clinicians may provide these services, but the total time for intervention and documentation may be claimed by a **maximum of two clinicians**. (If there are more than two clinicians providing the service, there should be documentation of services provided by all clinicians present, but only two clinicians may bill for the service.) Different amounts of time may be claimed by each clinician, depending on the number of minutes each provided mental health services. The time billed for each group must be allocated evenly among all members of the group, whether or not the clients are Medi-Cal beneficiaries.

All group providers must be eligible to bill the service type. If the group is Therapy, all group co-providers must be able to provide therapy.

All members of the group must be current clients (or collaterals of current clients) of BHRS or of a contractor providing the service. Only one progress note is written for each client even if two staff lead the group. One staff writes and signs/finalizes the note. In BHRS, we provide several types of group services that vary based on the primary focus of activities and interventions, as follows:

Group Assessment Groups focused on mental health assessment—billing/service code (50).

Group Rehabilitation: Groups focused on psychosocial rehabilitation—code (70).

Group Therapy: Groups providing therapy and focused primarily on symptom reduction in order to minimize functional impairments—code (10).

Group Collateral: Group services using a multi-family modality and focused on enhancing the family's ability to address the client's/youth's mental health needs—code (120). Provided to parents or other significant persons in a client's life. A collateral group assists significant support persons with the development of skills needed to specifically address clients' mental health issues. All documentation will be in the chart of the client being treated.

Medication Support Groups: Groups providing medication support services—code (150).

Group Documentation:

- Group progress notes are documented in AVATAR using the BHRS Outpatient Progress Note.
- Enter the number of clients *present*, not the total number of clients normally enrolled in the group.
- Indicate any co-provider/therapist who participated in the group.
- Indicate how much time each therapist spent on the group and any documentation/travel time; therapists may spend unequal times with the group.
- The computer will calculate the correct time to allocate for each member.
- Indicate the overall group focus in each note. Then **document the client's participation**. Address behaviors/goals, interventions, responses, and plan **as related to the client's Diagnosis/impairments**.
- Co-providers—If there are two providers, both providers' participation must be documented in the progress note. Medical Necessity for two providers must be documented.

Example Calculation: A group service is provided by two staff for a group of seven clients, and the reimbursable service, including direct service, travel time, and documentation lasts one hour and thirty-five minutes (95 minutes) for each staff member. The total units reported will be 95 minutes times two staff members divided by seven clients (95 min. x 2 staff ÷ 7 clients = 27.1 minutes). Within BHRS, the Avatar system will provide the allocation of time for each client present. Round to the nearest minute.

Coding Examples:

- Healthy Living type groups – Rehabilitation (70) if led by non-medical clinician. Coded Medication Support (150) if led by a nurse and related to med-related weight gain, impact of smoking on stress/anxiety, etc.
- Medication Groups (150) led by MDs and/or RNs.
- Therapy Groups (10) DBT, Cognitive Behavioral Groups, Trauma Focused Therapy, etc.

Note: Family Therapy is *not* a Group

MEDICATION SERVICES include prescribing, administering, dispensing and monitoring of psychiatric medications necessary to alleviate the symptoms of mental illness. The services include evaluation of the need for medication, clinical effectiveness and side effects, obtaining informed consent, ordering related lab work, medication education, plan development related to the delivery of the service, and assessment of the client.

MEDICATION SCOPE OF PRACTICE Medication Support Services may be provided by the following staff:

- Licensed Physician
- Mental Health Nurse Practitioner
- Registered Nurse
- Licensed Vocational Nurse
- Licensed Psychiatric Technician
- Licensed Pharmacist

When providing a service that is not primarily medication support, physicians and nurses must use the relevant service charge code—e.g. (9) for Therapy, (51) for Case Management/ Brokerage, (7) for Rehabilitation.

TYPES OF MEDICATION SUPPORT SERVICES

MEDICATION INITIAL MD/NP ASSESSMENT (14) is used for initial assessments (PINs).

MEDICATION SUPPORT (15) is used for:

- Medication evaluation, prescribing, or dispensing.
- Evaluation of clinical effectiveness and side effects of medication.
- Obtaining informed consent for medication.
- Medication education (discussing risks, benefits and alternatives with client/support persons).
- Completion of annual assessment.
- Plan Development (MD and Nurse Practitioners when the client is present).

MEDICATION RISPERDAL/INVEGA INJECTION(19) is the injection of Risperdal (Consta or Invega Sustenna) by a RN, LPT or LVN.

MEDICATION INJECTION (16) is the administration of medication by injection by a RN, LPT or LVN.

MDs and NPs only use Medication Support (15) for face-to-face services with clients.

MDs and NPs use Medication Support MD/NP ***not*** face-to-face (17) when providing a service that is not billable to Medicare (when the client is not present).

RNs, LPTs or LVNs may use Medication Support (15) for both face-to-face and not face-to-face billable services.

MEDICARE CLAIMING

Although the predominant payer for services provided to our adult clients remains Medi-Cal, it is critical that we are scrupulous in documenting services for clients who are insured by Medicare, or who have Medicare/Medi-Cal coverage. Accurate claiming is necessary for full compliance with State and Federal law.

Even though Medicare and Medi-Cal both utilize Federal dollars, they do not follow the same rules. Medicare will reimburse for services according to strict definitions, using a medical model that does not emphasize a rehabilitative focus. Only face-to-face time is reimbursable to Medicare. We cannot submit claims for time spent on the telephone, documenting services, or in collaboration, unless connected to a face-to-face service.

The key to Medicare compliance is through the use of correct service charge codes and by accurately recording the location where services are provided.

MEDICATION SUPPORT MD/NP NOT FACE-TO-FACE (17) USED BY MD AND NP ONLY

Examples of services by physicians and nurse practitioners that are not billable to Medicare but that may be billed to Medi-Cal include the following:

- Time spent filling out disability and other reports, writing letters with clinical content, managing documentation.
- Conferences with team members during which the MD/NP imparts medical information.
- Services provided over the phone.
- Time reviewing chart (without client present) for prescribing or assessment.
- Medical consultations with other providers.

When providing a service that is not primarily medication support, physicians and nurses use the relevant service charge code, such as (9) for therapy, or (51) for Case Management.

- Do not use code (15) for an initial assessments (PIN); use code (14).
- Use code (15) for follow-up visits, annual assessments, plan development, and any medication-related activities you perform with the patient face-to-face.
- MD/NP Use code (17) for activities when the patient is not present; RN use (15). Includes services over the phone, medical consultations with other providers, chart review for prescribing or assessment (without patient present), filling out disability forms, writing letters with clinical content, and conferences with team members during which you impart medical information.

MEDICATION SERVICES WITH CODES, PLANNED SERVICES

SERVICE	DESCRIPTION	EXAMPLES OF DOCUMENTATION IN NOTES
MEDICATION INITIAL MD/NP ASSESSMENT (14)	Used for initial assessments (PINs).	Completed Initial Assessment.
MEDICATION SUPPORT (15)	Services within the scope of practice of an MD or nurse include: Clinical assessment follow-up or annual with evaluation of the need for medication. Evaluation of clinical effectiveness and side effects of medication. Obtaining informed consent for medication. Prescribing, administering, and/or dispensing medication. Medication education (risks, benefits, alternatives) with client or significant support person). Plan Development with client present.	Evaluated client for anti-psychotic medications. Informed client of Prolixin's risks/benefits. Obtained informed consent for medication. Wrote the Physician Initial Note (PIN) Completed the Client Treatment Plan with the client, which the client signed and accepted a copy.
MEDICATION INJECTIONS (16)	Medication administered by injection.	Medication given IM, site, response, side effects, etc.
MEDICATION SUPPORT MD/ NP NON FACE-TO-FACE (17)	Services within scope of practice of an MD or NP including: Filling out disability/other reports, reviewing chart. Consultations with providers, team conferences. Phone calls to pharmacy. Plan Development when the client is not present.	Completed medical report for SSDI application Conferred with NP about impact of client's obesity on his mental health. Reviewed chart prior to meeting tomorrow with client.
MEDICATION RISPERDAL/ INVEGA INJECTIONS (19)	Risperdal Consta or Invega Sustenna medication administered by injection	Medication given IM, site, response, side effects, etc.

