SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

BHRS Documentation Manual for SMHS

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Last Updated: 4/30/2025

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INTRODUCTION

Behavioral Health System of Care

This manual provides the documentation standards and general descriptions of services provided by all BHRS mental health programs including BHRS contracted providers. This is a day-to-day resource for both clinical and administrative support staff. This manual also provides basic information on services for individuals experiencing a co-occurring Substance Use Disorder (SUD), but is not meant to be a comprehensive overview of SUD services. A separate SUD Documentation Manual will be provided in the future devoted to SUD services and programs.

Source material for this documentation manual includes, but is not limited to:

- ✓ Behavioral Health Information Notices published by the Department of Health Care Services (DHCS)
- ✓ Medi-Cal billing manual published by the Department of Health Care Services (DHCS)
- ✓ CalAIM Documentation Manuals published by the California Mental Health Services Authority (CalMHSA)
- ✓ San Mateo County BHRS (SMC BHRS) internal policies and procedures
- ✓ SMC BHRS Management Information System (MIS) Coding Manual
- ✓ Other State and Federal regulatory documents
- ✓ Medi-Cal Manual For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries

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 beneficiaries with co-occurring mental health and substance use disorders are documented using the rules presented in this manual.

MENTAL HEALTH SERVICES

Services provided by Behavioral Health and Recovery Services (BHRS) are designed to improve behavioral health outcomes for beneficiaries and families with substance use disorders, mental illness and/or co-occurring disorders. These services are based on the needs, strengths, and choices of beneficiaries and their families, who are involved in planning and implementing treatment. Services are based on the beneficiary'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

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focused on achieving specific objectives to support the beneficiary 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 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.

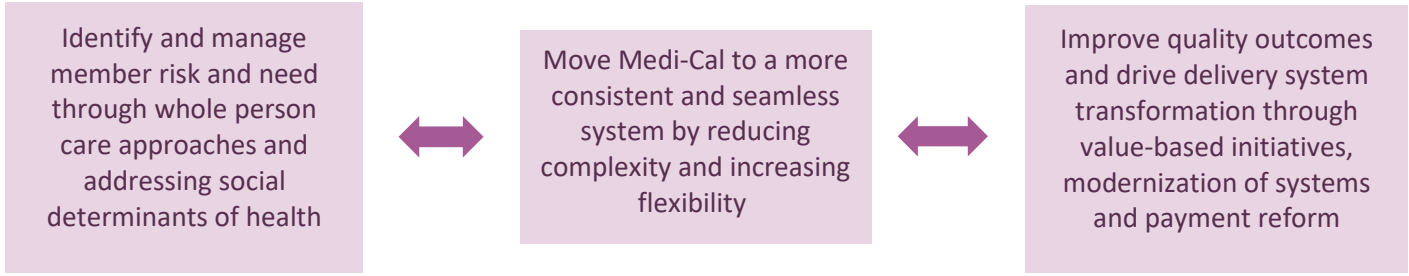
CalAIM

Established in 2021 by **AB 133**, the California Advancing and Innovating Medi-Cal (CalAIM) Initiative is an innovative, multi-year program designed to improve the state's Medi-Cal health insurance system.

California's Medi-Cal program is the largest Medicaid program in the country and is charged with providing care for approximately **15 million enrollees**, or one third of California's population.

To ensure affordability while maintaining quality and improving health care outcomes, CalAIM was created as California's newest approach to reform Medi-Cal, including changes to managed care plans and reimbursement of behavioral health plans.

CALAIM'S GOALS ARE:



We have updated this documentation manual to include the CalAIM updates mandated by DHCS to help you learn how to incorporate them into your practice. It may feel like a lot when starting these new changes, but gradually it will become as seamless as your practice today.

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Guide to Reading this Manual

MENU BAR

This menu bar has been added to the left of each page. The current section you are in will be highlighted in orange in the menu. Each item is also linked to the appropriate section in the manual. This means that if you access the manual on a computer, you can click on the section title to navigate to the first page of that section.

Compliance Alerts

Information here.

COMPLIANCE ALERTS

This manual is comprised mostly of documentation requirements that are necessary for compliance to state and federal regulations. Red boxes call out specific elements of the process that many staff forget, or might not be aware of.

Documentation

Tips will be listed here

DOCUMENTATION REMINDERS/TIPS

This manual contains a large amount of information regarding documentation requirements! Green boxes are used to provide tips to staff about documentation, such as documentation reminders and helpful tips on how to document certain services.

OTHER USEFUL INFO

Information here.

OTHER USEFUL INFORMATION

Sometimes staff have questions about terminology or other information that is general to behavioral health or how the system functions. This box provide this type of information to staff.

RELATED POLICIES TO REVIEW

The following are the main policies related to Topic.

Policy XX-XX: Name of Policy

POLICIES TO REVIEW

Policies related to the topic are noted in a yellow box. The policies that are listed are the main policies associated with the topic, but does not necessarily include ALL policies related to the topic.

Please contact your program supervisor directly or contact the BHRS QM Ask inbox at HS_BHRS_ASK_QM@smcgov.org if you have questions about what additional policies might be applicable to your program.

BHRS is currently in the process of updating several policies to reflect up-to-date information. If "Update in Progress" is written in this yellow box, it means that staff should follow the instructions in this manual until the policy updates are finalized.

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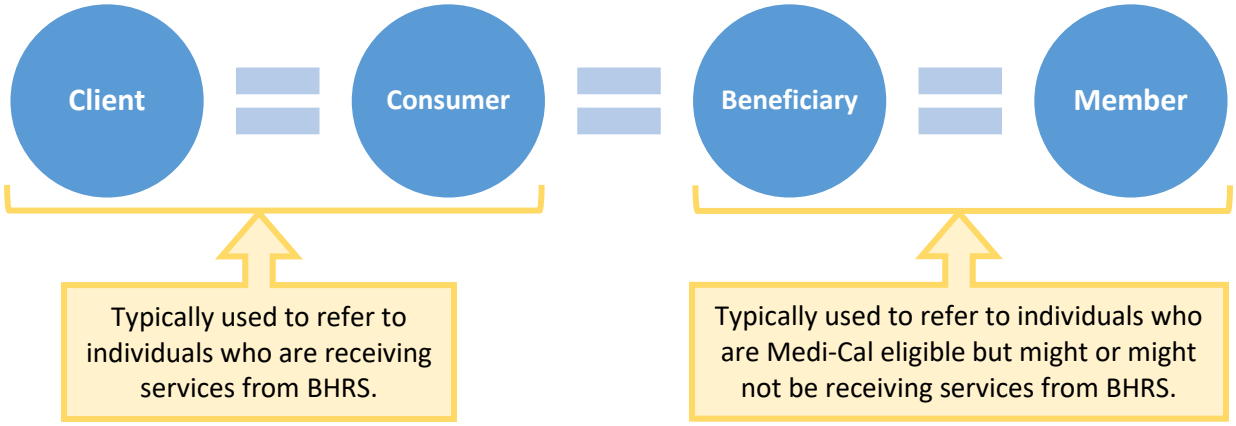
Terminology for Persons Receiving Services

As the State and the Behavioral Health system as a whole continues to refine and adapt language used to describe individuals who are eligible for, have received, or are receiving behavioral health services, staff will find that various documents, trainings, policies, etc. use different terms when referencing this population. Sometimes the differences are due to certain documents not yet being updated, other times it is because there is a specific reason for a particular term being used based on the use of the term. At times, it may be due to character limitations in the EHR, and so on and so forth.

Staff are not required to use a particular term over another, but should be sure to follow HIPAA guidelines and use appropriate terminology when determining what terms to use. Below are three of the main terms staff might see across different sources when referring to individuals who are eligible for and /or receive behavioral health services. All are acceptable for staff to use when referencing individuals who are seeking or receiving behavioral health services.



How to Get Help

This manual is BHRS policy and is the resource for all documentation issues. The Quality Management website provides links to other resources as well as trainings, guides and other helpful documents.

- Got a question? Send QM an email at HS_BHRS_ASK_QM@smcgov.org
- Visit us on the web at www.smchealth.org/bhrs/qm
- Access our recorded webinars via the LMS. For instructions on how to access the LMS (for BHRS Staff and Contracted Agencies) please visit the BHRS QM website at www.smchealth.org/bhrs/qm
- View our Compliance Program http://www.smchealth.org/bhrscompliance-program

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COMPLIANCE

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: https://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.

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.

RELATED POLICIES TO REVIEW

The following are the main policies related to Compliance.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 16-03: San Mateo County BHRS Compliance Plan

Policy 04-05: Compliance Improvement Hotline

Policy 03-15: Compliance Officer – Duties

Policy 03-16: Compliance Committee

Policy 16-05: Non-Retaliation and Non-Intimidation for Reporting Compliance Concerns

Policy 22-04: Documentation Requirements or all SMHS, DMC, and DMC-ODS Services

Policy 19-08: Credentialing and Re- Credentialing Providers

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General Information About Compliance

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.

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.

Fraud, Waste, Abuse Alert

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

General Rules for Compliant Documentation

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

- Accurately reflect the activity, location, and duration of each service.
- Notes should be written within 3 business days of the date of the service, with the exception of crisis services, which should be documented within 24 hours of the service.
- The date of a ***late entry*** must be clearly identified in the documentation.
- Notes must be signed legibly, including your discipline, or electronically signed in the electronic medical record.
- All services will be based on a current assessment, problem list, and, when applicable, current treatment plan.
- Services must be provided within the staff person's scope of practice, as indicated in this manual.
- Use Service Code 55 or 550 for services that are not claimable (see "Non-Reimbursable Activities" for more information about non-claimable services)
- 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.

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Fraud, Waste, and Abuse (FWA)

DHCS monitors Medi-Cal behavioral health delivery systems for compliance with their documentation requirements, and deviations from the requirements may require corrective action plans. DHCS' oversight will include verifying that services provided to Medi-Cal members are medically necessary, and that documentation complies with the applicable state and federal laws, regulations, and the MHP Contract. Recoupment shall be focused on identified overpayments and fraud, waste, and abuse.

WHAT IS A MENTAL HEALTH PLAN (MHP)?

Specialty Mental Health Services (SMHS) are managed locally by county MHPs under an MHP Contract with the CA Department of Health Care Services. San Mateo County BHRS is an MHP.

In addition to managing the benefit, MHPs directly deliver and/or contract with Community-Based Organizations (CBOs) or group/individual providers to deliver services to individuals with Medi-Cal who have significant and/or complex care needs.

Understanding FWA

All staff are required to complete FWA training at onboarding and annually, which includes reviewing BHRS' Compliance Plan and associated policies. The definitions below are provided to remind staff of what actions constitute Fraud, Waste, and Abuse; however, staff should refer back to the Compliance Bundle trainings and Compliance Plan and policies to learn more about FWA.

FRAUD

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 C.F.R. § 433.304, 455.2)

WASTE

Waste includes inappropriate utilization of services and misuse of resources. (Medicaid and CHIP Payment and Access Commission)

ABUSE

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary costs to the Medicaid program. (42 C.F.R. § 455.2)

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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 beneficiary/beneficiary's 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 beneficiary privacy, and to document mitigation efforts once a breach is recognized.

RELATED POLICIES TO REVIEW

The following are the main policies related to Critical Incident Reports.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 93-11: Critical Incident Reporting

Critical Incidents must be reported in writing and sent to BHRS Quality Management within 24 hours. BHRS Quality Management must report any required breaches to the DHCS Privacy Office (within 24 hours for federal breaches, within 72 hours for all others).

Critical Incident reports must NOT be scanned or otherwise included into the beneficiary's chart and should NOT be referenced in a progress note.

WHEN TO REPORT AN INCIDENT

Below are examples of when to complete an incident report.

- *An email sent to the incorrect email address with the beneficiary's Protected Health Information (PHI), including name, date of birth, and Social Security Number.*
- *Beneficiary slipped in the lobby of clinic.*
- *Facility elevator stopped functioning and staff were trapped inside.*

Compliance Tip

When in doubt, send it out!

If you're not sure if an incident report should be submitted, you should go ahead and submit one!

Remember, if you are unsure if incident requires the submission of an incident report, go ahead and send it – there is a greater risk if you do NOT send an incident report when it was required than sending one when you did not need to.

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Client Alerts & Urgent Care Plan

This section is applicable for programs that use BHRS Avatar.

Urgent care messages are used to notify staff about special circumstances which apply to individual mental health clients. For example, urgent care messages may provide information about violent behavior, use of weapons, substance abuse, drug seeking behaviors, co-insurance, hospitalization issues, and other factors which might impact clinical decisions, particularly those by an officer of the day, emergency, or crisis staff who have limited knowledge about the client.

To set an Urgent Care Plan, complete both a Client Alert and an Urgent Care Plan. In Avatar, use the "Urgent Care Plan Bundle."

RELATED POLICIES TO REVIEW

The following are the main policies related to Urgent Care Messages.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 97-09: Urgent Care Messages

CLIENT ALERTS

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

URGENT CARE PLAN

The Urgent Care Plan contains detailed documentation regarding the alert. It is a notification placed in the Avatar System that will be seen by any user opening the beneficiary's Avatar chart, including PES and 3AB. It is a statement of special problems, concerns and instructions about a beneficiary.

TYPES OF CLIENT ALERTS

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

- **Injection**

  Used to alert BHRS of medication issues. Onscreen Message says "PES - Long Term Injectable Medication Alert- See Urgent Care Plan."

- **Medication**

  Used to alert BHRS of medication issues. Onscreen Message says "Medication Urgent Care Plan on File."

- **Care Message**

  Used for routine alerts. Onscreen Message states: "Please review the Urgent Care Plan for information."

- **Care Alert**

  Used for urgent messages and safety notices. This should be viewed as soon as possible, without the beneficiary viewing. Onscreen Message states: "HIGH PRIORITY - Please review the Urgent Care Plan in Chart Review."

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DOCUMENTATION REQUIREMENTS

Overview

General Principles of Documentation

- ✓ Services must be clinically appropriate based on the clinical documentation that exists in the medical record (e.g., Assessment, Problem List, and, when applicable, the Care Plan).
- ✓ Clinical documentation should follow all relevant requirements (including, but not limited to: federal, state, county, and funding requirements) as well as best practice to ensure that a beneficiary's medical record is up-to-date and accurate.
- ✓ 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.

RELATED POLICIES TO REVIEW

The following are the main policies related to Documentation Requirements.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 22-04: Documentation Requirements for all SMHS, DMC, and DMC-ODS

Required Clinical Documentation

In order to comply with all state and federal documentation requirements, a chart must have all of the following items completed according to time frames established by BHRS policies and State and Federal regulations:

- ✓ Adult or Youth Screening Tools (if applicable)
- ✓ Assessments (including Diagnosis and Mental Status Exam)
- ✓ CANS (beneficiaries ages 6 through 20 years old)
- ✓ PSC-35 (beneficiaries ages 3 through 18 years old)
- ✓ ICC Eligibility Screening (beneficiaries under 21 years of age)
- ✓ Trauma Screening Tool (To Be Determined…)
- ✓ Problem List
- ✓ Care Planning Requirements (for select services and programs)
- ✓ Transition of Care Tool (if applicable)
- ✓ Progress Notes

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Scope of Practice

BHRS has provided a **Scope of Practice Matrix** to support staff in understanding what clinical documentation falls under their scope of practice. This includes, but is not limited to, information regarding:

- ✓ What can be practiced under the scope of practice of a Clinical Trainee
- ✓ Who requires supervision by an Licensed Practitioner of the Healing Arts (LPHA) to provide services and complete clinical documentation with the co-signature of the LPHA.

Guidelines for Co-Signatures on Clinical Documentation

Co-signature is not meant to enable someone to provide services beyond his/her scope of practice. For some categories of staff, such as clinical trainees, the co-signer must be an LPHA. For some other categories of staff, such as Peer Support Workers, unlicensed staff may co-sign notes for services that fall within their scope of practice only—e.g., rehabilitation or case management services. If you are unsure if a licensed or unlicensed staff must co-sign your notes, please ontact QM.