MENTAL HEALTH DAY TREATMENT SERVICES, PLANNED SERVICES

Day Rehabilitation is a structured program of rehabilitation and therapy utilized to improve, maintain or restore personal independence and functioning consistent with requirements for learning and development. These services are provided to a distinct group of beneficiaries.

For seriously emotionally disturbed children and adolescents, Day Rehabilitation focuses on maintaining individuals in their communities and school settings, consistent with their requirements for learning, development and enhanced self-sufficiency. Services focus on improvement in areas of delayed personal growth and development. This service may be integrated with an education program.

Day Treatment Intensive services provide a structured multi-disciplinary treatment program as an alternative to hospitalization, to avoid placement in a more restrictive setting, or to maintain the client in a community setting.

For seriously emotionally disturbed children and adolescents, Day Treatment Intensive provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration. Interventions are intended to prevent hospitalization, placement in a more restrictive facility, or out-of-home placement. This service may be in-

AUTHORIZATION REQUIREMENTS

The DHCS/MHP contract requires mental health plans to establish payment authorization systems for Day Treatment Intensive and Day Rehabilitation. MHPs must require providers to request MHP payment authorization for Day Rehabilitation at least every six months, and for Day Treatment Intensive at least every three months. The MHP also requires providers, including MHP staff, to request prior authorization when day treatment intensive or day rehabilitation will be provided for more than five days per week.

The MHP requires providers to request payment authorization for medication support, counseling, psychotherapy, other mental health services, and case management provided on the same day as day treatment intensive or rehabilitation, excluding services to treat emergency and urgent conditions. Providers must request payment authorization for continuation of these services on the same cycle as day treatment intensive or day rehabilitation.

The MHP shall provide notice of authorization decisions for day treatment expeditiously and within 14 calendar days following receipt of an authorization request. The MHP may use a 14-day extension if further information is needed. For expedited authorization requests, the MHP will issue an authorization decision within 3 working days of receipt of the request. For further information, see BHRS Managed Care Policy 04-09.

Requests for authorization and reauthorization of Day Treatment services, and certain contracted outpatient mental health services, shall be submitted using the approved Day Treatment Authorization Forms. Initial Authorization Requests must be submitted within one month following the child's entry into the program. If subsequent services are warranted, authorizations must be submitted within the one-month window prior to the expiration of the existing authorization. Forms must be fully completed and signed in order to prevent delays in authorization.

DOCUMENTATION

- For Day Rehabilitation, clinicians must provide a weekly summary, and document a monthly contact with family, caregiver or significant support person, focusing on the role the support person has in supporting the client's community reintegration. Further, every service contact will be documented for any authorized *mental health service.*
- For Day Treatment Intensive, clinicians must provide a daily progress note *and* a weekly summary, as well as a monthly contact with a support person as described above. Further, every service contact will be documented for any authorized *mental health service.*
- The weekly summary may only be signed by one of the following staff: physician; licensed, registered, waivered psychologist, clinical social worker or MFT; Registered Nurse.

THE BILLING UNIT is a Full Day of program time. The provider must keep an attendance log that verifies the hours of attendance, *excluding* breaks/meals.

- Full Day programs must have services available for over four (4) hours each day. The client must attend at least half of the day treatment day in order for the provider to claim for day treatment services. Providers must document the actual number of hours and minutes a client attends each day. If a client is unable to attend the full day, the reason *must* be documented.
- Individual or Group Therapy is a **required** component of Day Treatment Intensive and may not be billed separately.
- Medication Support Services are billed separately.

LOCKOUTS

- Day Treatment or Day Rehabilitation services are not reimbursable on days when Crisis Residential Treatment Services, jail, or Inpatient Psychiatric Facility services are reimbursed, except for the day of admission to those services.
- Mental Health Services are not reimbursable when provided by Day Treatment Intensive or Day Rehabilitation staff during the same period that Day Treatment services are being provided.

MENTAL HEALTH TBS PLANNED SERVICES

Therapeutic Behavioral Services (TBS) are one-to-one therapeutic contacts between a mental health provider and a beneficiary, for a specified period of time, designed to maintain the child/youth's residential placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals.

A contact is considered therapeutic if it is intended to provide the child/youth with skills to effectively manage behavior(s) or symptom(s) that act as barriers to achieving residence in the lowest appropriate level of care. These activities should be claimed using the TBS Service charge code (58).

TBS Assessment is the initial assessment and plan development for a child referred to TBS services. A TBS assessment, including functional analysis and TBS Client Plan, must be completed prior to initiating TBS services. These activities should be claimed using the TBS Assessment Service charge code (30).

The person providing TBS is available onsite to provide individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written treatment plan. The critical distinction between TBS and other rehabilitative Mental Health Services is that a significant component of this service activity is having the staff person on site and immediately available to intervene for a specified period of time. The expectation is that the staff person would be with the child/youth for a designated time period, and the entire time the mental health provider spends with the child/youth (in accordance with the treatment plan), would be reimbursable. These designated time periods may vary in length and be up to 24 hours a day, depending upon the needs of the child/youth.

Two important components of delivering TBS are:

- Making collateral contacts with family members, caregivers, and others significant to the client.
- Developing a plan clearly identifying specific target behaviors to be addressed and the interventions that will be used to address the target behaviors.

TBS must be identified as an intervention by the primary therapist on the overall Client Treatment and Recovery Plan. TBS is not a stand-alone service. For additional information, contract agencies should consult their contract with San Mateo County.

ELIGIBILITY FOR TBS

To be eligible to receive TBS services, a child/youth must meet all of the criteria noted below in sections A, B and C.

A. Eligibility for TBS, must meet criteria 1 and 2.

1. Full-scope Medi-Cal beneficiary under 21 years, and
2. Meets MHP medical necessity criteria.

B. Member of the Certified Class, must meet criteria 1, 2, 3, *or* 4.

1. Child/youth is placed in a group home facility of RCL 12 or above and/or a locked treatment facility, for the treatment of mental health needs, which is not an Institution for Mental Disease (if it were an IMD, it would disqualify Medi-Cal claiming).
2. Child/youth is being considered by the county for placement in a facility described in B.1 above; or
3. Child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months; or
4. Child/youth previously received TBS while a member of the certified class.

C. Need for TBS, must meet criteria 1 *and* 2.

1. The child/youth is receiving other specialty mental health services, and
2. It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of TBS that:

- The child/youth will need to be placed in a higher level of residential care, including acute care, because of a change in the child/youth's behaviors or symptoms which jeopardize continued placement in current facility; or
- The child/youth needs this additional support to transition to a lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS is needed to stabilize the child in the new environment. (The MHP or its provider must document the basis for the expectation that the behavior or symptoms will change.)

REQUIREMENTS

TBS services must be authorized in accordance with the following timelines:

- Referrals from mental health service providers are reviewed by the Supervisor of Youth Case Management for appropriateness. A complete referral must include: an Assessment completed by the Primary Mental Health Clinician, a qualifying Medi-Cal Diagnosis, and a Treatment Plan that indicates referral to, and collaboration with, TBS in relation to specific goals.
- Completed packets will be forwarded to the TBS service provider within 3 working days. The TBS service provider will have up to 30 days to complete a TBS assessment.
- The TBS provider will submit authorization requests to the TBS Coordinator in advance of service delivery. TBS services may not be authorized retroactively.
- The MHP shall provide notice of authorization decisions for TBS expeditiously and within 14 calendar days following receipt of an authorization request. The MHP may use a 14-day extension if further information is needed.
- For expedited authorization requests, the MHP will issue an authorization decision within 3 working days of receipt of an authorization request.
- For further information concerning authorizations, see BHRS Policy 04-09.

ADULT RESIDENTIAL TREATMENT SERVICES (TRANSITIONAL)

Adult Transitional Residential Treatment Services are rehabilitation services provided in a non-institutional, residential setting. They support clients in their efforts to restore, maintain and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a therapeutic community including a range of activities and services for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. This is a structured program with services available 24 hours a day, seven days a week.

Service Activities may include Assessment, Rehabilitation, Therapy, Group Therapy, Plan Development and Collateral, which are included in the daily billing rate. Medication Support Services shall be billed separately from Adult Residential Treatment Services.

Weekly Summaries by the treatment staff are required.

Residential treatment weekly summaries must address the following areas:

- Activities in which the client participated, including services and groups
- Client's behaviors and the staff's interventions addressing the client's mental health diagnosis
- Progress toward treatment plan objectives, or lack thereof, and involvement of family members, if appropriate.
- Contact with other programs/agencies/treatment personne involved with the client's treatment
- In the event of any incidents, 5150s, crises or medical concerns, there must be notes for all staff involved in the client's treatment

Outpatient Mental Health Services follow standards for mental health services cited earlier in this manual. There are no lockouts for Mental health services provided by other teams for a client in adult residential treatment.

Staffing Ratios

Staffing ratios and qualifications in Adult Residential Treatment Services shall be consistent with Section 531 of Title 9, California Code of Regulations.

A clear audit trail shall be maintained for staff members who function as both Adult Residential Treatment staff, residential staff, and/or in other capacities.

CRISIS STABILIZATION - EMERGENCY ROOM

Crisis Stabilization (PES) - Emergency Room is an immediate face-to-face response lasting less than 24 hours, to or on behalf of an individual exhibiting acute psychiatric symptoms, provided in a 24-hour health facility or hospital-based outpatient program. The goal is to avoid the need for Inpatient Services by alleviating problems and symptoms which, if not treated, present an imminent threat to the individual's or other's safety, or substantially increase the risk of the individual becoming gravely disabled. Services provided to clients in a Crisis Stabilization-Emergency Room program must be separate and distinct from services provided to clients in an Inpatient Facility or 24-hour health care facility. Services shall be available 24 hours per day.

Service Activities Service activities are provided as a package and include but are not limited to Crisis Intervention, Assessment, Therapy, Collateral, Case Management and Medication Support Services.

The maximum number of hours billable for Crisis Stabilization-Emergency Room, in a 24-hour period, is 20 hours.

CRISIS RESIDENTIAL TREATMENT SERVICES

Crisis Residential Treatment Services are therapeutic and/or rehabilitative services provided in a 24-hour residential treatment program (e.g., Redwood House) as an alternative to hospitalization. Services are for individuals experiencing acute a psychiatric episode or crisis who do not present medical complications requiring nursing care. Clients are supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Interventions that focus on symptom reduction shall also be available. The service is available 24 hours a day, seven days a week.

Service Activities Service activities may include Assessment, Plan Development, Rehabilitation, Therapy, Group Therapy, Collateral, and Case Management, which are included in the daily billing rate. Not all of the activities need to be provided for the service to be billable. Only Medication Support Services and Case Management can be billed separately from Crisis Residential Treatment Services.

Staffing Ratios

Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with Section 531 of Title 9, California Code of Regulations.

A clear audit trail must be maintained for staff who function both as Crisis Residential Treatment staff and also in other capacities.

Progress Notes

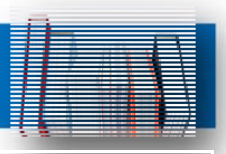
Crisis Residential Services require Daily Progress Notes.

Except for day of admission, Mental Health Services are locked out and cannot be claimed on days a client received crisis residential services. Targeted Case Management Services may be claimed for a client receiving crisis residential services.

MENTAL HEALTH SERVICES TABLE

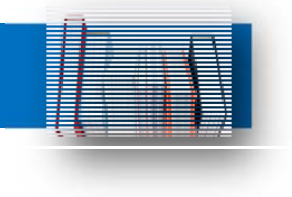
SERVICE TYPE	DESCRIPTION	EXAMPLES OF DOCUMENTATION IN NOTES
ASSESSMENT (5)	The evaluation and analysis of a client's historic and current mental, emotional, and/or behavioral disorders. Review of any relevant family, cultural, medical, substance use, legal, risks or other complicating factors.	Administered Mini-Mental Status Examination. Administered CAGE Questionnaire. Took Family History. Completed Annual Assessment (see form in chart).
COLLATERAL (12)	Consultation and training of the significant support person to assist in better utilization of mental health services by the client. Consultation and training of the significant support person to assist in better understanding the client's serious emotional disturbance. **Collateral progress notes must include specific, diagnosis-related content.**	Met with the client's parents to help them understand and accept the client's Schizophrenia and involve them in planning and providing care. Educated client's mother about Reactive Attachment Disorder to enable her to parent client more effectively.
PLAN DEVELOPMENT (6)	Development of client plan. Approval of client plan.	Met with client to develop and review client care plan, which client approved. Client signed plan and accepted a copy.
REHABILITATION (7)	Working with a client to develop skills that maintain and/or restore optimal functioning. Providing education/training to assist the client to achieve their personal goals in areas such as daily living skills, socialization, mood stabilization, resource utilization, and medication compliance. Assistance to assess housing needs and obtain and maintain a satisfactory living arrangement. **Rehabilitation progress notes must include specific, diagnosis-related content.**	Helped client develop budget and define housing needs. Interventions focused on reduction of depressive symptoms to improve functioning. Developed strategies with client to access Senior Center activities to alleviate isolation Provided support for medication compliance to maintain stability regarding psychotic symptoms. Used role modeling to assist client to reduce anxiety and prepare for meeting with boss.
VRS REHABILITATION (VRS -07) <u>Used only by VRS staff</u>	Working with a client to develop skills that maintain and/or restore optimal functioning. Providing education/training to assist the client to achieve his/her personal goals in such areas as daily living skills, socialization, mood stabilization, resource utilization, and medication compliance. **VRS progress notes must include specific, diagnosis-related content.**	Worked with client on development of skills to enable client to be less emotionally reactive while on the job. Accompanied client on public transportation to potential work site to help reduce client's anxiety about getting lost. Provided interventions (e.g., reassurance and support, monitoring client's emotional response) to help client reduce anxiety during a job interview.
INDIVIDUAL THERAPY (9)	Therapeutic interventions consistent with client goals and focuses primarily on symptom reduction to improve functioning.	Provided grief counseling. Reviewed homework assigned in Cognitive Behavioral Therapy session to address client's low self-esteem.
FAMILY THERAPY (41)	Therapy directed toward the family system in which the client is present with at least one or more family members or significant support persons. **Individual and Family Therapy progress notes must included specific, diagnosis-related content.**	Met with client and parents who reported using communication strategies to resolve conflict two times since the last meeting. Met with client, siblings, and parents who reported high levels of conflict in the past week.
ASSESSMENT TBS (30)	Assessment of the need for TBS services.	Met with client and family to discuss the frequency and circumstances of reported problematic behaviors.

MENTAL HEALTH COMMON SERVICES WITH CODES



SERVICE TYPE	DESCRIPTION	EXAMPLES OF DOCUMENTATION IN NOTES
CRISIS INTERVENTION (2)	Unplanned event that results in a client's need for immediate intervention which, if untreated, presents an imminent threat to the patient or to others, or results in the client being or becoming gravely disabled.	Assessed acuity of symptoms and coordinated 5150 process. Assessed intent/plan for self-harm. Client denies plan and agrees to go to a crisis house.
CASE MANAGEMENT(51)	Identification and pursuit of resources necessary for client to access service and treatment. Inter- and Intra-agency communication regarding needed services to address and stabilize mental health condition. Discharge planning and placement services. **Case Management progress notes must include specific, diagnosis-related content.**	*To be billable, all Case Management services must be linked to the symptoms/impairments resulting from the client's diagnosis. Helped client obtain Redi-Wheels application.* Consulted with eligibility worker re: client's Medi-Cal status.* Provided NAMI information.* Coordinated with Conservator to obtain transportation to private psychiatrist.* Negotiated Housing Contract.*
VRS CASE MANAGEMENT (VRS-51) Used only by VRS staff	To assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services. The service activities may include communication, coordination, and referral; monitoring service delivery to ensure client access to service and service delivery; monitoring of the clients progress once they receive access to services; and development of the plan for accessing services. **VRS Case Management progress notes must include specific, diagnosis-related content.**	*To be billable, all VRS Case Management services must be linked in the progress note to the symptoms/impairments resulting from the client's diagnosis. Helped client obtain Redi-Wheels application.* Consulted with eligibility worker re: client's Medi-Cal status.* Provided NAMI information.* Coordinated with Conservator to obtain transportation to private psychiatrist.* Negotiated Housing Contract.* Made a referral or called providers of needed services to determine availability. Followed up with the client or the provider about the outcome of a referral (e.g., did the client keep the appointment, etc.) * Completed applications and other forms related to seeking services.* (Please document the reason for staff involvement.) Assisted client to understand the requirements of participation in the program of service provider.* Coordinated with a service provider to help client to maintain a service.*

See pgs. 31 for Katie A Services



Transportation/Travel/Field Services Rehabilitation (7)	Case Management (51)	Unbillable Service (55)
Accompanying client on public transportation to help them learn new skills. (This activity must address the symptoms/impairments of the client's diagnosis.)	**All of the following (and all other) Case Management services must address the symptoms and/or impairments of the client's diagnosis in the progress note:**	Transportation of client to & from appointments.
Providing interventions (support, methods to reduce stress or anxiety) to help the client during an appointment off-site.	Finding bus schedules and determining fares to help client access public transportation. Referring a client to a stress reduction class.	Arranging for transportation of clients.
Travel time to site (home, school, etc.) where Rehabilitation is provided is billable using the service charge code (7).	Travel time to site where TCM is provided is billable using service charge code (51).	Travel time to a movie theater where you sit with clients from a drop-in center.