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.

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.

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Documentation Timelines (General List)

The following are a mix of required and suggested timeframes. Most items **should also be updated whenever there is a significant clinical change.** For more specific guidance on completion of each item below, please see the appropriate section in this manual as well as any associated BHRS policies related to that section.

Pre-Admission

Only Administered by Some Programs

- CalAIM Screening Tool

Admission

Complete within approximately 60 Days of Admission

- CalAIM Assessment - Initial
- Problem List
- CANS and PSC-35 (if applicable)
- ICC Eligibility Screening Tool (if applicable)
- Care Plan (if applicable)

Every 6 Months

- CANS and PSC-35 (if applicable)
- Review Problem List (Update as needed)

Every 1 Year

- Care Plan (if applicable)
- Review of Assessment (Update as needed)
- And all the applicable items in the "Every 6 months" category above.

Every 3 Years

- CalAIM Assessment - Reassessment

Discharge

Prior to Closing Episode

- CalAIM Assessment - Reassessment/Update (to document reason for discharge or transfer)
- Problem List (to update to reflect discharge diagnosis)
- Transition of Care Tool (if applicable)
- CANS and PSC-35 (if applicable)
- ICC Eligibilty Screening Tool (if discharge involves a change in Level of Care or other clinically significant change)

Check with Your Supervisor

The list to the left comprises only the main documentation requirements for a majority of BHRS clients. However, it is not an exhaustive list of ALL forms that need to be completed.

Some programs and some categories of clients require additional forms to be completed at various points in treatment. Staff should check with their supervisor to ensure that all documentation required for the program and/or client are completed.

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ACCESS TO SMHS AND MEDICAL NECESSITY

Overview

CalAIM has introduced a more nuanced manner of determining whether or not a beneficiary is eligible to receive Specialty Mental Health Services. This was done by breaking the concept of "Medical Necessity" into two types of criteria for receiving SMHS. The first type is criteria for "Access to SMHS" while the second type is called "Medical Necessity." The next sections describe each set of criteria.

Access to SMHS

- Answers the question: Is the individual **eligible** to receive SMHS?

Medical Necessity

- Answers the question: Is the **service** provided clinically appropriate?

RELATED POLICIES TO REVIEW

The four policies listed below are the main policies regarding access and medical necessity.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 22-01: Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements

Policy 22-03: No Wrong Door for Mental Health Services

Policy 22-04: Documentation Requirements for all SMHS, ODS and DMC-ODS

Policy 23-01: Adult and Youth Screening and Transition of Care Tools

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Criteria to Access Specialty Mental Health Services (SMHS)

Criteria to Access SMHS is used to determine if a beneficiary is eligible to access SMHS. There are different Access Criteria for Adults and Youth which will be outlined in the next few pages, but a feature shared across both age groups is that a beneficiary is no longer required to have an identified mental health diagnosis to receive services. This opens up the ability for health plans to provide clinically appropriate mental health services *prior to the determination of a diagnosis*. Therefore, Specialty Mental Health Services provided during the assessment process are no longer limited to assessment activities. This is related to the "No Wrong Door" policy that aims to ensure that beneficiaries are not delayed in receiving medically necessary services.

A Note About Mental Health Diagnosis

Except for psychiatric inpatient hospital and psychiatric health facility services, a mental health diagnosis is not a prerequisite for access to covered SMHS.

Also related to Criteria to Access to SMHS is the CalAIM Adult and Youth Screening Tool. The CalAIM Screening Tool determines under which system the beneficiary should access assessment services, however it does not determine level of care for ongoing treatment or which services are medically necessary. These determinations are made during clinical assessment. **Therefore, the Screening Tool must only be used when determining if a client should receive their clinical assessment through BHRS or an MCP.**

SMHS Access Criteria for Adults

SMHS Access Criteria for ADULTS	
For beneficiaries 21 years of age or older, a county MHP shall provide covered SMHS for beneficiaries who meet both of the following Criteria, (1) **AND** (2) below:	
Criteria (1)	**Criteria (2)**
The beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities, **AND/OR** b. A reasonable probability of significant deterioration in an important area of life functioning.	The beneficiary's condition as described in paragraph (1) is due to either of the following: a. A diagnosed mental health disorder*, **OR** b. A suspected mental disorder that has not yet been diagnosed.

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SMSH Access Criteria for Youth

SMHS Access Criteria for YOUTH		
For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet either Criteria (1) **OR** (2) below:		
Criteria (1)	**Criteria (2)**	
The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by **ANY** of the following:	The beneficiary meets **both** of the following requirements in a) **AND** b), below:	
a. Scoring in the high-risk range under a trauma screening tool approved by the department,* OR b. Involvement in the **child welfare system**, OR c. **Juvenile justice involvement**, OR d. **Experiencing homelessness** ** MHPs are not required to implement a trauma screening tool until DHCS issues additional guidance regarding approved tool(s) for the purposes of SMHS access criteria. As of the publication of this manual. DHCS has not yet provided this guidance.*	a. The beneficiary has at least one of the following: i. A significant impairment ii. A reasonable probability of significant deterioration in an important area of life functioning iii. A reasonable probability of not progressing developmentally as appropriate. iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.	b. The beneficiary's condition as described above (Criteria 2a) is due to one of the following: i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM-5 and the ICD-10. ii. A suspected mental health disorder that has not yet been diagnosed. iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.
If a beneficiary under age 21 meets the criteria as described in Criteria (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets Criteria (2) above.		

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Population Categories

The tables on the next two pages are provided to support staff's understanding of what it means to be involved in the Child Welfare or the Juvenile Justice systems, and what qualifies as "experiencing homelessness."

Population Categories

For use with Criteria (1) for beneficiaries under 21 years of age.

Child Welfare Involvement	Juvenile Justice Involvement
A child can have involvement in child welfare whether the child remains in the home or is placed out of the home. A child who meets **ANY** of the criteria below falls into this category:	The beneficiary is considered to fall under this category if the beneficiary:
1) Has an open child welfare services case, meaning: a) The child is in foster care or in out of home care, including both court-ordered and by voluntary agreement, or b) The child has a family maintenance case (pre-placement or post-reunification), including both court ordered and by voluntary agreement 2) Is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan 3) Is a child whose adoption or guardianship occurred through the child welfare system	1) Has ever been detained or committed to a juvenile justice facility, **OR** 2) Is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency, **OR** 3) Has ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, **OR** 4) Is on probation, or has been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who is otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency.

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Population Categories	
For use with Criteria (1) for beneficiaries under 21 years of age.	
Experiencing Homelessness	
The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.13 Specifically, this includes beneficiaries who fall under either criteria A **OR** B below:	
A) Beneficiaries who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act);	B. Children/Youth who meet **ANY** of the following criteria: i. Are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; ii. Have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); iii. Are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; iv. Migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

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Medical Necessity Criteria

All Medi-Cal services provided to persons in care need to meet the standard of being "medically necessary". The definitions of medical necessity are somewhat different, based upon the age of the person in care.

Pursuant to Welfare and Institutions Code section 14184.402(a), for beneficiaries aged 21 and older, a mental health service is considered "medically necessary" when it is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain" as set forth in Welfare and Institutions Code section 14059.5.

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services (CMS) makes it clear that **mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition, and are thus medically necessary and covered** as EPSDT services.

Pre-CalAIM, medical necessity required a mental health diagnosis that was included in a list of select diagnoses published by the Department of Health Care Services (DHCS). With the implementation of CalAIM, this "included diagnosis" list is no longer published and an "included diagnosis" is no longer required to establish medical necessity.

Medical Necessity Criteria for SMHS	
Beneficiaries <u>under</u> 21 years of age	For beneficiaries under 21 years of age, a service is "medically necessary" or a "medical necessity" if… **…the service is necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.** **Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition**, and are thus medically necessary and covered as EPSDT services.
Beneficiaries 21 years of age and older	For beneficiaries 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is… **…reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain…**

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Documenting Access Criteria and/or Medical Necessity Criteria

The beneficiary's medical record should demonstrate that the services provided, even during this assessment period, were clinically appropriate. Clinical Documentation should support the ultimate determination of whether or not criteria to access SMHS was met and whether or not the services provided were medically necessary. Remember, under CalAIM, services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.

THE ASSESSMENT – The completion of an Assessment establishes the foundation of the seven domains that develops a clinical understanding of the beneficiary's care needs, determines an accurate diagnosis, confirms the appropriate treating system, and what services are medically necessary to support the Beneficiary in their goals so they can thrive in their community.

THE PROBLEM LIST /DIAGNOSIS – The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

THE PROGRESS NOTE – Progress Notes document delivered services that are clinically appropriate for the problems/diagnoses identified on the problem list and the goals of the mental treatment plan. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

The connection between the above components 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.

DIAGNOSTIC CRITERIA

While clinically appropriate services are covered and reimbursable prior to diagnostic criteria being met, and a person may access necessary services prior to determining a diagnosis, **an ICD-10 code must be assigned to submit a service claim** for reimbursement. See Diagnosis section for more information on this requirement.

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SCREENING TOOLS

CalAIM Adult and Youth Screening Tools for SMHS

Important Information about Emergency /Urgent Requests

The Adult and Youth Screening Tools shall not replace protocols for emergencies or urgent and emergent crisis referrals. For instance, if a beneficiary is in crisis or experiencing a psychiatric emergency, emergency and crisis protocols shall be followed.

Persons seeking care may access treatment in several different ways including self-referral, referral from another behavioral health practitioner, or a primary health care provider, etc. Persons seeking care, and sometimes even the referring provider (if the provider did not do a screening or assessment) may not always know which system (BHRS or MCP) is the appropriate system for the individual's current needs. To ensure that beneficiaries receive timely care from whichever delivery system they initially seek care, DHCS has created standardized screening tools – one for adults aged 21 and over, and one for youth under age 21 – to facilitate and standardize this process. The goal is to ensure that beneficiaries seeking care have access to the right care in the right place at the right time, regardless of what door they initially enter through.

Standardized Screening Tools

PURPOSE OF THE SCREENING TOOL

The Adult and Youth Screening Tools are designed to capture information necessary to determine where a beneficiary should be referred for an assessment. A beneficiary who scores within a specific range on the screening tool will either be referred to an MCP or one of BHRS' county-operated or contracted programs to receive a clinical assessment.

Completion of the Screening Tool is not considered an assessment and do not replace assessments. Once the screening tool has been administered, the beneficiary will be referred to the appropriate Medi-Cal mental health delivery system for a clinical assessment that will determine the level of care and medically necessary services.

A second screening should not be administered upon referral to the delivery system if the referral originated as a result of the use of the Screening Tool. For example, if a beneficiary is referred to BHRS based on a score generated by Kaiser (Medi-Cal), BHRS must offer and provide a timely assessment without requiring an additional screening.

WHAT IS A MANAGED CARE PLAN (MCP)?

MCPs are responsible for the majority of medical (physical health care) benefits. They also provide mental health services to those with less significant /complex care needs. These services (also called "mild-to-moderate" mental health services), may be provided at a lower frequency/intensity than what is typically provided in BHRS.

Some MCPs operate across multiple counties, and others operate only in specific counties. Ask your supervisor for an up-to-date list of which MCPs operate in San Mateo County.

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SUBSTANCE USE IDENTIFICATION AND SUD REFERRALS

While the CalAIM Screening Tools are not specifically designed as an SUD screening tool, the CalAIM Screening Tools include questions related to substance use disorder (SUD) that do not impact the screening score. If a beneficiary responds affirmatively to an SUD question, the MCP or BHRS must offer them a referral for an SUD assessment in addition to completing the screening tool and making an appropriate mental health delivery system referral.

The person seeking care may decline the referral for an SUD assessment without any impact to their mental health delivery system referral.

Staff should note that screening for SUD does not only occur during the administration of the Screening Tool. Substance use, including nicotine/tobacco and caffeine, should be explored with all beneficiaries during the initial assessment and periodically during the course of ongoing treatment.

Screening Tool Administration

WHO CAN ADMNISTER THE SCREENING TOOL?

The screening tools are designed to be administered by both non-clinicians and clinicians and do not require clinical judgment to complete. They may be administered in person, by telephone, or by video conference.

Within the BHRS System of Care, only staff in the BHRS Access Call Center are required to administer the Screening Tool. If a beneficiary is referred directly to a BHRS program or BHRS Contracted Agency, the Screening Tool process may be bypassed and the individual may proceed to a full assessment to determine medical necessity without being required to complete the Screening Tool.

WHERE SHOULD THE SCREENING TOOL BE DOCUMENTED?

Because the Screening Tool is to be administered prior to an individual being open to services, the Screening Tool should be completed in an ICI episode in Avatar NX, and not a treatment program episode.

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WHEN SHOULD THE SCREENING TOOL BE ADMINISTERED?

- ✓ The Screening Tools for Medi-Cal Mental Health Services **must** be used by BHRS when a beneficiary, or a person on behalf of a beneficiary under age 21, who is not currently receiving mental health services, contacts the BHRS Access Call Center seeking mental health services. The screening tool is not meant to be used for determining if an existing beneficiary should step up or step down from current services.
- ✓ If a third party (including but not limited to a health care provider) simply connects the beneficiary to the BHRS Access Call Center as a resource without having conducted a screening or brief assessment to determine the appropriate delivery system for referral, **the screening tool must be used.**
- ✖ If a provider (e.g., a primary care physician, school nurse, case manager, etc.) refers a beneficiary to the BHRS Access Call Center based on an understanding of the beneficiary's needs, the **screening tool is not required**. In these scenarios, BHRS and MCPs should follow existing protocols for provider referrals and begin the assessment process.
- ✖ If a person seeking care contacts a BHRS County-Operated treatment program directly or a BHRS County-Contracted provider directly, **the screening tool is not required** and the provider may begin the assessment process and provide services during the assessment period without using the screening tool (consistent with the No Wrong Door for Mental Health Services Policy).

"COLD" REFERRALS AND THE SCREENING TOOL

"Cold" referrals are when the referring provider suspects that the beneficiary *might* have a behavioral health struggle but did not assess the beneficiary's needs or appropriate level or type of service, and might or might not have even informed the beneficiary of the referral. In these cases, if BHRS Access Call Center received the referral (also known as a request for service), the screening tool must be administered.

WHEN TO RE-ADMINISTER THE SCREENING TOOL

The following describe when the screening tool must be re-administered.

One Year Rule

In most cases, a re-referred individual who is **not currently receiving services** from either the MCP or BHRS should be re-screened using the appropriate CalAIM Screening Tool **if they meet either of these conditions:**

- ✓ The individual is requesting services after 365 days (1 year) of the administration of their most recent screening, OR
- ✓ The individual is requesting services after 365 days (1 year) of their last billable direct service.

Exception to this rule:

- ✓ If a returning individual had a Youth Screening Tool completed recently and are now of age for the Adult Screening Tool, the Adult Screening Tool must be administered even if they are returning within a year of the administration of the Youth Screening Tool. This is because the Criteria for Access to SMHS for Youth and Adult are different.

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HOW TO ADMINISTER THE SCREENING TOOL

The specific wording and ordering of the questions /fields in the tools must remain intact and the scoring methodology for the screening tools may not be altered. Deviation from the specific wording of screening questions is allowable as part of translation into another language if a translation is not currently available – see DHCS website for links to currently available translations of the Screening Tool (https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx). Additional translations may be requested through the BHRS Office of Diversity and Equity.