Helping Client Obtain Needed Medical, Social, Housing, SSI, and Other Non-Mental Health Services

Rehabilitation (7)	Case Management (51)	Unbillable Service (55)
Providing interventions (e.g., reassurance and support, monitoring client's emotional response to the stress of an interview with a service provider) to help the client during an appointment with an off-site service provider.	Making a referral or calling providers of needed services to determine availability. Completing applications and other forms related to seeking services. (Please document the reason for staff involvement.)	Transporting the client to an appointment. Completing a monthly budget, requesting checks and other ongoing rep payee functions.
Counseling the client about the anxiety they felt during the referral appointment.	Following up with the client or the provider about the outcome of a referral (e.g., did the client keep the appointment, etc.).	Assistance provided to family members of a client to seek needed services for themselves.
Rep-Payee Services Providing interventions (e.g., helping client develop a list of realistic alternatives) to help the client make a realistic budget is billable as Rehabilitation (7).	Assisting clients understand the requirements of participation in the program of service provider. Coordinating with a service provider to help client to maintain a service. Making a referral and providing directions to complete necessary forms is billable. Working with clients to complete applications for Rep-payee. (Please document the reason for staff involvement.)	Providing translation for a client receiving a Mental Health or other service.

CRITICAL INCIDENT REPORTS

The Critical Incident Report is a CONFIDENTIAL reporting tool to document occurrences inconsistent with usual administrative or medical practices. A Critical Incident is an event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a client, family member, volunteer, visitor or staff. Reporting and analyzing Critical Incidents is a recognized Quality Improvement (QI) mandate and process. The Critical Incident reporting system also provides a mechanism to organize information concerning potential breaches of client privacy, and to document mitigation efforts once a breach is recognized. Critical Incidents must be reported in writing and sent to BHRS Quality Management within 24 hours. BHRS Quality Management will report any required breaches to the DHCS Privacy Office as needed (within 24 hours for federal breaches, within 72 hours for all others). The policy and reporting form is located at http://www.smchealth.org/bhrs-doc/critical-incident-reporting-93-11

CLIENT ALERTS & URGENT CARE PLAN

To set an alert, complete both a Client Alert and an Urgent Care Plan. The alert is a pop-up window that alerts any user in Avatar that an Urgent Care Plan is posted for the client. The Urgent Care Plan contains detailed documentation regarding the alert. In Avatar, use the Urgent Care Plan Bundle.

CLIENT ALERTS

The Client Alert is a pop-up window that alerts any user in Avatar that an Urgent Care Plan is posted on the client

CLIENT ALERT (Step 1)

There are two types of clinical alerts. Choose the appropriate alert.

- Care Message – used for routine alerts. Onscreen Message says "Please review the Urgent Care Plan for information."
- Care Alert – used for urgent messages and safety notices. Onscreen Message says "HIGH PRIORITY - Please review the Urgent Care Plan in Chart Review." View as soon as possible, without the client viewing.

URGENT CARE PLAN (Step 2)

The Urgent Care Plan describes the Client Alert. It is a notification placed in the Avatar System that will be seen by any user opening the client's Avatar chart, including PES and 3AB. It is a statement of special problems, concerns and instructions about a client. To set the Urgent Care Plan, complete the Urgent Care Plan and the Caution Note.

View Care Alerts as soon as possible - without the client viewing

SERVICE CHARGE CODE & ELIGIBLE PROVIDERS

CO-SIGNATURE

Co-signature is **not** meant to enable someone to provide services beyond his/her scope of practice.

Examples where co-signatures are allowed and who can co-sign:

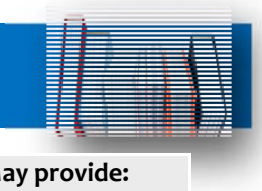
- Licensed clinical supervisor co-signing trainee's notes.
- MD co-signing prescriptions for a resident before the resident is licensed.
- Co-signing the work of unlicensed staff before the required education or experience for independent recording of services has been acquired.

Unlicensed staff may co-sign notes recording services that fall within their scope of practice only—e.g., rehabilitation or case management services.

An example of where a co-signature is not permitted:

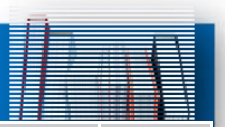
- Co-signing a diagnosis, mental status exam, or a clinical formulation without the co-signer knowing or seeing the client is not permitted. The only exception to this would be a clinical supervisor co-signing the diagnosis, MSE or clinical formulation, completed by a trainee, after close supervision.

Service Charge Code	Eligible Providers
2-Crisis Intervention	All clinical staff
5-Assessment 50-Assessment Group	All clinical staff; **however**, **MSE, Clinical Formulation & Diagnosis** may only be provided by certain licensed/registered/waivered staff and trainees.
6-Plan Development	All clinical staff
7-Rehabilitation Services 70-Rehabilitation Group Service 7-VRS Rehabilitation Services 7-Intensive Home Based Services (Katie A)	All clinical staff
9-Individual Therapy 10-Group Therapy	Licensed/registered/waivered staff and trainees; eligible RNs only (see scope of practice)
12-Collateral 120-Collateral Group	All clinical staff
15-Medication Support 150-Medication Group	MD/RN/NP/LPT/LVN
16-Medication Injection	MD/RN/NP/LPT/LVN
14-Medication Initial MD/NP Assessment 17-MD/NP, not Medicare-billable	MD/NP
19-Risperdal Consta/Invega Injection	MD/RN/NP/LPT/LVN
30-TBS Assessment	Licensed/registered/waivered staff and trainees
41-Family Therapy	Licensed/registered/waivered staff and trainees; eligible RNs only (see scope of practice)
51-Targeted Case Management 51-VRS Case Management	All clinical staff
55-Direct Client Care Unclaimable	All clinical staff All clinical and administrative staff
58-TBS (Therapeutic Behavioral Services)	All clinical staff; staff not licensed/registered/waivered must be under the direction of such staff



STAFFING QUALIFICATIONS FOR AUTHORIZING, TX PLAN, ASSESSMENT	May authorize mental health services	May direct services by either: Signature on Client Plan Supervision of staff providing service	May provide services and be client's care coordinator	Needs co-signature for Weekly Summaries: Day Treatment Adult Residential	May provide: Mental Status Examination Diagnostic Information
Physician	Yes	Yes	Yes	No	Yes
Psychologist	Yes	Yes	Yes	No	Yes
LCSW	Yes	Yes	Yes	No	Yes
LMFT	Yes	Yes	Yes	No	Yes
Intern, ASW/ MFTI (post Master's degree and registered with BBSE) **Intern, Psychologist (post PhD and DHCS waiver of licensure)**	Yes	Yes	Yes	No	Yes
RN with Master's Degree in Psychiatric/ Mental Health	Yes	Yes	Yes	No	Yes
RN	Yes	Yes	Yes	No	No
LVN/LPT	PES only	No	Yes	Yes	No
Trainee for CSW, MFT, Clinical Psychology (post BA/BS but pre Master's/ PhD degree)	No	No	Yes	Yes+	Yes+
Mental Health Rehabilitation Specialist (MHRS)	No	No	Yes	Day TX-No Adult Res-Yes	No
Staff with MH related BA/BS, or 2 years experience in Mental Health	No	No	Yes	Yes	No
Staff without either BA/BS, or 2 years experience in Mental Health	No	No	Yes	Yes+	No

MENTAL HEALTH SCOPE OF PRACTICE



	MD/ OD	Lic. or Waiv-ered Psych-ologist	ASW LCSW MFT-I LMFT LPCC	RN with MS-MH Nurs-ing	MH-NP	RN no MS MH Nursing	Lic. Voca-tional Nurse or Licensed Psych Tech	MHRS!	Trainee for ASW, MFT,PCCI PhD (post BA/ BS and pre MA/ MS/ PhD)	Staff with BA/BS in MH relat-ed field or with 2 years in Mental Health	Staff NO BA/ BS or 2 years in Mental Health
Assessment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+	Yes	Yes, w cosign
MSE	Yes	Yes	Yes	Yes	Yes	No^	No	No	Yes+	No	No
Dx	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes+	No	No
Approve Cli-ent Plan	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes+	No	No
Crisis Inter-vention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+	Yes	Yes, w cosign
Medication Administra-tion	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Medication Dispensing	Yes	No	No	Yes*	Yes	Yes*	No	No	No	No	No
Medication Prescribing	Yes	No	No	No	Yes, with disp ap-prov al	No	No	No	No	No	No
Medication Sup	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Psych Testing	No^	Yes	No^	No^	No^	No	No	No	Yes+	No	No
Therapy	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes+	No	No
Rehab	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+	Yes	Yes, w cosign
Case Mgmt	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes, w cosign
TBS	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes+	Yes	No

+ Must be co-signed.

*** RNs may dispense if trained in dispensing and follow the guidelines set forth in BHRS Policy 91-19 (http://www.smchealth.org/sites/main/files/file-attachments/91-19dispensingmedsbyrns.pdf)**

^ Staff with specific training and experience may qualify upon approval of the Mental Health Director and subsequent state regulation.

!Mental Health Rehabilitation Specialist (MHRS) A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year–for–year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years experience in a mental health setting.

SUD - SUBSTANCE USE DISORDER TREATMENT PROCESS

Introduction

The San Mateo County Substance Use Disorder (SUD) Treatment Provider Documentation Manual is a guide for Drug Medi-Cal providers. The manual is intended to clarify documentation procedures for all staff delivering DMC-billable services to clients with substance use disorders. This documentation manual incorporates the Department of Health Care Services (DHCS) DMC requirements as approved on July 1, 2015.

Drug Medi-Cal Organized Delivery System Waiver: The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a State Pilot to test a new paradigm for the organized delivery of health care services for Medi-Cal eligible individuals with substance use disorders. The DMC-ODS is intended to demonstrate that organized SUD care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM).

Continuum of Care Services Covered in this manual include the following SUD treatment modalities:

- Outpatient Drug Free (ODF)
- Intensive Outpatient (IOT)
- Residential Services
- Narcotic Treatment Program (NTP)
- Withdrawal Management
- Recovery Services
- Case Management
- Physician Consultation
- Medication Assisted Treatment
- Perinatal Services

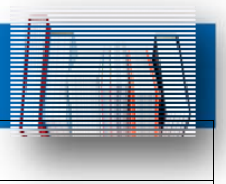
Guidelines for Evidence-Based Practices:

BHRS adopted the Standards of Care in October 2010 that meet the needs under the new requirements under the DMC- ODS. Providers currently are required by BHRS to use the following EBPs: Motivational Interviewing, CBT, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education

Guidelines and Timelines

- Date of admission must involve a face-to-face contact; this date starts the clock for all further timed documentation requirements.
- Initial Treatment Plan for Narcotic Replacement Treatment must be completed within 28 days.
- Initial Treatment Plan for all other modalities must be completed within 30 days.
- Physician/LPHA signatures on all documents must be obtained within 15 days of Initial Treatment Plan and all Treatment Plan Updates.
- Physician signatures on Physical Examination must be completed within 30 days of admission, or the exam must become a goal on the treatment plan, with a date for completion.
- Clients are required to have a physical exam, completed within the previous 12 months, on file. If a physical exam is not on file, the exam must be completed within 30 days of admission.
- Updated Treatment Plans must be completed within 90 days of Initial Treatment Plan, and no later than every 90 days thereafter, unless a major life event or change occurs which would require an updated plan.
- Medical Necessity must be re-authorized every six months.
- Discharge Plan must be completed within 30 days of treatment admission.
- Discharge Summary must be completed for any client with whom the provider has lost contact, within 30 days of the last face-to-face treatment contact.

- Providers are responsible for verifying the Medi-Cal eligibility of each client for each month of service prior to billing for DMC services to that client for that month. Medi-Cal eligibility verification should be performed prior to rendering service.



Date of admission	Starts clock for all documentation	Must be a face-to-face contact
Intake		
Assessment		
Cal OMS Admission		
Initial Treatment Plan for all OP and IOP	30 days from admission	Must be completed, signed and dated, within 30 calendar days of a client's admission to treatment, by the primary counselor and the client. Must be reviewed for medical necessity by MD, licensed physician or LPHA, and signed and dated within 15 days of the initial signature of the counselor. If clinician is unable to obtain client's signature within 30 days, both the reason for not obtaining the signature, and the plan to obtain it, must be documented in a progress note.
Initial Treatment Plan for Residential Services	30 days from admission	Must be completed, signed and dated, within 30 calendar days of a client's admission to treatment, by the primary counselor and the client. Must be reviewed for medical necessity by MD, licensed physician or LPHA, and signed and dated within 15 days of the initial signature of the counselor. If clinician is unable to obtain client's signature within 30 days, both the reason for not obtaining the signature, and the plan to obtain it, must be documented in a progress note.
Initial Treatment Plan for Narcotic Treatment Programs	28 days from admission	Must be completed, signed and dated within 28 calendar days of a client's admission to treatment by the primary counselor and the client. Must be reviewed, signed and dated for medical necessity by the supervising counselor AND the licensed physician within 14 days initial signature of the counselor.
Health Screening Questionnaire	At admission	
Physical Examination	30 days from admission or within 12 months prior to admission	With written proof of completion of an exam, the counselor and MD will review the exam paperwork and document that the client is appropriate for participation in treatment. This documentation shall be on the Health Questionnaire, with the date of exam, the date of review by MD, and MD's license number, signature and date. Proof of Physical Exam shall be kept in the Medical section of the chart. Clients who are unable to provide verification of a physical exam must have completion of this exam as a goal on their Treatment Plan *until the physical exam is completed.*
Updated Treatment Plans		Must be completed within 90 calendar days of Initial Treatment Plan, and every 90 days thereafter ***or*** when a change in problem identification or focus of treatment occurs. Plan must be signed by client and counselor. If the client is unavailable to sign the plan. The notes must reflect efforts to meet with the client to review the plan and sign it.

Medical Necessity	Every 6 months	Initially required within 30 days of admission. Continually, required within 15 days of signature of therapist or counselor on updated treatment plan(s); or no sooner than 5 months and no later than 6 months from admission or the completion of the most recent continuing service justification.
Discharge Plan	Planned discharge when client is still in treatment includes: ♦ Description of relapse triggers ♦ Plan to avoid relapse ♦ Support plan	Must be completed within 30 days of treatment admission
Discharge Summary	Includes: ♦ Duration of treatment ♦ Reason for discharge ♦ Narrative of treatment episodes ♦ Prognosis	Must be completed within 30 days post discharge when provider has lost contact with client
Cal OMS Discharge		

Medical Necessity

SUD treatment providers must ensure that treatment services are medically necessary. For Medical Necessity, clients must meet the following two (2) criteria:

1. Client must be diagnosed with SUD based on the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5), Section: Substance-Related & Addictive Disorders.
   - For youth 12-17 & young adults 18-20: Substance Use Disorder criteria are met **or** it is determined that the client is "at risk for developing" a Substance Use Disorder.
   - The DSM-5 diagnosis must be documented in the client record within *30 calendar days* of the admission date.
   - In addition to Substance Use Disorders, other DSM-5 codes may be used for Medical Necessity. Medical Necessity may include a physical examination and laboratory testing by lawfully authorized staff.