RELATED POLICIES TO REVIEW

The policy below is the main policy about the Screening Tool.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 23-01: Adult and Youth Screening and Transition of Care Tools

The adult tool contains 14 questions, and the youth tool contains 23 questions. If a provider is conducting a screening with a person on behalf of a youth under age 21, the provider must use the "Respondent on Behalf of Youth" version of the tool. If a person responds affirmatively to certain questions (e.g., emergency, suicidality, homicidality, already receiving mental health services from the MCP or BHRS, certain youth access criteria), the screening must be discontinued, and the provider must complete appropriate next steps as indicated in the tool.

Upon Completion of the CalAIM Screening Tool

Individuals **must** be referred to the appropriate Medi-Cal mental health delivery system (an MCP or BHRS) for a clinical assessment based on their screening score. Once referred to the MCP or BHRS, the beneficiary will receive a clinical assessment that will determine the level of care and medically necessary services. The results of the screening tool do not guarantee that the system in which the beneficiary will receive the clinical assessment will be the system in which they will meet medical necessity for ongoing treatment services. In some cases, a beneficiary might have been screened to complete the assessment in one delivery system, but upon completion of the clinical assessment, it was determined they actually meet medical necessity for the other delivery system.

WHAT IF THE BENEFICIARY DECLINES REFERRAL TO MCP

If a beneficiary receives a screening in one delivery system but declines the referral to the other delivery system for assessment, the delivery system that administered the screening must provide an assessment. MCPs and BHRS can receive reimbursement for assessment and clinically appropriate services during the assessment period, regardless of whether the assessment results in the beneficiary meeting access criteria.

WHAT IF THE BENEFICIARY IS NOT ENROLLED IN THE MCP

If a beneficiary's screening score requires a referral to an MCP but the beneficiary is not enrolled in an MCP, BHRS must provide an assessment or facilitate enrollment in an MCP and coordinate the Medi-Cal member's referral to ensure a timely clinical assessment.

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ICC Eligibility Screening Tool

Background

As a result of the Settlement Agreement in Katie A. v. Bontá (2002), the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services. The settlement specifically changed the way a defined group of children and youth with the most intensive needs, referred to as "Katie A. subclass members", are assessed for mental health services.

Pursuant to the settlement, beginning in 2013, subclass members were required to be provided an array of services, and specifically medically necessary Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC), consistent with the Core Practice Model (CPM).

RELATED POLICIES TO REVIEW

The policy below is the main policy that includes information about ICC, IHBS, and TFC Services.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 20-04: Authorization of Youth Specialty Mental Health Services (SMHS) [Update In Progress]

While the Katie A. Settlement only concerned children and youth in foster care, or at imminent risk of placement in foster care, this was changed in 2017 when membership in the Katie A. class or subclass ceased to be a requirement for receiving medically necessary ICC, IHBS, and TFC. **Therefore, a child or youth need not have an open child welfare services case to be considered for receipt of ICC, IHBS, or TFC.**

ICC must be provided to all children and youth who meet medical necessity criteria for those services.

Eligibility for ICC Services

ICC is provided through the EPSDT benefit to all children and youth who:

- ✓ Are under the age of 21;
- ✓ Are eligible for the full scope of Medi-Cal services; and
- ✓ Meet medical necessity criteria for SMHS.

ICC is intended to link beneficiaries to services provided by other child-serving systems; to facilitate teaming; and to coordinate mental health care. If a beneficiary is involved with two or more child-serving systems, the child should be getting ICC, and the MHP should utilize ICC to facilitate cross-system communication and planning. Children and youth receiving SMHS, who also are involved with the child welfare system, special education, juvenile probation, drug and alcohol, and other health and human

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services agencies or legal systems, should have improved outcomes from receiving ICC. These examples illustrate various child-serving agencies that may be involved in a child's or youth's care, and result in a need for ICC, but are not an exhaustive list.

Eligibility for ICC services does not establish eligibility for IHBS or TFC. IHBS will be recommended through the CFT process based on the individual's needs and level of functioning.

INTENSIVE CARE COORDINATION (ICC) VERSUS TARGETED CASE MANAGEMENT (TCM)

The difference between ICC and the more traditional TCM service functions is that ICC is intended for children and youth with more intensive needs, and/or whose treatment requires cross agency collaboration.

Eligibility Process within BHRS

MHPs must make individualized determinations of each child's/youth's need for ICC, based on the child's/youth's strengths and needs. These services are appropriate for children and youth with more intensive needs who are in, or at risk of, placement in residential or hospital settings, but could be effectively served in the home and community.

BHRS has developed the "ICC Eligibility Screening Tool" to support staff in making determination of if children and youth who meet medical necessity criteria need ICC.

The ICC Eligibility Screening Tool is required to be used for all beneficiaries 20 years old and under at admission and whenever there is a clinically significant change for as long as the beneficiary is under 21 years of age.

And whenever there is a clinically significant change.

*Must be completed within approximately 60 days of admission.

**Only if discharge involves change in Level of Care or other clinically significant change. If client was lost to follow up or discharged for a reason other than a clinically significant change, then the ICC Eligibility Screening does not need to be completed.

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ASSESSMENT

A Mental Health Assessment is the foundation of any individual's Mental Health treatment. It is the process by which providers develop a clinical understanding regarding an individual's needs, determines an accurate diagnosis, confirms the appropriate treating system, and what services are medically necessary to support the person in their goals so they can thrive in their community.

In order to ensure that an assessment current, accurate, and respectfully represents that beneficiary's perspective, the following applies to all assessments:

- ✓ The assessment cannot be solely based on history or chart review.
- ✓ The person conducting the assessment must have direct contact with the beneficiary (either via video, phone, or in-person).
- ✓ Assessment appointments may occur remotely; however you should have at least one face-to-face appointment (either by video or in-person) before finalizing the assessment.

RELATED POLICIES TO REVIEW

There are many policies in BHRS related to the providing remote services.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 22-06: Electronic Communication (General Guidelines) [Update In Progress]

Policy 22-07: Electronic Communication (for Communication with Clients) [Update In Progress]

DHCS does allow for Specialty Mental Health Assessments to be completed with only synchronous audio-only communication (e.g., non-video phone calls), but does not mandate that MHPs allow all assessments to be completed using synchronous audio-only communication. The decision to complete an assessment using only audio-only communication with the beneficiary is a clinical and programmatic decision. Staff should consult with their supervisor to determine if it is clinically appropriate and allowable under their program to finalize an assessment if all contact with the beneficiary was through synchronous audio-only communication.

Required to Finalize Initial Assessment

- At least one Face-to-Face interaction, either through video or in-person

Needs Approval to Finalize Initial Assessment

- No Face-To-Face Interaction, meaning all communication with beneficary was audio-only.

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Scope of Practice

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 their scope of practice under California State law. The provider must be licensed, waivered, and/or under the direction of an authorized LMHP.

For example, a mental health diagnosis and the mental status exam (MSE) can only be provided by a Licensed Mental Health Professional (LMHP)/Licensed Professional of Healing Arts (LPHA) for whom these activities are part of their scope of practice. Within BHRS, this includes:

- ✓ Physician (MD)
- ✓ Licensed/waivered Psychologist
- ✓ Licensed/registered Clinical Social Worker
- ✓ Licensed/Registered Marriage and Family Therapist, Licensed/Registered Licensed Professional Clinical Counselor
- ✓ Registered Nurse (RN) with a Master's degree in Psychology
- ✓ Nurse Practitioner (NP) licensed in a mental health-related field

RELATED POLICIES TO REVIEW

The policy below provides information on Scope of Practice as it relates to documentation.

Please note that there are additional policies not listed below that may be related to a particular staff classification, program, or situation.

Policy 93-10: Practice Standards

The LPHA will sign as the "assessor" on the signature page of assessment forms used by BHRS. 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.

Additional Staff Who May Contribute to the Assessment

Certain other qualified providers may 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. These staff may contribute to and conduct all other portions of the assessment and will sign the assessment form as "authorized clinical staff." Please see the **Scope of Practice Matrix** for up-to-date list of what functions certain qualified positions are able to complete as it relates to clinical documentation (e.g., assessment, care planning).

Clinical trainees may sign an assessment as "authorized clinical staff" and may provide a diagnosis and mental status exam **as long as it is within the scope of practice of their discipline and they are operating under the supervision of a licensed clinician (LMHP/LPHA) in one of the disciplines noted above.** The supervisor must then sign the assessment as the "assessor."

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WHO IS A "CLINICAL TRAINEE"?

A clinical trainee is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Mental Health Professional; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets Professional; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship or internship and provide rehabilitative mental health services, including, but not limited to, all coursework and supervised practice requirements.

WHAT DOES IT MEAN TO "CONTRIBUTE" VERSUS TO "FINALIZE" A CLINICAL DOCUMENT?

Contribute

- May add information that falls within the staff's scope of practice.
- Save contribution as "Draft"
- May NOT submit as "Final" even with co-signature
- Avatar Users: Use "To Do" feature rather than "Document Routing" to send notification to primary clinicain or supervisor that you have added information.

Finalize <u>with</u> Co-Signature

- May finalize (submit as "Final") but requires a co-signature from an LPHA for whom it is within their scope of practice to do so.
- Only staff who are under certain categories of licensed/waivered/registered or clinical trainees may do so.
- Avatar Users: Use "Document Routing" to request co-signature.

Finalize <u>without</u> Co-Signature

- May finalize (submit as "Final") without needing approval from Supervisor or other Co-Signer.
- Not all LPHAs may finalize all types of clinical documents. Only staff who are under certain categories of licensed/waivered/registered or clinical trainees may do so.
- For example which Licensed Occupational Therapists are LPHAs, they cannot diagnosis a psychiatric condition and therefore cannot finalize an assessment.

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Assessment Domains

The assessment contains a standard set of Assessment domains required by DHCS that should not vary from provider to provider. Below is information on the standardized domains comprising the assessment for understanding the person's care needs. While each of the domains are required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure that a clear and ideally chronological account of the person's current and historical need is accurately documented.

Below are the domain categories, key elements, and guidance on information to consider under each domain. The information in the outline below is not meant to be an exhaustive list. The practitioner should always consider the person within the context of their developmental growth and their larger community, including cultural norms or expectations when completing and documenting an assessment. Information within the assessment should come from the person seeking care, in their own words whenever possible. For children/youth and those with disabling impairments, this may also include information from collateral sources. Please note that these are general descriptions of required content for the assessment.

Please also note that the actual BHRS Assessment Form may have certain sections broken down into sub-categories or include other data collection or required elements that are mandated outside of the CalAIM documentation requirements.

Note for contract agencies: If you have an assessment form in your own EHR, your assessment does not have to exactly match the BHRS format. The assessment may be in any format so long as the assessment domains and components are included, and the assessment information is comprehensive, consolidated, and can be produced and shared as appropriate to support coordinated care, in accordance with applicable state and federal privacy laws. To the extent the information is available, all components listed within each of the seven domains shall be included as part of a comprehensive assessment.

Domain 1

Domain 1 focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint.

- ☑ **Presenting Problem(s)** – The person's and collateral sources' descriptions of problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.
- ☑ **History of Presenting Problem(s) –** Describe progression/course of the beneficiary's current presenting problem, including how the beneficiary has been impacted historically by the problem, if/how the severity/frequency of the problem has changed over time, and what barriers/resources may have helped or further impaired the beneficiary's functioning in relation to the problem.
- ☑ **Member-Identified Impairment(s)** – The person and collateral sources identify the impact/impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to

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functioning. Functioning should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.

☑ **Current Mental Status (Mental Status Exam)** – The person's mental state at the time of the assessment. This can be in the form of an informal or formal Mental Status Exam, to be **completed by an LPHA.**

- **An informal Mental Status Exam (MSE)** includes observing the beneficiary's functioning at the time you are assessing the beneficiary, and using their responses and behaviors to determine their mental status at that point in time. The mental status exam does not need to be a formal MSE. While the client's mental status should be examined and documented, a formal mental status exam is not required to finalize the Assessment.
- **A formal Mental Status Exam (MSE)** (either full MSE or mini MSE) includes using standard techniques to, for instance, assess a beneficiary's long-term and short-term memory; orienting the beneficiary to person, place, and time; and conducting the serial 7s. A formal MSE is not required in order to finalize an assessment. However, those trained in conducting a formal MSE may conduct a formal MSE and document it in the beneficiary's assessment.

Domain 2

Domain 2 involves information on traumatic incidents, the reactions of the person in care to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care — it is not necessary in every setting to document the details of traumatic incidents in depth.

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

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

Domain 3

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

☑ **Behavioral Health History**

- **Mental Health History** – Review of acute or chronic mental health conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included. Include information regarding any past mental health treatment.

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- **Co-Occurring Substance Use** – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included. Co-occurring disorders that are not related to Substance Use should be inputted in Domain 4. Include information regarding any past SUD treatment.

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

Domain 4

Domain 4 integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides an important context for understanding the needs of the people we serve.

☑ **Co-occurring Medical Conditions (other than substance use)** – This includes physical, neurological, developmental, etc. conditions but does not include substance use issues/conditions. For example, you would include in this section prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for beneficiaries 21 years old or younger). Be sure to include information about treatment history (medications, treating providers, etc.) related to the co-occurring medical condition. Co-occurring substance use would be inputted in Domain 3.

☑ **Medical History** – Relevant past medical conditions (that were not included in the co-occurring medical conditions section), including the treatment history of those conditions.

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

Domain 5

Domain 5 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

☑ **Social and Life Circumstances** – Current living situation, daily activities, social supports/networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community.

☑ **Culture/Religion/Spirituality** – Cultural factors, linguistic factors, SOGIE (Sexual Orientation, Gender Identity and Expression), and/or Black, Indigenous and People of Color (BIPOC) identities, spirituality and/or religious beliefs, values, and practices

☑ **Family** – Family history, current family involvement, significant life events within the family (e.g., loss, divorce, births).

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Domain 6

Domain 6 explores areas of risk for the beneficiaries we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the beneficiary is experiencing.

- ☑ **Strengths and Protective Factors** – Personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships.
- ☑ **Risk Factors and Behaviors** – Behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/planning/intent, aggression, inability to care for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse). May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used.

Domain 7

Domain 7 provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis. **This section must be completed by an LPHA.**

- ☑ **Diagnostic Impression** – Clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified diagnoses)
- ☑ **Medical Necessity Determination/LOC/Access Criteria** – Summary of medical necessity determination, including if beneficiary meets criteria for SMI services through BHRS, or will be transferred to another system of care (for instance, the MCP for mild-to-moderate services).
- ☑ **Treatment Recommendations** – Recommendations for detailed and specific interventions and service types based on clinical impression and overall goals for care.
- ☑ **Clinical Formulation /Summary** – Summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below)

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Additional Assessment Components

Evidence Based Practices

An Evidence-Based Practice (EBP) is an intervention that has a strongly rooted scientific foundation that has been demonstrated to be effective when implemented to fidelity.

DHCS collects data on select Evidence Based Practices (EBP) that are being utilized for beneficiaries. The following list includes EBPS that DHCS is gathering data on. **Staff may use other EBPs in their practice that are not listed below.** However, if any of the EBPs from the list below are being utilized with a particular beneficiary, staff should mark the appropriate EBPs in the assessment.

- ☐ Assertive Community Treatment
- ☐ Supportive Employment
- ☐ Supportive Housing
- ☐ Family Psychoeducation
- ☐ Integrated Dual Diagnosis Treatment
- ☐ Illness Management and Recovery
- ☐ Medication Management
- ☐ New Generation Medications
- ☐ Therapeutic Foster Care
- ☐ Multisystemic Therapy
- ☐ Functional Family Therapy
- ☐ Unknown Evidence-Based Practice/Service Strategy

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 beneficiary's Assessment when it is anticipated to be a part of the core services provided to the beneficiary. These strategies are a broader category of strategies that will be used to address the items on the beneficiary's problem list and/or entered into a treatment plan. For more information on services/interventions that would require a formal treatment plan, see the Care Planning section.