2. Must meet ASAM treatment criteria for services, including adolescent treatment criteria, confirming placement in the appropriate Level of Care.
   - Physician or LPHA, acting within the scope of their respective practices, may determine if a client has a Substance Use Disorder at intake.
   - Physician or LPHA must review each client's diagnosis, and document his or her approval of the diagnosis, by signing legibly and dating the client's Treatment Plan. After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.
   - Medical Necessity determination must be performed through a face-to-face review or via Telehealth.

If a client does not meet Medical Necessity for the assigned Level of Care, the physician or LPHA must document the rationale.

Prior Authorization for a Residential Level of Care will not guarantee that this Level of Care can be provided.

If Residential Treatment is authorized, but the provider determines that it is NOT medically necessary, the provider will have seven (7) working days to transfer the client out of the program to an appropriate Level of Care.

Re-Verification of Medical Necessity for Continued Services

A physician must determine if continued services are medically necessary. The determination of Medical Necessity must be documented by the physician in the client record and shall include service justification areas—in addition to the therapist's or counselor's recommendation for continuing services—based on substance abuse history, a review of previous progress notes, the client's Treatment Plan goals, and the client's prognosis.

A physician-signed Treatment Plan Update at the six-month point in treatment ***does not*** meet the continuing service requirement. An actual determination by a physician regarding the need for continued treatment based on Medical Necessity, including application of the ASAM criteria, is required. A therapist or counselor must discharge the client from treatment if the physician determines that continuing treatment for the client is not medically necessary.

Initial Placement Screen (ADD ASI Requirement)

Clients may enter the Organized Delivery System at several entry points (provider site, BHRS Call Center, Emergency Room, Psych Emergency Services).

- At the entry point, the Initial Placement Screen tool, based on ASAM criteria, is used to rule out the need for emergency services, and to determine if a person should be referred to outpatient or intensive outpatient services.
- If outpatient or intensive outpatient services are recommended, a direct referral to a provider may be made.
- The screening tool may also recommend that an individual be referred to BHRS for an evaluation to determine if there is a need for residential treatment services.
- If a residential treatment evaluation is indicated, the BHRS Residential Treatment Team will be notified; the Screening Tool will be sent to the team by fax or email.
- The residential treatment evaluation may be administered in a face-to-face interview or via Telehealth.

Residential Treatment Evaluation

Following the Initial Placement Screen, if a residential treatment evaluation is recommended, the BHRS Residential Treatment Team will evaluate the individual and complete a Residential Treatment Evaluation form. This evaluation ***does not*** establish Medical Necessity.

- Once an individual is evaluated for residential treatment, a determination will be made to refer to residential treatment through a formal "authorization" process.
- The authorization gives a residential provider permission to conduct an intake, determine Medical Necessity, and admit an individual into residential services.

Intake and Admission

The Intake must include:

- Substance use history and medical history to evaluate the cause or nature of the substance use disorder as well as any emotional, psychological or behavioral issues
- Social, economic, and family background
- Education and vocational achievements
- Criminal history/legal status
- Previous treatment history
- An evaluation to diagnose a DSM-5 substance use disorder, completed within 30 calendar days of the client's admission to treatment date. It must be completed by a physician **OR** it may be completed by a licensed therapist, physician assistant or nurse practitioner (LPHA), with subsequent review/approval by a physician

ASAM criteria must be applied to determine Level of Care placement following a substance use disorder diagnosis, as part of the determination of Medical Necessity.

Following establishment of Medical Necessity and determination of the appropriate Level of Care (utilizing ASAM criteria), the next step in the treatment process is ***admission***.

Drug Medi-Cal requires providers to have written documentation on procedures for client admission to SUD treatment.

A client's admission to treatment date is the date on which any face-to-face treatment service is first provided. Once the intake process is completed, the individual becomes a client of the program.

The following forms, notifications, and agreements must be presented to the client and documented at time of admission:

- *Consent for Treatment
- *Admission Agreement
- *Client's Rights
- *Statement of Non-Discrimination
- *Grievance/Fair Hearing Information
- *Program Rules
- *Client Fees and Payment Agreement
- *Access to Treatment Files
- *Privacy and Confidentiality
- *42 CFR Part 2
- *Release of Information
- *Discharge Appeal Process Information
- *Health Questionnaire
- Referrals Provided
- Race/Ethnic Background
- Address/Telephone number
- DOB/Gender/Sexual Orientation
- Emergency Contact
- Verification of DMC Eligibility

*Require client's signature, date, and translation (if needed)

Initial Treatment Plan

Also see pages 10-12 of this manual for additional information about developing treatment plans.

The Initial Treatment Plan guides the treatment process. Each Treatment Plan must be documented, individualized, and based on information obtained during the Intake and Assessment. There also must be clear and documented links between client needs, treatment goals and provided services.

In assessing treatment needs, all SUD treatment providers must consider client needs in the following areas:

- Educational opportunity/attainment
- Vocational counseling and training
- Job referral and placement
- Legal services
- Medical services including physical health, mental health and dental services
- Social/recreational services
- Individual and group counseling

The Treatment Plan shall include:

- Statement of problems to be addressed
- Goals which address each problem
- Action steps to be taken by provider and/or client to help achieve goal
- Target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and frequency
- Treatment Plans must have quantifiable goal/ treatment objectives
- A Discharge Plan with action steps, goals, and dates for accomplishment
- A physical examination goal ***if the client has not had a physical exam*** within the twelve months prior to the client's admission to treatment date
- If a client refuses to sign his or her Treatment Plan, the provider must indicate the reason for refusal and document strategies that will be taken to engage the client in treatment
- The Treatment Plan must be completed, signed and dated within 30 calendar days of a client's admission to treatment date and signed by the therapist or counselor and the client
- Must be reviewed, signed and dated for medical necessity by the LPHA or medical director within 15 days of the initial signature of the counselor.
- Treatment Plan Updates or Revisions should reflect treatment progress or barriers.
- Each Treatment Plan Update must include all of the components included in the Initial Treatment Plan
- Each Treatment Plan Update will include a redetermination of ASAM criteria for changes to Level of Care needs. A redetermination of ASAM criteria for Level of Care may be necessary prior to 90 calendar days.
- The Treatment Plan Update must be completed, signed and dated by a therapist or counselor *no **later than 90 calendar days*** after signing the Initial Treatment Plan.
- For Residential Treatment, a 60-day Continuing Care Plan must be completed and sent with the Treatment Plan Update to the Residential Evaluation Team to document changes in the Treatment Plan reflecting discharge plans to another Level of Care and/or to Recovery Services.
- Subsequent Treatment Plan Updates must be completed no later than 90 calendar days thereafter or when a change or focus of treatment occurs
- Major life changes should trigger a Treatment Plan Update, regardless of previous Treatment Plan date.
- Must be reviewed, approved, signed and dated by client, indicating whether client participated in the preparation of the plan within 30 calendar days of the signature of the therapist or counselor. If client refuses to sign the Treatment Plan Update, documentation of the reason for refusal and the strategy to engage the client to continue participating in treatment is required
- Must be reviewed for Medical Necessity by physician, and signed and dated within 15 calendar days following the signature of the therapist or counselor.

Physical Examinations—NO WAIVERS PERMITTED

DMC requires that all clients have a documented physical examination.

- All clients must have had a physical examination within the twelve-month period prior to admission to treatment.
- If documentation of a physical examination cannot be obtained, providers must describe in the client record efforts taken to obtain documentation.
- If a client had a physical exam within twelve months prior to treatment admission, a physician must review the exam within 30 calendar days of the admission date to determine if the client has any significant medical illnesses. A copy of the physical exam must be included in the client record.
- Treatment Plans must incorporate any relevant findings from the physical examination that need to be addressed or followed up.
- When there is no documentation of a client physical exam within the last twelve months from the admission to treatment date:
  1. DMC certified providers must either incorporate the physical exam as a client goal in the initial and updated Treatment Plans, or
  2. Refer the client for a physical exam within 30 calendar days of the admission date.
- A physician, registered nurse practitioner or physician assistant may conduct the exam. A copy of the exam must be included in each client record. It is not sufficient to include a progress note alone that the exam was completed.

Throughout the treatment process, client records must document and demonstrate that a physician directed the provision of treatment. This includes the establishment of Medical Necessity at admission, the development and review of client Treatment Plans, and medical consultation and evaluation.

Client Contacts & Progress Notes

At a minimum, a progress note must be written each day there is a patient encounter in outpatient settings.

In intensive outpatient and residential settings, progress notes must be documented at least weekly by staff who have provided services to that client.

Using the BIRP Format, (Behavior, Intervention, Response, Plan) SUD requirements include:

- Type, number and length of counseling sessions
- Client's participation in treatment
- How the contact addresses goals and Objectives delineated in the Treatment Plan

See pages 13-16 of this manual for additional guidance on writing progress notes.

Progress Notes tell a client's treatment story. Progress note requirements vary depending on the treatment modality. The client's therapist or counselor must document, sign and date each progress note. Each Progress Note must include the following elements:

The topic of the session

For each Individual and Group counseling session, a description of each client's progress on specific Treatment Plan goals, action steps, objectives and/or referrals within the correct ASAM Dimension

Information on the client's attendance including the date, start and end times of each individual or group counseling session

Total time of each counseling session

For each Individual and Group counseling session, the therapist or counselor must record a progress note for each participating client, type or legibly print their name, sign and date the Progress Note *within 3 calendar days* of the counseling session

Clients will be offered a copy of their treatment plan, and the counselor/clinician will document that in Progress Note.

Components of Outpatient, Intensive Outpatient and Residential Treatment Services include:

Intake
Individual Counseling
Group Counseling
Family Therapy
Patient Education (individual or group)
Medication Services
Collateral Services
Crisis Intervention
Treatment Planning
Discharge Services

Intake

The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of SUD; the diagnosis of SUD; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for SUD treatment.

Individual Counseling

Individual counseling sessions between a therapist/counselor and a client may be face-to-face, by telephone or telehealth and conducted in a confidential setting.

Group Counseling

For outpatient, intensive outpatient treatment services and narcotic treatment programs, group counseling will be conducted with no less than two and no more than twelve clients at the same time. In each group, one participant must be a Medi-Cal beneficiary.

All Group Counseling sessions must follow a documentation protocol, including the focus of Group Counseling sessions and a sign-in sheet. The sign-in sheet must include the following: The name and signature of the therapist and/or counselor conducting the counseling session; the date, topic, and start and end times of the session; each participant's name, signature and time they entered and time they left the group.

The sign-in sheet must be signed at the start of or

Components of Treatment Services Cont.

Family Therapy
The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

Patient Education
Provide research based education on addiction, treatment, recovery and associated health risks.

Medication Services
The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.

Collateral Services
Collateral Services are defined as face-to-face contact with significant persons in the life of the client. Significant persons are defined as individuals that have a personal, not an official or professional relationship with the client. For example, a client's social worker would not meet the "significant persons" criteria, but their parent would. Collateral service focuses on the treatment needs of the client to support the achievement of Treatment Plan goals. A client does not need to be present during a collateral service for the service to be billable.

Crisis Intervention Counseling
Crisis Intervention counseling must be provided face-to-face by a therapist/counselor and a client in crisis. A crisis must be an actual relapse or an unforeseen event or circumstance causing imminent threat of relapse. Crisis Intervention services must be limited to stabilization of the client's emergency situation and include a focus on alleviating crisis challenges.

BIRP Progress Note Format:

B—Behavior: client statements that capture the theme of the session. Brief quotes may be used. Observations such as physical appearance, results of lab tests, medications/

I– Interventions: Methods used to address the client statements, provider observations and treatment goals.

R– Response: Client response to intervention and progress made toward individual goals and objectives.

P-Plan: The treatment plan going forward based on information gathered and clinical assessment.

Discharge Plan

All clients must have a Discharge Plan in the chart.

The Discharge Plan must include:

Level of Care changes (step up or step down) as needed

· A description of the client's relapse triggers and a plan to assist the client to avoid relapse when confronted with each relapse trigger

· A support plan to include

Recovery Services

12-step or other self-help supports

Other support services, as needed

· Be completed for all clients by the therapist or counselor a minimum of 30 calendar *days prior* to the client's planned or anticipated discharge date. (However, a Discharge Plan should already be part of the Initial Treatment Plan)

· Be signed by the therapist or counselor and the client with a copy provided to the client and placed in the client record.

Discharge Summary

A Discharge Summary must be completed for all clients who provider has lost contact with following discharge.

The Discharge Summary must include:

- The duration of the client's treatment, as determined by the dates of admission to and discharge from treatment
- The reason for discharge
- A narrative summary of the treatment episode
- The client's prognosis
- Be completed within 30 calendar days of the provider's last face-to-face treatment contact with the client

Note: For a client with whom a provider has lost contact or who does not attend treatment for more than 30 days, providers must discharge the client and complete a Discharge Summary within 30 days of the date of the provider's last face-to-face treatment contact with the client.

Outpatient/Outpatient Drug Free (ASAM Level 1)

Counseling services are provided less than 9 hours per week for adults (less than six hours per week for adolescents)

At minimum, all clients shall receive two counseling sessions per 30 day period (or be subject to discharge)

Services can be provided by a licensed professional or certified counselor

Services may be face-to-face or by telephone or telehealth

The licensed professional or certified counselor must record a Progress Note for each client participating in structured activities.

Intensive Outpatient (ASAM Level 2.1)

Medical Necessity must be determined by Medical Director or LPHA, and length of treatment may be extended when determined to be medically necessary.

Each client must be seen for a minimum of 9 hours each week and a maximum of 19 hours each week of counseling and/or structured therapeutic activities; for adolescents, the minimum is 6 hours each week and a maximum of 19 hours per week of structured programming.

Services may be face-to-face or by telephone or telehealth

The licensed professional or certified counselor must record a minimum of one progress note per calendar week for each client participating in structured activities including counseling sessions

Residential Services

Providers who admit clients to residential treatment must secure authorization 24 hours in advance for residential services.

The length of residential services are individually determined based on need, and may be a maximum of 90 days with a one-time extension of up to 30 days on an annual basis.

Perinatal clients may receive a length of stay up to the duration of the pregnancy, and a post-partum period of 60 days after the pregnancy ends.

A limit of two non-continuous 90 days treatment stays may be authorized per client within a one year period.

Documentation regarding preparation for Outpatient Treatment is required.

The licensed professional or certified counselor must record a minimum of one progress note per calendar week for each client participating in structured activities including counseling sessions.

Programs shall provide a range of activities and services for clients admitted into care. Supervision and treatment services shall be available day and night, seven days a week.

Residential (ASAM Level 3.1)

A minimum of 5 hours per week of treatment must be provided and documented.

Residential (ASAM Level 3.3)

Intended for clients with cognitive impairments who need additional help in order to be successful in treatment. (hrs per week?)

Residential (ASAM Level 3.5)

A minimum of 20 hours per week of treatment must be provided and documented. Intended for clients with co-occurring mental health or complex needs.

<u>Weekly Progress Note Requirement</u>

Counselors must record a minimum of one progress note per calendar week for each client participating in structured activities including counseling sessions and type or legibly print their name and sign and date the progress note.

Progress notes include:

- The client's full name medical record number
- Description of client's progress on the Treatment Plan challenges, goals, action steps, objectives, and/or referrals.
- Record of the client's attendance at each counseling session including the date, start and end times and topic of the counseling session.
- Include degree/license/ job title with provider's signature and date progress note completed– due with in 3 working days of service.

Case Management

Case Management is defined as a service to assist in accessing needed medical, educational, social, vocational, rehabilitative or other community services. Medical Necessity for Case Management Services must be determined and documented in the Treatment Plan.

Case Management Components include:

Comprehensive assessment and periodic re-assessment of needs.

Transition to a higher or lower level of care.

Development and periodic revision of Treatment Plan including service activities.

Communication, coordination, referral and related activities.

Monitoring client progress.

Patient advocacy, linkage to physical and MH care, transportation, and retention in primary care services

Case Management may be provided in treatment programs or alternative settings (if approved by SMC). They may be provided face-to-face, via telephone or telehealth, or in the community.

When Case Management services are provided in a treatment program setting, the service must be documented and billed as a separate service.

Recovery Services address the recovery and wellness process following a primary treatment episode. It is intended that providers will assess the treatment needs in the recovery environment during the transfer/ transition planning process.