- ☐ **Peer/Family Delivered** – Services provided by beneficiaries or family members (of someone who has behavioral health conditions) who are hired as program staff.
- ☐ **Psycho-Education** – Services providing education regarding diagnosis, assessment, medication, supports, and treatments.
- ☐ **Family Support** – Services provided to beneficiary's family members in support of the beneficiary.
- ☐ **Supportive Education** – Services supporting a beneficiary to achieve educational goals with the aim of productive work and self-support.

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- ☐ **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.)

WHERE DO I DOCUMENT MORE SPECIFIC STRATEGIES?

While "Service Strategies" that are included in the assessment are broad categories of services, more specific services and strategies within these broad categories may be identified and described in other documentation, such as a written care plan.

Specific strategies that may fall within one of the broad "Service Strategy" categories include, but are not limited to, Parenting Groups, CFTs, Rehab Services, Collateral Services, etc.

- ☐ **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 colocation or collaboration with providers and sites offering services for beneficiaries 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.

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Assessment Types

There are several types of Assessments used in BHRS. It is important to select the correct assessment type to ensure that you are meeting documentation requirements. An assessment is considered completed on the date the LPHA signs and submits it as final. ***Quality Management may approve alternate assessment forms for use in certain situations.***

INITIAL ASSESSMENT TYPES

1) **Initial Assessment** (Clinician, Case Manager)
2) **Initial Assessment – Prenatal to Three Assessment** (only available in Youth Assessment Form) – only to be used by staff in the Prenatal to Three programs.
3) **Initial Assessment – School Based Mental Health** (only available in Youth Assessment Form) – only to be used by staff in the School-Based Mental Health Program.

OTHER ASSESSMENT TYPES

1) **Reassessment**
2) **Update Assessment**
3) **Assessment Review Progress Note** (using standard progress note)

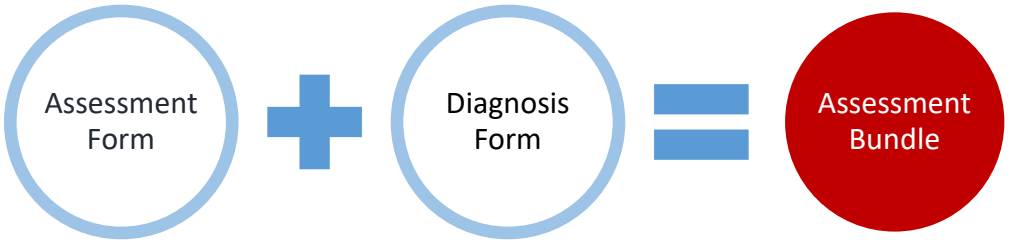
WHICH ASSESSMENT TYPES QUALIFY AS COMPLETE MEDI-CAL ASSESSMENTS?

Only the **Initial Assessment Types** and the **Reassessment Type** may be used to fulfill the requirement for a complete Medi-Cal Assessment. However, even if these forms are used, the information must be sufficiently complete to meet full criteria for a complete Medi-Cal Assessment.

Important Requirement for Completing Assessments in BHRS Avatar

As of 12/16/2024, assessment and diagnosis information must now be entered in two separate forms – The CalAIM Assessment form AND the Diagnosis form in Avatar. **It is critical that staff remember to enter a current diagnosis into the beneficiary's chart to ensure an accurate medical record and to document medical necessity,** especially upon completion of the initial assessment and whenever a reassessment is required or clinically indicated.

"Bundled" versions of the Adult and Youth CalAIM Assessment Forms have been created to assist staff in completing both the Assessment and Diagnosis Forms as required. These Assessment Bundles include the Assessment Form and the Diagnosis Form.



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For Initial Assessments and Reassessments, staff MUST use the CalAIM Adult Assessment Bundle or the CalAIM Youth Assessment Bundle to ensure that both the Assessment Form and the Diagnosis Form are completed. Staff should **NOT** bypass the Diagnosis Form if they are finalizing an Initial Assessment or Reassessment. Staff who require co-signature should only complete the Diagnosis form *after* the assessment is approved by the co-signer.

The standalone non-bundled CalAIM Assessment Forms may be used when completing an Update Assessment if the update does not include an update to the diagnosis.

In order to ensure that it is easy for staff to determine which assessment is associated with which diagnosis, **QM recommends that you finalize the assessment form on the same day that you finalize the diagnosis form.**

Initial Assessment

Resets the Assessment Timeline: YES

Initial Assessments must be completed for beneficiaries who are new to the BHRS SMHS system of care. Beneficiaries are considered "new" when they are not already connected to a BHRS Specialty Mental Health Program (including contract agencies) at the time of the assessment. If the individual is connected to a BHRS program that does not complete SMHS assessments and does not provide SMHS (e.g., they are open to SUD but not to MH), then they would be considered "new" to the BHRS SMHS.

"New" beneficiaries may also include those who had previously been discharged from a BHRS program or one of its contracted agencies and is now returning for services, or who are enrolled in a program but had an extended period without services.

WHAT ABOUT RETURNING BENEFICIARIES?

Be sure to use clinical judgment, consult with supervisors, and reference relevant policies to determine whether or not an **Initial Assessment** or **Reassessment** is appropriate for these "returning" beneficiaries.

BHRS Avatar Users: Remember to use the Assessment Bundle when completing this type of assessment.

Reassessment

Resets the Assessment Timeline: YES

Use the reassessment form any time there is a significant change in level of care, disruption of services (extended absence from services or if returning after having been discharged), any major psychosocial events, or whenever a beneficiary needs to be reevaluated to determine if they still meet criteria to access medically necessary services. This is the main Assessment type used to document reassessments for beneficiaries with ongoing services (with no lapse of services over 180 days).

All treatment programs are responsible for ensuring that the beneficiary's record includes a complete Medi-Cal assessment meeting all requirements even if the program is not considered the lead/care coordinating team/episode. **It is not sufficient to state "no change," "see progress notes," or "see previous assessment."**

BHRS Avatar Users: Remember to use the Assessment Bundle when completing this type of assessment.

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Update Assessment

Resets the Assessment Timeline: NO

Use this form to provide updates to specific sections of the assessment or when you need to update information in the assessment to substantiate an update made to the client's diagnosis (in Avatar NX, the updated diagnosis itself would be entered into the Diagnosis Form that is part of the Assessment Bundle).

This form may be completed when additional assessment information is gathered or a change occurs after the completion of the Initial Assessment, or between required assessments. You may add information to existing, specific sections of the assessment.

DIAGNOSIS UPDATES

When updating diagnosis information, use your clinical judgment to determine whether or not the diagnosis update is significant enough to warrant a full **Reassessment** rather than an **Update Assessment.**

BHRS Avatar Users: If making an update to a diagnosis, don't forget to complete the Diagnosis Form, too.

Assessment Review Progress Note

Resets the Assessment Timeline: NO

This is a standard progress note that documents that a review of the most recent assessment occurred and the outcome of that review. You do not need to also complete a formal Assessment form if the outcome of your assessment review resulted in a determination that all information in the assessment continues to be relevant and, therefore, a Reassessment Form or Update Assessment Form do not need to be completed.

An Assessment Review Progress Note is **NOT** sufficient to document updates to the assessment or when a beneficiary is returning to services after 180 days of their last billable date. Additionally, a progress note is NOT sufficient for new beneficiaries or for beneficiaries for whom a reassessment is due (e.g., it has been over 3 years since their last assessment).

In cases where an assessment review resulted in assessment information needing to be updated, you must document those updates using one of the Assessment Forms listed above.

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A Note About Incomplete Assessments

There are a number of reasons why the assessment process might begin but will not result in a completed assessment. For example, an individual might be lost to follow up or might change their mind in the middle of the assessment about wanting services.

Clinicians may finalize the assessment based on the type of the assessment that they had originally intended to complete (e.g., initial assessment or reassessment). However, they should indicate in each required field for which information was unable to be gathered that they were unable to assess the individual in that area. The clinical formulation should also indicate that a full clinical formulation was not able to be completed and that the individual should be reassessed should they return for services.

If the individual returns to BHRS to re-request services, it is the responsibility of the next clinical team to read the full assessment and ensure that the beneficiary's assessment is up-to-date and accurate. It is **not** sufficient to solely use the date of the last assessment to determine if a previously submitted initial or re-assessment is complete.

Importance of Reading the Most Recent Assessment

A due date reminder or a finalization date for the last assessment **does not** indicate that the most recent assessment met all requirements to be considered a complete Medi-Cal Assessment.

Rather than determining if a new assessment is needed based on the date of the most recent assessment, **staff should review the full contents of the most recent assessment.**

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Assessment Timelines

Initial Assessment Timeline

Under CalAIM, there is more flexibility with the amount of time that it takes to complete an assessment. This is because DHCS no longer specifies a timeframe by which initial assessments must be completed. However, the time it takes to complete an assessment should be reasonable and clinically appropriate. **Generally accepted timeframe for completion of the assessment is within 60 days of admission.** Therefore, staff should aim to complete initial assessments within this generally accepted timeframe.

An assessment may exceed the 60 day guideline in cases in which, for instance, the beneficiary's presentation is complex and requires a longer time to assess then expected, appointments had to be rescheduled multiple times, or the beneficiary does not have a reliable mode of communication to facilitate timely scheduling. If an assessment is not able to be finalized within 60 days, the reasons for the delay and any attempts to contact the beneficiary to complete the assessment should be documented in progress notes and staff may continue to take the time needed to develop a complete assessment.

Reassessment Timeline for Beneficiaries with Ongoing Services

Under CalAIM, DHCS no longer specifies a timeframe by which reassessment must be completed. However, a reassessment continues to be required at clinically appropriate and generally accepted time frames to best support the beneficiary's needs and goals. **Generally accepted timeframes for completion of the assessment is every 3 years, or sooner if clinically indicated.**

If, after 3 years, it is determined that there has been no changes to the individuals' circumstances, level of functioning, diagnosis, or other areas that would point to the need for a reassessment, then staff should consult with their supervisor if the individual continues to be best served with the current level of care or if a different level of care or the addition or removal of services are indicated. For example, a lack of change in the beneficiary's functioning after three years since the last assessment may point to:

- a level of stability that would indicate the need for a transition to a lower level of care
- the need for a higher level of care to better support the individual's progress on goals
- the need for additional services within the current level of care to better support the individual's progress on goals
- the removal of certain ancillary services that are no longer necessary within the current level of care

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Assessment /Reassessment Timelines for Returning Beneficiaries

Assessment completion timelines for returning beneficiaries depends on a number of circumstances and clinical considerations. The next few subsections explain some of the key considerations and guidelines for completing assessment for returning beneficiaries.

RE-OPENING AN EPISODE

Decisions about whether or not to re-open a recently closed episode or open a new episode for returning beneficiaries should include but is not limited to the following:

- Review of beneficiary's most recent assessment
- Internal program/team protocol
- Clinical judgement and Supervisor consultation
- BHRS Policies

All re-openings must include a progress note that specifies that the client returned to service after an extended absence, noting the last date of billable service. Progress note should also include information about whether or not a reassessment was completed.

RELATED POLICIES TO REVIEW

There are many policies in BHRS related to the opening/closing of beneficiaries in different circumstances. For example, the following two policies are related to closure of cases.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 16-01: Review and Closure of Inactive Mental Health Treatment Cases [Update In Progress]

Policy 97-11: Absence from the State for More than 60 Days

DETERMINING THE TYPE OF REASSESSMENT

In addition to the above, when determining whether or not a new assessment, reassessment, or update assessment should be completed for returning beneficiaries, information to consider includes but it not limited to:

- The last date that the beneficiary was provided a billable service.
- Reasons client was previously discharged and when they were discharged.
- Any significant events or changes that may have changed the clinical assessment and level of functioning for the beneficiary as compared to the last completed assessment.

DOCUMENTATION REMINDER

You may consider an assessment complete if you have the minimum required elements of an assessment and are able to determine medical necessity.

Remember, in the event that you receive additional information that is important to add to the assessment, you always have the option to add information to the assessment after you finalize, either through a Reassessment or Update Assessment form.

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ALLOWABLE ASSESSMENT TYPES BASED ON LENGTH OF ABSENCE FROM SERVICES

Determining what type of assessment documentation needs to be done for returning beneficiaries depends on several factors. The following table provides guidelines to assist staff in determining the type of assessment that may be completed for a returning beneficiary. Timeframes to keep in mind are 180 Days and 360 Days from the date of the last billable service.

0-180 Days	**181-360** Days	**361 and over** Days
✓ Initial Assessment Form	✓ Initial Assessment Form	✓ Initial Assessment Form
✓ Reassessment Form	✓ Reassessment Form	
✓ Update Assessment		
✓ Assessment Review Progress Note		

0-180 DAYS (INCLUSIVE OF 180TH DAY)

If the beneficiary was discharged and returned to services within 180 days of the last date of billable service.

Depending on the circumstances of the beneficiary, the clinician should use their clinical judgment in consultation with their supervisor to determine if the beneficiary should be reopened to the most recent episode for that program. If appropriate, the clinician may resume services in the most recent episode by having the program admin back out the discharge date.

The clinical team has some flexibly here to determine the level of reassessment needed. Clinicians may either do a **reassessment**, **update assessment**, or, if no there was no change in circumstance since the last assessment was completed, a progress note documenting the assessment review may be completed. An assessment review note documents that the most recent assessment was reviewed and that the information continues to be up-to-date (this note does not restart the assessment timeline).

DOCUMENTATION REMINDER

If the clinician determines that the beneficiary will be opened to a new episode, and the beneficiary will be receiving services that require a care plan progress note or formal care plan, these will need to be re-done in the new episode.

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181-360 DAYS (INCLUSIVE OF 360TH DAY)

If the beneficiary was discharged and returned to services between 181 days – 360 days of the last date of billable service.

The clinical team has some flexibly here to determine the level of reassessment needed based on the beneficiary's level of functioning and life circumstances. However, there is not as much flexibility as the 0-180 day scenario with regards to the type of assessment that must be completed.

For returns to service between 181-360 days of the last billable service, a reassessment is required. This reassessment may be done in the form of an initial assessment, reassessment, or Update Assessment, depending on the situation.

An Assessment Review Progress Note is not sufficient for beneficiaries who return to service over 180 days since their last date of billable service.

DOCUMENTATION REMINDER

Beneficiaries who return to services within 180 days may be reopened to the previous episode ONLY if they meet criteria outlined in Policy 16-01: Review and Closure of Inactive Mental Health Treatment Cases.

Beneficiaries who do not meet criteria outlined in Policy 16-01 **must** be opened to a new episode.

361 AND OVER DAYS

If the beneficiary was discharged and returned to services more than 360 days of the last date of billable service.

If a beneficiary is discharged and returns to care after 360 days (1 year): The treatment team should complete an Initial Assessment. The information from the previous assessment may be pulled into the new assessment, then update the information as needed.

If the beneficiary is going to be evaluated by the physician, the physician's evaluation must be documented in either an assessment form or in a PIN progress note. Whether or not a PIN progress note is sufficient depends on if there is also a current and valid Medi-Cal Assessment in place.

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Multiple Teams or Providers for A Single Beneficiary

Physician Initial Assessment and Physician Initial Note (PIN):

For some teams, both the clinician and the MD will conduct an assessment. However, the form that is used to document the assessment in the chart determines which assessment to use as the beneficiary's "official" Medi-Cal assessment. While entry to care clinicians primarily use the Assessment form, MDs sometimes complete the Assessment form and the progress note, and sometimes submit a progress note only. (Note: All appointments must have a progress note included to capture billing information. An Assessment alone does not capture that information.)

- If there is a current and valid Medi-Cal Assessment already completed by another clinician, the MD must complete at least a Mental Health Progress Note that includes a statement that the MD/NP reviewed the Assessment. The MD/NP can also document any changes / updates from the original Assessment. The MD/NP may also complete a Reassessment or Update Assessment in addition to the Mental Health Progress Note if enough information has changed that a Reassessment is appropriate.
- If someone else on the treatment team will be completing an Assessment then the MD/NP may complete a Mental Health Progress Note without completing the Assessment. Otherwise, the MD/NP should complete the full Assessment and complete a Mental Health Progress Note.

For questions about whether you need to complete an Assessment in addition to your usual Mental Health Progress Note, please contact your Med Chief and/or the Deputy Medical Director for the most current guidance.

Multiple Teams

When two or more treatment teams are treating the same beneficiary, the teams should coordinate care and determine which team will be the lead in developing and completing the assessment. **However, it is every team's responsibility to ensure that there is a complete and current assessment that meets requirements for any beneficiary enrolled in their program.**

For example, If the beneficiary is already open to a treatment program and an additional team will be added to co-support the beneficiary, each team is responsible for ensuring that there is a current and accurate assessment in the clinical record. Additionally, if an assessment has not been updated for quite some time (beyond generally accepted practice or long after a significant change occurred), teams should communicate with each other regarding the lapse and actively coordinate to complete a current assessment.

Remember, not only should active communication and coordination between teams sharing a beneficiary occur, it should also be documented in a progress note.

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ADDITIONAL REQUIRED ASSESSMENT TOOLS

CANS and PSC-35

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

The CANS is a structured assessment used for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes. Clinical staff will complete the CANS through a collaborative process which includes, at a minimum, children and youth, ages 6 to age 20, and their caregivers.

PEDIATRIC SYMPTOM CHECKLIST (PSC-35)

The PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional and behavioral problems so that appropriate interventions may be initiated as early as possible. Parents/caregivers will complete PSC-35 (parent/caregiver version) for children and youth ages 3 to age 18. For the PSC-35, if the child/youth does not have a parent/caregiver or the parent/caregiver declines, then staff will document this in their progress notes.

The PSC-35 can be found in Avatar utilizing the "Generic Access" Widget. Instructions on how to add the PSC-35 widget and PDF versions of the forms are available here: https://www.smchealth.org/bhrs-policies/cans-child-and-adolescent-needs-and-strengths-psc-35. If using the PDF version of the PSC-35, please make sure the completed PSC-35 forms are also scanned into the beneficiary's medical record.

RELATED POLICIES TO REVIEW

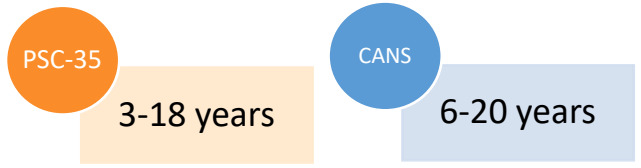
The following Memo is the primary guidance in BHRS regarding the CANS and PSC-35.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Memo 01-22: CANS and PSC-35 – All Providers

AGE RANGES FOR CANS AND PSC-35

The administration of the CANS and PSC-35 depends on the age of the beneficiary, not the program in which the beneficiary is enrolled. Depending on the age of the client, both a PSC-35 and a CANS may both be required.



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Timelines for CANS and PSC-35

BHRS Clinical Staff: All BHRS clinical staff are required to administer the CANs for the beneficiaries and time frames specified in the memo. Staff must be CANS-certified before administering the CANS and must maintain annual certification status. BHRS Quality Management will track that BHRS clinical staff are CANS-certified. To become CANS-certified, first create an account with the PRAED Foundation: https://www.schoox.com/academy/CANSAcademy/register and then contact HS_BHRS_QM@smcgov.org to access the CANS training code. You must provide the certificate of completion of the CANS training to QM immediately after completing/passing the online exam. The programs responsible for completing the assessment are also responsible for completing the CANS and PSC-35. BHRS clinical staff will complete the CANS directly in Avatar. A paper version may be utilized but the information must also be entered into Avatar. CANS can be found in Avatar as the form titled: "Child and Adolescent Needs and Strengths."

Contractor Staff: All contractors are required to be CANS-certified before administering the CANS, and to maintain annual certification status. Contract agencies are required to track certification of their staff and this must be made available upon request. The PRAED foundation is the only certifying body: https://praedfoundation.org/training-and-certification.

Contractors with Avatar administrative access will utilize the paper version of the forms and will either have their administrative staff enter the information into Avatar or submit the documentation to the BHRS MIS department to be entered, depending on their agency's workflow. Paper versions will be kept in their agency's official medical record. Contractor Clinical Staff will complete the CANS in their official medical record and submit the CANS data set to their administrative staff for entry into Avatar, or it may be sent to BHRS MIS for entry into Avatar.

TIMEFRAME: THE CANS AND PSC-35 SHOULD BE COMPLETED AT THE FOLLOWING POINTS IN TIME:

And whenever there is a clinically significant change.

*Must be completed within approximately 60 days of admission.

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BHRS SMHS Eligibility Tool

The determination of whether a beneficiary meets or continues to meet Access Criteria for SMHS, including whether or not transition of care should occur and the determination of what services are medically necessary, **must be made by a clinician.** DHCS allows for the development of protocols, which could include the use of a rubric or other methodology, to support this determination. The use of the BHRS SMHS Eligibility tool **does not replace a full clinical assessment**. It is intended to be used to support staff's ability to confirm their determination of eligibility after the completion of the full assessment (or reassessment).

BHRS currently has **three versions** of the BHRS SMHS Eligibility Tool to support clinical staff in determining if a beneficiary meets criteria to access specialty mental health services.

When and How should this Tool be used?

Use of the BHRS SMHS Eligibility Tool is optional.

The SMHS Eligibility Tool is intended to be used as a supervisory tool to help supervisors in supporting their staff's learning of how to determine if an individual meets criteria to access SMHS. It is **not** meant to replace clinical decision making, nor is it meant to determine the specific types of services that are medically necessary.

The BHRS SMHS Eligibility Tool may be used whenever there is a determination being made about whether or not a beneficiary meets or continues to meet Criteria to Access SMHS. This includes: the Initial Assessment, Reassessment(s), and at Discharge.

DOCUMENTATION REMINDER

The use of the BHRS SMHS Eligibility tool does not replace a full clinical assessment. It is intended to be used to support staff's ability to validate their determination of eligibility after the completion of the full assessment (or reassessment).

Please refer to the Assessment section of this manual for more guidance on when a reassessment should be conducted.

What staff /programs may use the BHRS SMHS Eligibility Tool?

Only LPHAs for whom it is within their scope of practice to finalize assessments may use the BHRS SMHS Eligibility Tool. Please refer to the **Scope of Practice Matrix** on the BHRS QM website for information on who may finalize assessments.

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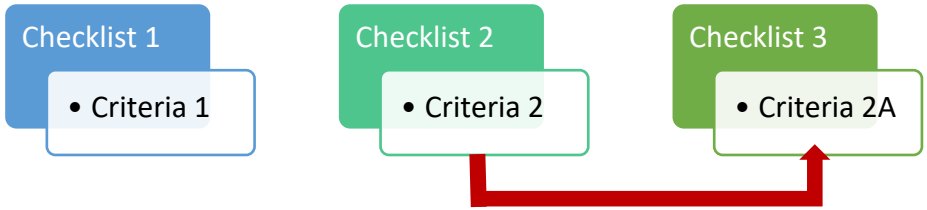
Structure of the BHRS SMHS Eligibility Tool

The BHRS SMHS Eligibility Tools align with the Criteria for Access to SMHS based on age group, and an additional set of criteria is provided to help staff assess whether or not an individual's level of functioning would be considered, for instance, a "significant impairment" or a "probability of significant deterioration."

YOUTH (0-5 YEARS AND 6-20 YEARS)

The Youth (0-5) and Youth (6-20) Eligibility Tool include 3 checklists.



Checklists 1 and 2

The first two checklists are checklists that directly align with Criteria 1 and Criteria 2 of the Criteria to Access to SMHS criteria for beneficiaries under 21 years of age (See "Access to SMHS" section of this manual for details on these criteria).

Checklist 3

The third checklist, titled Criteria 2A, is to support staff's determination of whether or not the beneficiary may likely meet Criteria 2A. Criteria 2A includes that the youth beneficiary must have at least one of the following:

- a significant impairment;
- a reasonable probability of significant deterioration in an important area of life functioning;
- a reasonable probability of not progressing developmentally as appropriate;
- and/or a need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

Criteria 2A is a checklist that supports staff's ability to determine if, for example, the beneficiary's functioning indicates a "**significant impairment**" that would satisfy the requirements for A under Criteria 2A.

Beneficiaries 20 years and under only need to meet criteria in **either** Criteria 1 or Criteria 2, not both. However, in order for a beneficiary to be eligible to access SMHS under Criteria 2, both Criteria 2A **and** Criteria 2B must be met.

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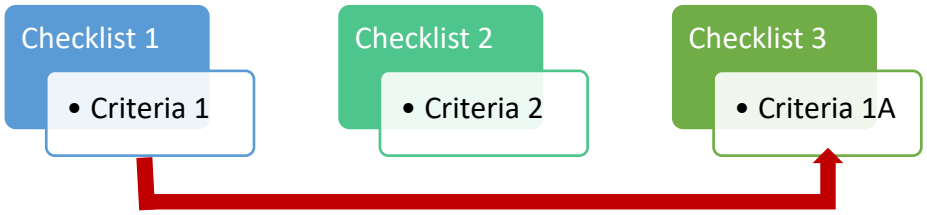
ADULTS (21+ YEARS)

The Adult (21+ years) Eligibility Tool also includes 3 checklists.



Checklists 1 and 2

The first two checklists are checklists that directly align with Criteria 1 and Criteria 2 of the Criteria to Access to SMHS criteria for beneficiaries 21 years of age and older (See "Access to SMHS" section of this manual for details on these criteria).

Checklist 3

The third checklist, titled Criteria 1A, supports staff's determination of whether or not the beneficiary may likely meet Criteria 1.

Criteria 1 requires that an adult beneficiary has either:

- a significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities, **AND/OR**
- a reasonable probability of significant deterioration in an important area of life functioning.

Criteria 1A is a checklist that supports staff's ability to determine if, for example, the beneficiary's functioning indicates a "significant impairment" that would satisfy the requirement to meet Criteria 1.

Beneficiaries 21 years of age and older must meet **both** Criteria 1 and Criteria 2 to be eligible to access SMHS.

What if my clinical determination is different from the result of the BHRS SMHS Eligibility Tool?

If staff's determination regarding the beneficiary's eligibility at the conclusion of the assessment is different from the outcome of the BHRS SMHS Eligibility tool, staff should consult with their supervisor to review the draft of the full assessment and the completed tool to explore reasons for the discrepancy. Staff and supervisors should use their clinical expertise to make the appropriate determination of eligibility.

In addition to making a clinical assessment of the beneficiary's medical necessity, best practice is to include beneficiaries in ongoing conversations throughout treatment including reviewing treatment progress, potential transitions or changes in types of services offered, and readiness for transition. If transitioning a beneficiary to another level of care, the transition should happen within a clinically appropriate timeframe as determined by the clinician in collaboration with the beneficiary.

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DIAGNOSIS

Information used to determine a diagnosis is obtained through a clinical assessment and may include a series of structured tools. Information may come directly from the person in care or through other means, such as collateral information or health records. A diagnosis captures clinical information about the person's mental health needs and other conditions based on the DSM-5. Diagnoses are determined by an LPHA commensurate within their scope of practice (See **Scope of Practice Matrix**).

Diagnoses serve several purposes, including, but not limited to:

- Diagnoses are used to communicate with other team members about the person's mental health symptoms and other conditions and may document the level of distress/impairment.
- Diagnoses also help guide practitioners in their advisement about treatment options to the person in care.

Diagnoses should not remain static. For example, the person's clinical presentation may change over time and/or the practitioner may receive additional information about the person's symptoms and how the person experiences their symptoms(s) and conditions.

As a practitioner, it is solely the responsibility of the LPHA acting within their scope of practice to ensure that all mental health diagnoses in the problem list are up-to-date. This includes documenting all diagnoses, including preliminary diagnostic impressions and differential diagnoses. The LPHA should also update the health record of the person in care whenever a diagnostic change occurs.

WHAT IS MEANT BY THE TERM "DIAGNOSIS"?

To provide further clarification regarding diagnoses that can be added to the problem list, this documentation manual will use the following definitions:

Mental Health Disorders – refers to diagnoses (using "F" and certain "Z" codes in the ICD-10) that MUST be diagnosed by an LPHA. These diagnoses may be used for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system.

Mental Health Disorders include, for instance, Major Depressive Disorder or Post-Traumatic Stress Disorder, but does NOT include substance-related and addictive disorders (e.g., stimulant use disorder) or neurocognitive disorder (e.g., dementia).

Social Determinants of Health – refers to a subset of Z-Codes that represent various social factors and life circumstances that may impact a beneficiary's functioning. These may be identified by an LPHA or non-LPHA and are not considered "mental health disorder" diagnoses.

While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SMHS, the covered benefits and services responsibilities of the MHPs and MCPs remain unchanged. For example, MHPs are not required to provide Applied Behavior Analysis (ABA), a key intervention in the treatment of autism spectrum disorder (ASD), as the responsibility for providing that service remains with the MCP. However, a person in care who has ASD is able to additionally receive treatment from the MHP if their service needs require it and services are not duplicative with the other care they are receiving.

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Diagnosis Scope of Practice

The introduction of the "Problem List" under CalAIM allows for both LPHAs and non-LPHAs to add items to the Problem List. However, LPHAs and non-LPHAs differ in the types of "problems" they can add to the Problem list. While LPHAs diagnose mental health conditions such as Major Depressive Disorder, non-LPHAs are limited to adding only a subset of the Z-codes in the ICD-10, commonly referred to as social determinants of health.

For purposes of clarity, the term "diagnosis" in this manual will be used for those codes that may only be diagnosed by an LPHA. Z-Codes that may be used by all providers, including non-LPHAs, will be referred to as "Z-Codes" or "Social Determinants of Health (SDOH)" and will NOT be referred to as Diagnoses.

Diagnosis codes for use by LPHAs	Z-Codes for Use by All Providers*
• Any clinically appropriate code. • Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out). • "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."	• Z55-Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances). **May be used during the assessment period prior to diagnosis; do not require supervision of a Licensed Practitioner of the Healing Arts (LPHA).*

Diagnosis Oversight

Formulation of a diagnosis requires a provider, working within their scope of practice, to be licensed, waivered and/or under the direction of a licensed provider in accordance with California State law. Determining a diagnosis is within 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.)

LPHAs are responsible for reviewing the diagnoses entered into a beneficiary's problem list, including Z-codes entered by non-LPHAs.

All diagnoses, including any substance use diagnosis, must be included on the mental health Assessment.*

* Note that this does NOT include diagnoses or other information that falls under 42 CFR Part 2 privacy restrictions.

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Clarification Regarding "Claimable" Diagnosis Codes

Services provided prior to determination of a diagnosis (including services provided during the assessment, or prior to determination of SMHS access criteria) are covered and reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for access to SMHS.

However, while a mental health diagnosis is not a prerequisite for access to covered services and while a person may access necessary services prior to determining a diagnosis, **an ICD-10 code must be assigned to submit a service claim for reimbursement**

In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA in the CMS approved ICD-10 diagnosis code list, which may include Z codes. LPHAs may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

SELECTING A "PRIMARY" DIAGNOSIS

An ICD-10 Code that is the focus of treatment should be identified as the "Primary" diagnosis as this is the code that will be attached when claiming (billing) services.

- During the Assessment phase, if a formal mental health diagnosis is not yet determined, clinicians should use code Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out) as the primary diagnosis.
- When a more definitive mental health diagnosis (not a Z-code) is determined for the client, the diagnosis should be updated in the chart as soon as the diagnosis is determined. If more than one mental health diagnosis is appropriate for the client, select the one that is the primary focus of treatment as the "Primary" diagnosis.
- You may provide treatment for the other diagnoses that are added even if they are not the primary diagnosis as long as treatment of the condition is within your scope of practice and any applicable care planning requirements are met.