Components of Recovery Services include the following:

Outpatient Counseling, as needed

Recovery Monitoring (may be via telephone/ telehealth)

Substance Abuse Assistance (including peer to peer services and relapse prevention)

Support for education and job skills

Family support (including linkages to child-care, parent education, support groups, among other ancillary services)

Note: Peer-to-Peer services are eligible for reimbursement as a component of Recovery Services, but *only* for Substance Abuse Assistance.

Professional staff must be licensed, registered, certified, or otherwise recognized under CA statute.

Physician:

- Review each client's personal, medical and substance abuse history
- Document the basis for the SUD diagnosis in the client's medical chart
- Determine whether SUD services are medically necessary
- Ensure physical exam requirements are met
  - Within 30 days of admission
- Review, approve and sign treatment plan and treatment plan updates
- Complete Continuing Services Justification **unless** continuing treatment services are determined no longer medically necessary
  - Between 5 and 6 months from date of admission
  - Document determination of medical necessity

Licensed Practitioner of the Healing Arts (LPHA):

This may include Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Psychologist, LCSW, Licensed Professional Clinical Counselor (LPPC), LMFT, and licensed eligible practitioners working under the supervision of licensed clinicians

- Determination of Medical Necessity, utilizing ASAM criteria for appropriate Level of Care placement. Must be done through a face-to-face review or telehealth.
- Diagnosis
- Mental Status Exam
- Signature on Initial Treatment Plan and Treatment Plan Updates
- Supervision and co-signature with staff providing services

Registered, certified counselors/Unlicensed Clinical Staff (requires weekly co-signature):

- Treatment Plan Development
- Collateral Services
- Case Management
- Counseling Services
- Crisis Intervention

MFT Intern, MSW Intern, and Psychology Interns (with supervisor signature):

- Assessment
- Mental Status Exam
- Diagnosis
- Treatment Plan Development
- Collateral Services
- Case Management
- Crisis Intervention
- Counseling/Therapy

The Role of the Medical Director

The Medical Director has medical responsibility for all clients and must be available on a regularly scheduled basis. Duties of the Medical Director may vary, but at a minimum, Medical Directors are responsible for ensuring that:

- Medical care provided meets standard of care
- Physicians are not delegating their duties
- Medical personnel follow medical policies and standards
- Medical decisions are not influenced by fiscal considerations
- Physicians are adequately trained to perform diagnosis of SUD, and determine medical necessity
- Delegated duties to physicians are properly performed
- Developing medical policies and standards
- Receiving continuing medical education in addiction medicine annually

AOD NON-BILLABLE CODES and Discharges

BLOCK BILLING WITH LOCATION CODES AND NON-BILLABLE SERVICE CODES

Providers must understand how services are claimed and know that some services are not claimable. Non-reimbursable codes and certain location or service codes block the service from being billed.

NON-DMC BILLABLE SERVICE CHARGE CODES

Leave of Absence (LOA) / Interruption in residential treatment (RTX)

RTX episodes may be "interrupted" due to:

- Medical emergency - including but not limited to: psychiatric stabilization, 5150, other primary health condition
- Withdrawal management / stabilization needs - specify what type of detox/ WM
- Criminal Justice Sanction
- Family Emergency / Death in the Family
- Or other unforeseen emergency situation

While the client is on a LOA, the provider shall utilize the Service Code - *AD555*- ODS Residential Absent when entering services under re-occurring charge input for the days the client was on the LOA

The residential treatment service is not billable. However, the provider may provide case management while keeping the client engaged in treatment.

Residential Transfers

At anytime, a provider can request to transfer a client to another residential facility with no break in service, by following these steps:

- Send completed transfer for request to RTX CM that made initial authorization
- If granted, the client will have the remaining balance left up to 90 days in the new facility
- Provider will assure the CALOMS is discharged as a transfer and assure the transfer is well documented in the clients chart.
- If provider is transferring to another residential level of care or facility within the agency, and updated ARF is needed
- If denied, the provider will continue to work with client

Discharge Requirements

Outpatient loss of contact after 30 days

Residential

Under the ODS, some services can be provided in treatment programs or alternative settings. They may be provided face-to-face, via telephone or telehealth, or in the community. When determining which location type to code:

- all location codes default to actual location of the program
- consider where the client is located,
- then consider updating the location.

AOD ALLOWABLE AND EXCLUDED SAME-DAY SERVICES

DMC ODS will permit a beneficiary to receive more than one service per calendar day by various providers. Many services will be allowed to have a multiple billing in the same day when the combination of services does not have a conflict. An example of same day billing that would not be allowed is for two residential daily rates, or any combination of daily rates. The following table illustrates the allowed same day service exceptions.

For Same Beneficiary on Same Date of Service

Service Name	NTP Methadone Dosing	NTP LAAM Dosing	NTP Individual Counseling	NTP Group Counseling	IOT	RES	NAL	ODF Individual Counseling	ODF Group Counseling
Narcotic Treatment Program (NTP) Methadone Dosing (a) Date range is allowed.	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Levoalphacetylmethadol (LAAM) Dosing	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Individual Counseling *Taken from DMC Billing Manual 2015*	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
NTP Group Counseling	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
Intensive Outpatient Treatment (IOT)	NO	NO	NO	NO	YES	NO	NO	NO	NO
Perinatal Residential (RES)	NO	NO	NO	NO	NO	NO	NO	NO	NO
Naltrexone (NAL)	NO	NO	NO	NO	NO	NO	YES	NO	NO
Outpatient Drug Free (ODF) Individual Counseling	NO	NO	NO	NO	NO	NO	NO	YES	YES
Outpatient Drug Free (ODF) Group Counseling	NO	NO	NO	NO	NO	NO	NO	YES	NO

Client Fair Hearing Right

In addition to other appeal processes that may be required, DMC providers must advise clients in writing of their Medi-Cal fair hearing rights upon the denial, reduction or termination of DMC services as these relate to their eligibility or benefits. This requirement applies to all clients who discharge involuntarily as well. This notification must be in writing at least 10 calendar days prior to the effective date of the intended action to terminate or reduce services. The written notification must include:

1. A statement of the action the provider intends to take;
2. The reason for the intended action;
3. A citation of the specific regulation(s) supporting the intended action;
4. An explanation of a client's right to a fair hearing for the purpose of appealing the intended action;
5. A statement that the provider must continue treatment services pending a fair hearing decision only if the client appeals in writing within 10 calendar days of the mailing or personal delivery of the notice of intended action to the Department of Social Services;
6. The address where the client must submit his or her request for a fair hearing:

Department of Social Services
State Hearing Division
P.O. Box 944243, MS 9-17-37
Sacramento, California 94244-2430
1 (800) 952-5253
TDD 1 (800) 952-8349

Title 22 & Title 9 DMC Services Crosswalk

Review Step	ODF/DCH/Residential	NTP
Admission	Title 22, 51341.1 (h)(1) & Special Terms and Conditions	Title 9, 10270
DSM Code*	Title 22,51341.1 (h)(1)(D)(ii) & Special Terms and Conditions	Same
Assessment	Title 22, 51341.1 (b)(10),(h)(1)	Title 9, 10305
Treatment Planning*	Title 22, 51341.1 (h)(2 & Special Terms and Conditions	Title 9, 10305
Treatment Requirements	Title 22, 51341.1 (d) & I & Special Terms and Conditions	Same
Progress Notes	Title 22, 51341.1 (d)(2),(h)(3)	Title 9, 10345
Group Counseling Sign- in	Title 22, 51341.1 (g)(2)	Same
Dosing Services	n/a	Title 9, 10255
Provider & Client Contact	Title 22, 51341.1 (h)(4) & Special Terms and Conditions	Title 9, 10345
Continuing Services*	Title 22, 51341.1 (h)(5) & Special Terms and Conditions	Title 9, 10410
Discharge	Title 22, 51341.1 (h)6) & Special Terms and Conditions	Title 9, 10415
Fees Charged to Client	Title 22, 51341.1 (h)(7)	Same
Good Cause Codes	Title 22, 51490.1 (a)	Same
Second Service	Title 22, 51490.1 (d)	n/a
Fair Hearing	Title 22, 51341.1 (p) & Special Terms and Conditions	Same

**These areas establish medical necessity for treatment services and deficiencies can result in recoupment of the entire treatment episode.*