ARE Z-CODES ACCEPTIBLE "ICD-10" CODES FOR CLAIMING PURPOSES?

Z-codes meet the federal requirement for claims which is why they may be the primary code used during the assessment phase. Keep in mind, though, Z-codes do not indicate a diagnosis of a mental health disorder or a substance use disorder.

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WHAT IS CONSIDERED A "MENTAL HEALTH DIAGNOSIS"?

Mental Health Diagnoses are included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) [published by the American Psychiatric Association (APA)] and can also be found in the "Mental, Behavioral and Neurodevelopmental disorders" section of the ICD-10 Tabular [published by the Centers for Medicare and Medicaid Services (CMS)].

Different reference sources assign different codes to the same diagnosis. For instance, each mental health diagnosis can be identified by an ICD-10 Code, a SNOMED code, or an ICD-9 Code, and so on and so forth. ICD-10 codes that fall in the "Mental, Behavioral and Neurodevelopmental Disorders" category are designated with an alphanumeric code that begins with the letter F. Past versions of the DSM listed both the ICD-9 and ICD-10 codes for each diagnosis.

DHCS has moved toward identifying diagnoses by the ICD-10 code for billing purposes. Staff may continue to use the current version of the DSM to diagnose and use the ICD-10 code listed in the DSM rather than the ICD-9 code when identifying the diagnosis code alongside the longform name of the diagnosis. *[Example: Major Depressive Disorder, recurrent episode, with psychotic features (F33.3)]*

CMS updates the ICD-10 CM Tabular throughout the year and the Avatar system updates the diagnosis lists on a regular basis. However, if staff are curious to see a complete, up-to-date list in real-time, staff may look up the most up-to-date Tabular on the CMS website. Staff may also check the APA's DSM website for information on updates to the DSM codes.

Code Range	Category Description
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39	Mood [affective] disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities*
F80-F89	Pervasive and specific developmental disorders*
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

Remember, BHRS serves individuals who meet criteria to access SMHS and require medically necessary SMHS. BHRS is not the service delivery system for ALL individuals who are diagnosed with a mental health condition. Therefore, clinical documentation, including diagnoses, must demonstrate that the individual meet SMHS criteria. It is helpful to include Z-codes to further substantiate and clarify the medical necessity of SMHS.

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*** Special Note about Intellectual Disabilities and Non-Verbal Clients**

Under CalAIM, a mental health diagnosis is no longer a prerequisite for receiving SMHS. However, individuals must present with a medically necessary need for SMHS to receive SMHS. For individuals diagnosed with solely an intellectual disability or for individuals who are non- verbal, it is important for the clinician to determine if the individual also meets criteria for another F-code diagnosis that more clearly demonstrates the individual's mental health struggles, or if adding additional Z-codes will support the medical necessity of SMHS. Additionally, some specialty programs in BHRS also have specific requirements for entry into their program, including specific diagnostic requirements. Staff should consult with their program supervisors if they have questions about their program's criteria for admission.

DOCUMENTATION REMINDER

Clinical Documentation, including diagnoses, should demonstrate how client meets criteria for SMHS.

MORE ABOUT Z-CODES

A Z-code alone may be utilized while a clinician takes time to gather information about the beneficiary's presenting needs and determine the most appropriate diagnosis and next steps. However, the Z-code should not be utilized indefinitely as the primary diagnosis (see access to SMHS criteria for beneficiaries 21 and up) as it may be challenging to justify ongoing medical necessity for SMHS without a formal diagnosis of a "mental health disorder" (e.g., an "F-Code" diagnosis, such as Depressive Disorder or Schizophrenia).

DOCUMENTATION REMINDER

The assessment or other documentation in the medical record should substantiate the use of a Z-code.

In some settings or for some service types, particularly with children and youth, services can more easily be justified based only on Z codes. In these cases, consult with your supervisor and QM to determine if you have a case which should continue using only a Z code.

Code Range	Category Description
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z55-Z65	Persons with potential health hazards related to socioeconomic and psychosocial circumstances

ADDITIONAL GUIDELINES FOR "BY HISTORY," "RULE OUT," AND "PROVISIONAL" DIAGNOSES

"By history," "Rule Out," and "Provisional" diagnoses may be included as part of the list of diagnoses, but they should not be the sole diagnoses on record for the beneficiary if the beneficiary is receiving ongoing SMHS post-assessment. The beneficiary should meet criteria for a mental health diagnosis at the completion of the assessment to meet medical necessity criteria for ongoing SMHS. If there is no clear clinical diagnostic picture at the conclusion of the assessment, reconsider if the assessment was completed prematurely prior to the acquisition of the necessary information to determine a diagnosis, or if the beneficiary should be seen in a lower level of care (a.k.a., mild-to-moderate services through the MCP).

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Other Diagnosis-Related Issues

DIAGNOSES FROM INPATIENT FACILITIES

An assessment, which includes a diagnosis, evaluates the *current status* of a beneficiary's mental, emotional or behavioral health. This status may change as a beneficiary 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 documents should be reviewed to inform the outpatient assessment process and to verify that the diagnosis reflects the beneficiary's current mental, emotional or behavioral health status.

MULTIPLE PROVIDERS AND MULTIPLE DIAGNOSES

- If there is a difference of opinion between providers regarding a beneficiary's diagnosis—e.g., between a physician and a therapist—it is best practice for the providers involved to consult and collaborate to determine the most accurate diagnosis.
- A beneficiary's diagnosis may be used by multiple providers if the diagnosis reflects the current status of the beneficiary's mental, emotional, or behavioral health.

CHANGE OF DIAGNOSIS

- A reassessment and change in diagnosis may be required when a beneficiary has experienced a significant medical or clinical change. Either a **Reassessment** or **Update Assessment** should be completed to update any relevant sections of the assessment that explain the changes in the beneficiary's presentation or function that indicated the need to update the diagnosis.

  For Avatar users, when changing a diagnosis, use an **Assessment Bundle** (see section on Assessment Types) and select the most appropriate assessment type. If, for instance, the change to the diagnosis is a minor change in a severity specifier, then an **Update Assessment** using the **Assessment Bundle** may be used.

  However, if you are making a significant change – for instance, if you are adding or removing a diagnosis of psychosis – then a **Reassessment** using an **Assessment Bundle** should be used.

  DOCUMENTATION REMINDER

  BHRS Avatar users must use an "Assessment Bundle" and select the most appropriate assessment type when updating a diagnosis.

- Assignment of a mental health diagnosis may be deferred until the completion of the assessment. A diagnosis listed as provisional or rule-out should be confirmed or changed upon the completion of the assessment and determination of medical necessity. Diagnoses may be changed at any time during the course of treatment.

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DIAGNOSIS & TREATMENT WITHOUT MEETING ACCESS CRITERIA FOR SMHS

Occasionally, it may be appropriate to provide ongoing treatment services to a beneficiary whose condition does not meet Criteria for Access to SMHS. In these cases, the clinician must obtain supervisor approval to continue treating the beneficiary after the assessment period.

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PROBLEM LIST

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CARE PLANS

Pre-CalAIM Care Plans (Treatment Plans)

Until BHRS implements the new CalAIM Care Plan requirements, staff should continue to follow guidelines for pre-CalAIM Treatment Plan requirements using the existing "Client Treatment and Recovery Plan" form in Avatar or the PDF version of the form. Below are the Pre-CalAIM Treatment Plan Guidelines. **This Pre-CalAIM section will be removed and replaced with a new Care Plan section that includes new CalAIM guidelines in November 2024 to coincide with the Care Planning Training that will be offered that month.**

Client Treatment and Recovery Plan (Formal Plan)

The Client Treatment & Recovery Plan is a primary way of involving clients in their own care. The development of the Client Plan is a collaborative process between the client and their 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 or verbal approval of the client/parent/guardian and when possible providing a copy of the plan to the client/family member, and, most importantly, documenting in a Plan Development or medication support 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 if 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.

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

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THE 9 ELEMENTS REQUIRED BY THE CURRENT CLIENT PLAN

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 dates;
4. Specific behavioral interventions (description) for each proposed service and how it will ameliorate diagnosis;
5. Observable and measurable goals and objectives; SMART (*See p. 15)
6. Provider's signature with Degree/License or job title, and signature date, and co-signature of LPHA if applicable;
7. Adequate documentation that the beneficiary was offered a copy of the Plan;
8. Client's dated signature (or progress note documenting verbal approval);
9. Documentation that the beneficiary participated in development of and agreed to the Plan

Treatment Plan Timelines

A client plan must be completed prior to service delivery of all Planned Services*. The State Plan requires services to be provided based on medical necessity criteria, in accordance with an individualized client plan and an approved and authorized assessment, according to 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 all programs the treatment plan must be completed within 60 days from admission to your program. A new treatment plan should be completed before the previous plan expires; there should be no gap between treatment plans.

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.

The 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.

REVIEWING THE PLAN WITH THE CLIENT

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 a Plan Development progress note, including outcomes, progress (or lack thereof) on the previous treatment plan's goals/objectives. The note should include the client's participation in formulating the plan, and approval of the plan (can be verbal approval).

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Updates to Treatment 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, or a client who has been attending therapy regularly suddenly stops coming to appointments...etc.

Treatment Plan Signatures

The client's verbal approval and/or signature or the verbal approval and/or signature of the client's parent 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. Verbal approval, with a progress note documenting agreement, from client or client's caregiver is acceptable. 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

If the client/parent refuses to sign or is unavailable to sign the treatment plan, a detailed progress note must be written to explain the client's participation in developing the plan and/or agreement to treatment in general, and the reason for the missing signature. Verbal approval, with a detailed progress note, is also sufficient if you cannot meet with client or caregivers in person. It is expected that you would follow best practice protocols and make additional attempts to obtain the client's verbal approval and/or signature and document these attempts in the client's chart. We do not recommend writing "clinician will obtain signature during next session."

MINORS CAN SIGN (OR GIVE VERBAL APPROVAL) TO 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 that 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 document the client's involvement in plan development—e.g., a telephone discussion about the plan—and document this involvement (and approval of the plan) by the client on the treatment plan AND in a Plan Development progress note. It is not sufficient to document this client involvement only on the plan itself; a Plan Development or medication support note must be written whenever you work with a client to formulate/review/obtain approval for a treatment plan.

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Staff Who Must sign the Client Plan

A client plan must be signed (or electronic equivalent) with a credential, 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 Clinical Social Worker
- ✓ Licensed/registered/waivered Marriage & Family Therapist
- ✓ Licensed/registered/waivered Professional Clinical Counselor
- ✓ Registered Nurse, Nurse Practitioner (NP), Clinical Nurse Specialist

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

Services that Require a Treatment Plan

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

- + Mental Health services (except assessment, client plan development, crisis intervention, urgent Med Support)
- + 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)

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- Psychiatric Health Facility services
- Psychiatric Inpatient services

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.

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 is connected to the client's mental health condition. Goals must relate to the diagnosis and case formulation.

OBJECTIVE(S)

What the client will do to reach the goal.

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, 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 S.M.A.R.T. (Specific, Measurable, Attainable, Relevant, Time-bound).

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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.

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 per month).

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Examples of Treatment Plan Elements

Examples of Recovery Barrier/Problems linked to Diagnosis

- ☑ Auditory hallucinations leading to self-harm and hospitalization.
- ☑ Exhibits angry behavior in class; refuses to complete tasks or accept help; learning disabilities impede progress in school.

Examples of Goals

- ☑ Reduce auditory hallucinations and improve symptom management.
- ☑ Get along better with others at school, without physical aggression.

Examples of Objectives

- ☑ From a baseline of 0, I will meet with MD 1x/month to discus positive and negative impact of medication over the next 12 months.
- ☑ Within 12 months, I will identify at least 2 activities, from a baseline of 0 activities, that will help me not listen to negative voices.
- ☑ Within 12 months, I will have at least one friendly talk with peers 2-3 times per week from a baseline of 0 friendly talks weekly.

Examples of Interventions

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

Examples of specific, diagnosis-related interventions

- ☑ Clinician will provide Individual Therapy 1x per week, for 6 months, utilizing Cognitive-Behavioral techniques, to assist client to reduce his anxiety.
- ☑ (AOD) Case Management to be provided twice monthly, for 1 year, to ensure that client is utilizing support/resources to maintain sobriety.
- ☑ 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. If a proposed intervention is not included on the treatment plan, that service cannot be provided and billed for.

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COORDINATION OF CARE

All Staff are responsible for ensuring that they are up-to-date on regulations and policies related to sharing of information, including sharing of information as it relates to coordination of care.

RELATED POLICIES TO REVIEW

The policies below are the main policies related to care coordination and sharing PHI and medical records with other providers.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 23-01: Adult and Youth Screening and Transition of Care Tools

Policy 22-03: No Wrong Door for Mental Health Services

Policy 93-13: Restricted Material in Beneficiary Chart

Policy 96-15: Application for Services and Consent to Treatment

Policy 03-01: Confidentiality - Privacy of Protected Health Info (PHI)

Policy 03-02: Notice of Privacy Practices

Policy 03-04: Disclosure of Protected Health Information (PHI) Minimum Necessary

Policy 03-05: Disclosures of Protected Health Information (PHI), Incidental

Policy 03-06: Disclosures of Protected Health Information (PHI) with Beneficiary Authorization

Policy 03-08: Restrictions on Use or Disclosure of Protected Health Information (PHI), Beneficiary Request

Policy 03-09: Amendment of Protected Health Information (PHI), Beneficiary Request

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Co-Occurring Substance Use Disorders

Beneficiaries 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.

SCREENING FOR SUD

For information on how beneficiaries get screened then referred for SUD services, see the Screening Tools Section.

DIAGNOSIS

All diagnoses for mental illness and substance abuse/dependence shall be documented in the BHRS chart when criteria are met. However, keep in mind that substance-related and addictive disorders (e.g., stimulant use disorder) are not “mental health disorders" for the purpose of determining whether a member meets criteria for access to the SMHS delivery system.

CARE PLANNING OF SERVICES

Care Planning for beneficiaries and families with children with co-occurring disorders must address both mental health and substance use issues. Care Planning (including the problem list and, if required, formal treatment plans) will be tailored to the beneficiary’s readiness to address an issue, with the understanding that the beneficiary and family members may have different levels of readiness to address each issue.

CO-OCCURRING VS CO-MORBID

San Mateo County Behavioral Health and Recovery Services (BHRS) assesses and treats co-occurring disorders including substance abuse/dependency, trauma- related disorders, and developmental disorders.

Because this section focuses on Substance Use Disorders, the following definitions will be used **for this section**:

Co-Occurring Disorders: The coexistence of both a Mental Health diagnosis and Substance Use Disorder.

Co-Morbid: Moves beyond the existence of co-occurring diagnoses. When a beneficiary is experiencing a co-morbidity, it means, that the interactions between these co-occurring disorders can worsen the course of both.

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.

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Integrated System

For beneficiaries and families with co-occurring conditions and other complex needs, the provision of integrated services matched to the multiple needs of the beneficiary and/or family is an evidence-based practice. The "No Wrong Door" Policy under CalAIM makes it easier for beneficiaries with these co-occurring diagnoses to be seen concurrently by the MH and SUD systems. The following guidelines should be used when treating individuals with co-occurring diagnoses.

BENEFICIARIES IN A MH PROGRAM WHO ALSO HAVE AN SUD DIAGNOSIS

- ✓ Clinically appropriate and covered SMHS delivered by BHRS Mental Health Providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD.
- ✓ The session must primarily address the member's mental health, e.g. symptom, condition, diagnosis, and/or risk factors which can include co-occurring SUD.
- ✓ The reason for the service encounter must include an ICD-10-CM code that corresponds to their mental health.

WHAT ARE DMC-ODS PROGRAMS?

Put simply, Drug Medi-Cal Organized Delivery System (DMC-ODS) is another term for health plans that provide Substance Use Disorder Services under Medi-Cal. BHRS' SUD delivery system falls under the DMC-ODS category.

BENEFICIARIES IN AN SUD PROGRAM WHO ALSO HAVE MH DIAGNOSIS

- ✓ Clinically appropriate and covered DMC-ODS services delivered by DMC-ODS providers are covered by DMC-ODS counties, whether or not the beneficiary has a co-occurring mental health condition.
- ✓ The session must primarily address the member's substance use, e.g. symptom, condition, diagnosis, and/or risk factors, which can include co-occurring mental health conditions.
- ✓ The reason for the service encounter must include an ICD-10-CM code that corresponds to their SUD.

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 rates of SUDs and mental illness are typically reported as 40 percent to 80 percent, depending on study characteristics and population. There is a growing body of research associating poorer outcomes with a lack of targeted treatment efforts. These studies have highlighted the importance of addressing the unique needs of this population.

CO-OCCURRING FAMILIES

Families in which a significant family member /caregiver of a beneficiary has a substance use issue. Integrated services and documentation apply to co-occurring families as well as to co-occurring beneficiaries receiving adult or child mental health services funding. However, clinicians must use care when documenting family member /caregiver SUD in the beneficiary's chart.

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Beneficiaries Shared Between BHRS and an MCP

The respective responsibilities of MHPs, Medi-Cal MCPs, and the Medi-Cal Fee for Service (FFS) delivery systems has not changed with the adoption of CalAIM. Services for symptoms or conditions solely due to a medical condition (e.g., traumatic brain injury) remain the responsibility of the MCP or the FFS delivery system.

Additionally, while both MCPs and MHPs are able to provide mental health services to beneficiaries, the level of care and impairment for a BHRS beneficiary is typically identified as "severe" versus the "mild to moderate" criteria that supports the provision of non-specialty mental health services (NSMHS) by an MCP. Because a beneficiary's needs and condition may require a transition from one level of care to another, coordination of care between the MHP and the MCP has long been best practice. What has changed under CalAIM is the ability of providers in each system to better coordinate care with each other for the same beneficiary.

Specialty Mental Health Services (SMHS)	Non-Specialty Mental Health Services (NSMHS)
Specialty Mental Health Services (SMHS) provided to Medi-Cal beneficiaries by BHRS SMHS programs include but are not limited to: • Assessment • Plan Development • Rehabilitation Services • Therapy Services • Collateral • Medication Support Services • Targeted Case Management • Crisis Intervention • Intensive Care Coordination (ICC) • Intensive Home-Based Services (IHBS) and • Therapeutic Behavioral Services (TBS).	Non-Specialty Mental Health Services (NSMHS) are delivered by MCPs and Medi-Cal Fee-for-Service (FFS) providers and include the following: • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition. • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements

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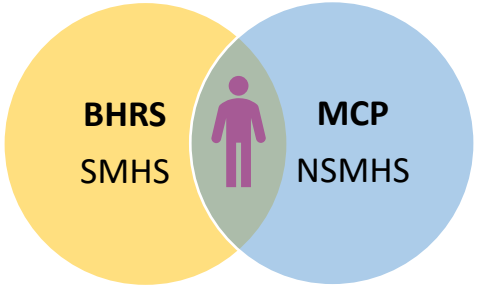
Concurrent Care

Under "No Wrong Door," beneficiaries may concurrently receive NSMHS via a FFS or MCP provider and SMHS via BHRS when the services are clinically appropriate, coordinated and not duplicative. When a beneficiary meets criteria for both NSMHS and SMHS, the beneficiary should receive services based on beneficiary clinical need and established therapeutic relationships.



This means that a beneficiary can continue to receive services from a provider in one system if they have an established relationship with that provider, as long as services are **coordinated** and **non-duplicative**. For example, a beneficiary may only receive psychiatry services in one network, not both networks; or a beneficiary may only access individual therapy in one network, not both networks.

In other words, No Wrong Door allows flexibility for clinically appropriate and nonduplicative **concurrent** care between the two systems, However, this does NOT mean that an individual who meets criteria for NMHS can choose to be exclusively seen by BHRS, or that an MCP must be the exclusive provider for an individual who meets criteria for SMHS. Individuals should still be seen by the appropriate service delivery system for which they meet medical necessity.

Transitioning Care Between the MCP and MHP

BHRS staff must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, and make good faith efforts to ensure that the referral loop is closed, and the new provider accepts the care of the beneficiary. For more specific information regarding requirements of the Closed Loop process, see the "Closing the Loop" subsection of the "Discharges and Transfers" section of this manual.

When transitioning care between BHRS and an MCP, the Transition of Care Tool should be used. For more specific information about the Transition of Care Tool process, see the "Transition of Care Tool" subsection of the "Discharges and Transfers" section in this manual.

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DISCHARGES AND TRANSFERS

For transfers that involve a **change in level of care** and for **all discharges**, a brief progress note using code 55 (unclaimable) documenting the discharge or transfer should be written AND a "Reassessment" or "Update" should be completed to document the reasons for the transfer or discharge in more detail. Most importantly, if there was a change in the beneficiary's level of functioning, symptoms, etc. include those elements that led to the decision to discharge or transfer. This includes beneficiaries transitioning from a BHRS program's mild-to-moderate episode to the same BHRS program's SMHS episode.

A Reassessment / Update MUST be Completed when Discharging a Beneficiary or Transferring a Beneficiary to a higher or lower level of care.

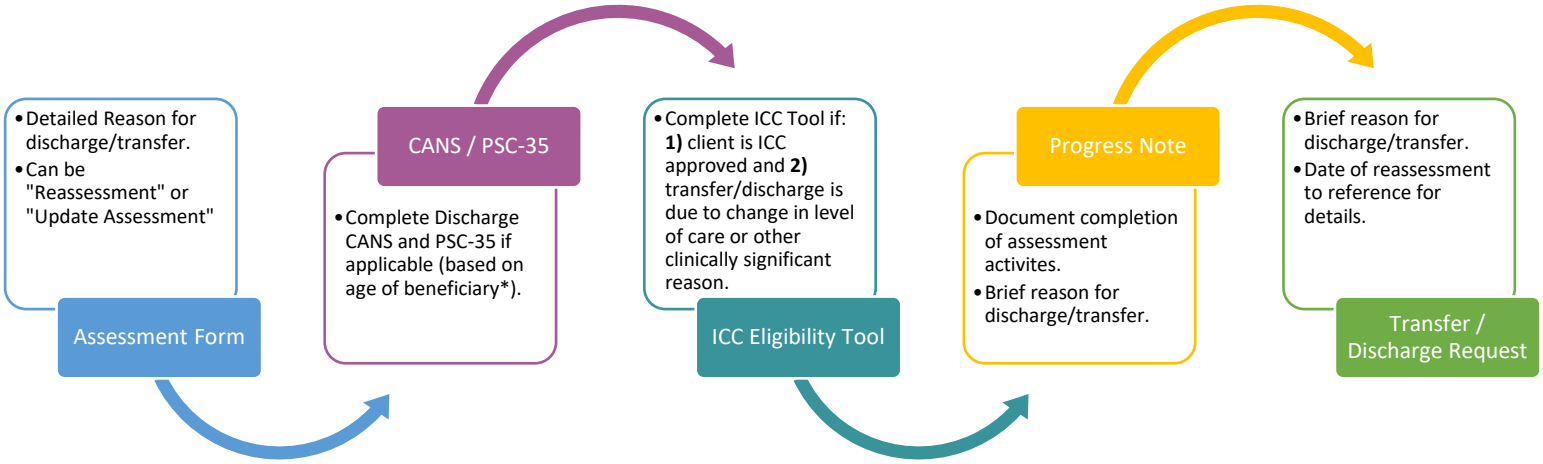
Use clinical judgement to determine which type of reassessment form is most appropriate to document the beneficiary's progress or changes in circumstance that led to the discharge or transfer decision.

It is NOT sufficient to ONLY document the reason for discharge / transfer in a progress note or Transfer Discharge Request Form.

The Transfer/Discharge process should include a review of where the beneficiary can receive support if there is a clinical need for ongoing care. Information contained in discharge documentation and shared with the person in care includes:

- ✓ How the person's needs may be addressed, information on prescribed medications, available community services
- ✓ The type of care the person is expected to receive and by whom, information on crisis supports

DOCUMENTING DISCHARGES / TRANSFERS (A.K.A "DISCHARGE SUMMARY")



** The CANS and/or PSC-35 must be completed at discharge for those beneficiaries who fall within the age range for each tool. Please see the Additional Assessment Tools section of this manual for clarification on the age-ranges for these tools.*

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Assessment Form

The assessment form is where staff should document the most detail regarding the reasons for the beneficiary's transfer to a different level of care. The client's assessment should be updated using either the "Reassessment" or "Update" type depending how significant the changes were that led to the beneficiary's transfer to a different level of care or discharge. Staff should use clinical judgment to determine which assessment type is the most appropriate for the situation. **Staff must review the entirety of the most recent assessment to determine if updates should be made to any sections of the assessment** to fully document the change in functioning or circumstances that let to the discharge or change in level of care. **At minimum, the "Clinical Formulation" and "Treatment Recommendation" sections should be updated.**

Progress Note *("Discharge Progress Note")*

A discharge progress note should be written using the standard progress note form. This note may be brief. Elements to include in this Progress Note are:

1. A brief statement documenting your assessment activity (e.g., completing the reassessment or update assessment form).
2. A brief statement about the reason for discharge or transfer. This statement does not have to be as detailed as what was included in the Assessment form.

Transfer / Discharge Request Form *(For BHRS Avatar Users only)*

BHRS Avatar users use the Transfer/Discharge Request form to inform others that a Discharge or Transfer has occurred for a particular beneficiary. All programs using Avatar for clinical documentation should complete the "Transfer/Discharge Request" form when discharging or transferring a beneficiary to a different program or delivery system. Elements to include in the Transfer / Discharge Request form are:

1. A brief statement about the reason for discharge or transfer. This statement does not have to be as detailed as what was included in the Assessment form.
2. The date of the Reassessment or Update Assessment that includes more detailed information about reasons for transfer or discharge.

WHY DO I NEED TO COMPLETE A REASSESSMENT?

Completing a reassessment at discharge or when changing level of care is best practice because it provides a clear and standardized way for providers to document the reasons for a beneficiary's discharge or transfer. Additionally, for Avatar users, once the Transition Tool from is implemented in Avatar, the information from the reassessment will populate into the Transition Tool to help streamline additional documentation that is required for those beneficiaries transitioning to an MCP (HPSM or Kaiser Medi-Cal).

LINK FROM ASSESSMENT TO TRANSITION TOOL

For Avatar users the Transition Tool form in Avatar will be populated from the most recent assessment /reassessment form that was completed.

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Transition of Care Tool

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Closing the Loop

Coordinating care between transferring providers and making a good faith effort to ensure that a beneficiary is successfully connected to the next provider is an essential component of transitioning care.

"CLOSING THE LOOP" FOR ALL TRANSFERS /TRANSITIONS

If the beneficiary is in need of services at a lower level of care, it is not sufficient to simply provide the beneficiary with the phone number to the Access Call Center.

Staff should make a good faith effort to ensure that the client is successfully referred and connected to a lower level of care. This includes coordinating beneficiary care services with the referred provider to facilitate care transitions or addition of services. The Closing the Loop process includes, but is not limited to, ensuring that:

- ✓ All appropriate consents were obtained and in accordance with accepted standards of clinical practice
- ✓ The beneficiary understands that a referral has been placed on their behalf.
- ✓ The beneficiary is updated on the status of the referral
- ✓ The referral process has been completed
- ✓ The new provider accepts the care of the beneficiary
- ✓ The beneficiary has been connected with a provider in the new system or program
- ✓ Medically necessary services have been made available to the beneficiary

REFERRALS TO EXTERNAL PROVIDERS

If a beneficiary does not meet criteria for SMHS but would benefit from some care at the lower level, the beneficiary may be referred to:

- One of BHRS's MCPs if the beneficiary is also an MCP member
- The beneficiary's private health plan if they have private insurance available to use
- Another appropriate provider (e.g., community based organization that offers sliding scale fees, etc.)

If a beneficiary does not meet criteria to receive any behavioral health service at any level of care, or the beneficiary refuses a referral to another provider, then no referral needs to be made. Staff should document this information in the beneficiary's chart and discharge the beneficiary.

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SERVICES THAT CAN BE PROVIDED DURING THE "CLOSING THE LOOP" PROCESS

If a beneficiary does not meet criteria for SMHS, staff **should** make good faith efforts to ensure the referral loop is closed.

To support efforts to "close the loop" on referrals, limited case management services may be provided to support the beneficiary's connection to non-SMHS. Staff should use their clinical judgment and assessment of case management needs to determine what types of case management services and for how long they should be provided during the transition.

In other words, while staff should provide some case management services, staff do **not** need to provide case management services **indefinitely** until the beneficiary is successfully connected, nor do they need to provide case management services to a beneficiary if the beneficiary declines this service.

Staff are not required to provide other treatment services while the beneficiary awaits a full transition of care.

REIMBURSEMENT OF SERVICES POST-ASSESSMENT

While all clinically appropriate service are reimbursable during the assessment phase, services that are provided after access criteria and medical necessity is determined must be medically necessary in order to be reimbursed by Medi-Cal.

In other words, after the completion of the assessment, SMHS (outside of case management) that are provided to an individual who does not meet criteria for SMHS will not be reimbursed by Medi-Cal.

BARRIERS TO "CLOSING THE LOOP"

There are many reasons a referral may not result in a beneficiary ultimately being connected to services – for example, the beneficiary changes their mind about wanting services, the beneficiary is difficult to contact, the referred provider is difficult to contact, etc.

The expectation is not for staff to convince all beneficiaries to accept offers of referrals, or for staff to provide services indefinitely to beneficiaries for whom SMHS is not appropriate. Rather, the expectation is for providers to make a good faith effort to ensure that the beneficiary was successfully referred and connected to services.

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Below are some common issues and clarification of staff roles in these situations.

Barrier to "Closing the Loop" – Insurance Issues

BHRS is not responsible for completely resolving an individual's insurance issues. However, staff should provide the individual with information on who they can contact to help them resolve their insurance issues. For instance, if the individual needs support with Kaiser, staff should direct the beneficiary to Kaiser so that Kaiser can help them resolve any Kaiser-related insurance issues. Staff may offer to call Kaiser with the beneficiary to help "get the ball rolling" on the situation.

If an individual is not eligible or does not want to be connected to the MCP (for instance, they prefer to use their employer's insurance), staff are not obligated to continue to attempt to enroll or change the beneficiary's insurance plan to the MCP.

Staff should inform beneficiaries of the process of what they should do if they want to resume services once their insurance situation is resolved.

ADDITIONAL COUNTY RESOURCES

In some cases, BHRS staff can utilize county resources, such as the BHRS Health Insurance Outreach & Enrollment Team; however, the scope of these internal resources are limited and certain criteria must be met to use the services. If needed, staff are encouraged to reach out to their supervisors to determine if reaching out to these supports would be appropriate on a case-by-case basis.

Barrier to "Closing the Loop" – Not wanting to be referred out

If a beneficiary does not or no longer meets criteria for SMHS, but they express a desire to receive services through BHRS rather than through, for instance, an MCP, BHRS staff are not obligated to accommodate this request. Rather, staff should work with the beneficiary to educate them on the reason for the referral, and may offer to do a warm handoff or provide case management services for a limited time during the transition.

WHAT IF I WANT TO PROVIDE ADDITIONAL TREATMENT WHILE A BENEFICIARY IS AWAITING TO RESOLVE THEIR INSURANCE ISSUES OR I WANT TO PROVIDE ONGOING TRANSITION SERVICES AFTER THEY ARE CONNECTED TO THE NEXT PROVIDER?

In most cases, this would not be appropriate because it has been determined that the beneficiary does not meet medical necessity criteria for SMHS. If staff believe that it would be clinically appropriate to continue to provide services beyond the standard transition case management services, the decision should be made at the higher level. Talk to your supervisor to determine the process for getting approval in these special cases.

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CODING SERVICES

Under CalAIM, part of the changes include how counties are reimbursed for services. DHCS refers to this as Payment Reform. One important objective of payment reform is to align with other healthcare delivery systems and comply with CMS (Centers for Medicare & Medicaid Services) requirements for all state Medicaid programs to adopt Current Procedural Terminology and Health Care Common Procedure Coding System. We commonly refer to these as CPT and HCPCS codes. CPT and HCPCS codes are the standardized medical billing across disciplines and practice types, allowing for a wide range of health care professionals, including mental health. The internal service codes that are currently being used by BHRS staff are included in the Service Code Cheat Sheet.

Prior Authorization

Prior Authorization is a process that requires beneficiaries to get approval for a health care service or medication **before** it can be provided. Please see the table below for outpatient services for which DHCS requires prior authorization and those which DHCS has stated that prior authorization shall not be required.

Prior Authorization Required	No Prior Authorization Required
Required by DHCS ▪ Intensive Home-Based Services (IHBS) ▪ Therapeutic Foster Care (TFC) ▪ Day Treatment Intensive ▪ Day Rehabilitation ▪ Therapeutic Behavioral Services (TBS) **The services above are the outpatient services that are referenced in most DHCS Behavioral Health Information Notices when "outpatient services that require prior authorization" are mentioned.** There are other services within BHRS that require authorization for utilization management purposes but do not fall under the DHCS definition of a SMHS outpatient service that requires "prior authorization."	**DHCS stipulates that prior Authorization shall <u>NOT</u> be required for the following services.** ▪ Crisis Intervention ▪ Crisis Stabilization ▪ Mental Health Services, including initial assessment. ▪ Targeted Case Management ▪ Intensive Care Coordination ▪ Peer Support Services ▪ Medication Support Services

For services where no prior authorization is required, there may be other care planning requirements that must be completed in order to provide the service. For example, TCM, PSS and ICC have care planning requirements but do not require a "prior authorization." Please see the Care Planning section of this manual for more detail.

For information on how to request services that require authorization (prior or otherwise), please contact your program supervisor.

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Service Codes

For a list of available service codes, check the BHRS Service Code Cheat Sheet on the QM Website: www.smchealth.org/bhrs/qm

Location Codes

General Information

A location code is where the service is provided or received. Location Codes allow for the provider to specify where a service was conducted and are included in claims (billing). There are multiple categories and modalities of location codes, and which codes to use depends on a variety of factors, which will be explained later on in this section of this manual.

GENERAL TYPES (USED TO SPECIFY MODALITY)

- ✓ In-Person Location Codes
- ✓ Remote Services Location Codes (audio-only or videoconferencing)

GENERAL CATEGORIES RELATED TO BILLING

- ✓ Billable
- ✓ Non-Billable (Blocked from Billing)
  - Lockout
  - Partial Block

Determining Location Code

Blocked Billing Location Codes ("LOCKOUT" and "PARTIAL BLOCK") **always** supersede other location codes.

Please see the location code index for information on which locations are blocked from billing.

Location Code Index

Please see the **Location Code Index** located on the QM Website for a full list of all the location codes used within the BHRS system. The Location Code Index also notes which locations are considered "Lockout" locations or "Partial Block" locations.

Definition of "Home"

"Home" is a location, other than a hospital or other facility, where the patient receives care in a private residence.

This does not have to be a "traditional" home such as a single-family home or apartment. It can be a hotel, encampment, etc. as long as it is where the beneficiary resides AND is **not** a hospital or other facility, a location for which another code would be more appropriate (e.g., Homeless shelter, residential care, or skilled nursing facility), or a lockout location.

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Remote Services Location Codes

About Remote Services

Remote Service delivery includes services that are provided to the beneficiary when the provider and beneficiary are not in the same physical location unless the beneficiary is in a lockout location. ***If it is a lockout location, then use the lockout location code.*** Remote services have been available for quite some time but have become more commonly used in recent years. BHRS has updated its policies to reflect new/updated state and federal regulations that have been created to account for this increase in usage.

RELATED POLICIES TO REVIEW

For more on appropriate use of cell phone, text message, and email use with beneficiaries, review the following policies.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 22-06: Electronic Communication (General Guidelines)

Policy 22-07: Electronic Communication (for Communication with Clients)

SPECIAL CONSIDERATIONS FOR REMOTE SERVICE DELIVERY

- You **must** obtain consent from the beneficiary (BHRS Policy 22-07) before providing services remotely and/or before engaging in electronic communication with the beneficiary (e.g., text, email).
- It is best to use email and text to communicate non-sensitive information, such as to schedule appointments. Email and Text may be used to communication with beneficiaries in some cases but should NOT be used as the platform to provide therapy services.
- This applies whether the service is provided in-person or remotely.

Definition of "Home" for Remote Services

The definition of "Home" used for the Remote Services Location codes is the same as described in the previous section. Take a look at the full list of location codes if you aren't sure if you should select "Telehealth Home" or "Phone - Client at Home." If there is a location code other than "Home" that better describes your beneficiary location, then you would NOT select "Telehealth Home" or "Phone - Client At Home."

Remote Services labeled as "Home" refer to when the beneficiary is receiving services, not when a service is being provided to a collateral or other professional without the beneficiary present. For example, if the beneficiary is at home in their room while staff is speaking on the phone to the beneficiary's mother who is in the kitchen, the location code "Phone – Non-Client Contact"

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would be used. However, if the beneficiary is in the kitchen participating in the phone call with their mother, then "Phone – Client at Home" would be used.

Remote Location Code Index

The following location codes should be used when providing services remotely UNLESS the beneficiary is in a lockout location (e.g. jail, PES/Psych Hospital). ***If it is a lockout location, then use the lockout location code.***

Location Code	Modality of Service	Examples
Telehealth	Videoconferencing (with beneficiary)	• When you have a visual of beneficiary while using a video conferencing application.
Telehealth Home	Videoconferencing (with beneficiary)	• When you have a visual of beneficiary while using a video conferencing application AND the beneficiary is at home. • If you are using a video conferencing application but CANNOT see the beneficiary (e.g., beneficiary has turned their camera off), this should instead be coded as "Phone" since you are only able to engage in audio-only communication with the beneficiary.
Phone - Non-Client Contact	Phone (without beneficiary) Videoconferencing (without beneficiary)	• When you are speaking to a collateral over-the-phone or over videoconference. • When you are speaking to another provider over-the-phone or over videoconference.
Phone - Client At Home	Phone (with beneficiary)	• When you are speaking with the beneficiary over-the-phone without video and the beneficiary is at home.
Phone - Client Not At Home	Phone (with beneficiary)	• When you are speaking with the beneficiary over-the-phone without video and the beneficiary is not at home.
Voicemail/Fax/Email	Voicemail, Email, Fax, Text	• Services provided using these methods is NOT billable. • Please remember that texting and/or emailing are not appropriate methods to deliver behavioral health services. If you believe you have a situation that warrants the use of text/email to deliver services, contact your supervisor and BHRS QM.

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Blocked Billing Locations and Non-Reimbursable Services

All staff must understand how services are claimed and know that some services are not claimable. In general, progress notes using billable service codes are included in claims to be reimbursed by Medi-Cal. However, there are some situations in which services will not be reimbursed. These situations include:

1) **When a service is provided in a location that does not allow BHRS to bill for outpatient services**, even though a billable service code is used.

   There are two types of location codes that block billing: "**Lockout**" and "**Partial Block**" location codes.

2) **When a service does not fit the description of a billable service.**

   Services that do not fall into a billable service type should not use billable service codes; staff should instead use non-billable service codes.

DOCUMENTATION REMINDER

LOCKOUT and PARTIAL BLOCK location codes always supersede other location codes.

When using a blocked billing location code, you should still use the service code that most accurately describes the service you provided.

Non-reimbursable service codes and blocked billing location codes prevent the service from being inappropriately billed.

Facility Staff versus Non-Facility Staff

Whether or not you should use the locked out or partial block location codes depends on whether or not you are employed by the facility that is blocked from billing.

EXAMPLE OF NON-FACILITY STAFF

If you are a non-facility staff providing services to an individual placed in a blocked billing location, then you would use the facility as the location code (e.g., PES, Residential Adult, etc.).

For example, if you are a BHRS Clinic staff and provided telehealth services to an individual placed at Psychiatric Residential Treatment Facility, then you would use "Residential Care…" are the location code. You would not use the telehealth location code.

EXAMPLE FOR FACILITY STAFF

If you are employed by the blocked billing facility, you would use whatever location code is most appropriate for the modality (e.g., telehealth, phone, etc.) of service or physical location of service (e.g., office, field, etc.).

For example, if you are a staff employed by a Psychiatric Residential Treatment Facility and you provided services via telehealth to an individual placed at your Psychiatric Residential Treatment Facility, then you would use "Telehealth" as the location code.

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You would not use the "Residential Care…" location code. This is because the individual's placement at your facility is already established because both you and the individual are logged in the system as being associated with your facility. Also, remember that Residential facilities are not considered a "Home" location, so you would use the regular "Telehealth" location code and not "Telehealth – Home" in this situation.

Blocked Billing Location Codes (Type 1) – Lockout

Lockout location codes indicate that all services provided using these lockout location codes are blocked from billing, meaning they will **not** be sent to claims because they are not reimbursable by Medi-Cal.

Once a lockout location is entered, our information system will "lock out" (or "block') the claim from billing. For a list of all lockout location codes, please reference the **Location Codes Index** on the QM Website.

There are two types of situations that indicate a "**lockout,**" which would ensure that any services provided while the beneficiary is in the lockout situation is not inappropriately billed to Medi-Cal.1

See the next page for more information regarding these 2 types of lockout situations.

"LOCKOUT" VERSUS "LOCKED"

A "**Locked**" facility is **not** the same as a "**Lockout**" location.

A **LOCKOUT** location is a location that is blocked from billing.

A **LOCKED** facility describes a facility that is closed and locked, meaning that entry and exit from the facility is physically locked and visitors and beneficiaries must be checked in and out of the facility.

A locked facility is often either a lockout location OR a partial block location.

LOCKOUT SITUATIONS

1) **Lockout Location code that indicates an unbillable manner in which a service was provided.**

   For example, sending an email or leaving a voicemail would be unbillable even if a service, such as leaving information about a community resource, was provided. Missed visits fall under this type because a service was unable to be provided in any manner and is therefore unbillable.

2) **Lockout Location code that indicates the placement location of the beneficiary** that prevents claiming for outpatient services.

   Lockouts based on the placement location of a beneficiary only block claiming for services by outpatient providers (who are employed outside of the facility) providing services to an individual placed at that facility. For example, in PES, lockout does not apply to PES staff but does apply to a BHRS outpatient clinic staff providing services for a beneficiary while they are a PES patient.

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Blocked Billing Location Codes (Type 2) – Partial Block

While locations that are considered "lockouts" block all services from being billed, there is another type of blocked billing location type that allows for some, but not all, outpatient services to be billed. These are called "Partial Block" location codes. [Examples of locations considered "Partial Block" locations are available in the **Location Codes Index** on the QM Website.]

When staff select a "Partial Block" location, the BHRS information system will automatically determine which services to "block" from billing and which services should be passed on to claims for reimbursement.

Whether or not an outpatient service is billable while the beneficiary is located in these Partially Blocked locations depends on two factors:

When the Service was Provided

Most outpatient codes cannot be billed on the same date of service as residential codes or on the same day as a psychiatric health facility service except on the dates of admission or discharge.

Which Services were Provided

Depending on the facility type and provider type, only certain outpatient SMHS may be billed to Medi-Cal while also being provided services through the facility.

FOR STAFF WHO PROVIDE NON-MEDICATION SERVICES

On the next page is a table of the types of services which are allowed based on **Partial Block** facility type for **non-medication services** (e.g., case managers, peers support specialists, therapists). All services provided must be medically necessary. Peer Support Specialist Services include only those services that may be provided by certified Peer Support Specialists.

	Only billable on date of Admission or Discharge	May be billed in between Admission and Discharge Dates Any service that is not listed below is NOT billable.	
Partial Block Location	**Any Outpatient SMHS**	**Case Management**	**Peer Support Specialist Services**
Psychiatric Hospital	Yes	Yes	Yes
Residential Care – Adults (Licensed Community Care Facility) (Locked)	Yes	Yes	Yes
Residential Care – Adults (Licensed Community Care Facility)	Yes	Yes	Yes

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FOR STAFF WHO PROVIDE MEDICATION SERVICES

The only **Partial Block** location that blocks the billing of medication services is a psychiatric inpatient facility.

	Only billable on date of Admission or Discharge	May be billed in between Admission and Discharge Dates	
Partial Block Location	**Any Outpatient SMHS**	**Medication Support Services**	**Other Medication Services** (e.g., Medication Injection/Administration)
Psychiatric Hospital	**Yes**	**No**	**No**

Non-Billable Service Codes

DIRECT BENEFICIARY CARE UNCLAIMABLE (55) AND UNCLAIMABLE GROUPS (550)

These codes are used for services provided to beneficiaries and their families that are not claimable to Medi-Cal. These services include the wide variety of services deemed necessary for recovery and resiliency, but are not reimbursable as mental health or other claimable 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 beneficiary beneficiaries. These services may be documented by all members of the clinical teams working with beneficiaries.

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Non-Billable Services

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, 55 or 550, or enter the time in the "Other non-billable time" field of the progress note)

- ✖ Reviewing or preparing chart for assignment of therapist, to close a chart (discharge note) or for release of information
- ✖ Closing a chart (transfer of case could be Case Management or Plan Development)
- ✖ Any documentation after beneficiary is deceased
- ✖ Preparing documents for court/testifying/waiting in court
- ✖ Letter excusing beneficiary from jury duty/testifying, waiting in court
- ✖ Listening to or leaving voice mail or email message and sending/receiving faxes or emails
- ✖ 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 beneficiary missed an appointment.
- ✖ Leaving a note on a door, or a message on an answering machine or with another beneficiary about the missed visit.
- ✖ Personal Care services provided to beneficiaries including grooming, personal hygiene, assisting with self-administration of medication, meal prep
- ✖ Assistance provided to family members seeking needed services for him/herself
- ✖ Purely clerical activities (faxing, copying, filing, mailing...etc.)
- ✖ Scheduling/re-scheduling appointments
- ✖ Recreation or general play (e.g. teaching beneficiary how to play a sport)
- ✖ Socialization: generalized social activities which do not provide individualized feedback related to mental health diagnosis
- ✖ Walking groups, smoking cessation groups, etc.
- ✖ Academic/Educational services: Assisting beneficiary with homework, teaching math or reading...etc.
- ✖ Vocational services for the purpose actual work or work training. (Exception: VRS services clearly linked to mental health diagnosis)
- ✖ Supervision: Supervision of clinical staff or trainees is not reimbursable
- ✖ Utilization management, peer review, or other quality improvement activities
- ✖ Interpretation/Translation only (**without a billable service**)
- ✖ Transportation of a beneficiary
- ✖ Preparation for a service—e.g., set up for group therapy
- ✖ SSI paperwork with no beneficiary present

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Sometimes a service might look like a reimbursable service when, in fact, it is not reimbursable, or vice versa. The key is to look at what service was actually provided and if the focus of the service meets medical necessity criteria.

The following are examples that demonstrate when the actual service provided during the course of a seemingly simple activity actually results in vastly different answers to the question: "Is this a reimbursable service?"

Short Description of Activity	Detailed Description of Service	Detailed Description of Service
	NO, this is NOT Reimbursable	**YES, this IS Reimbursable**
Academic/Education Situation Sitting in a classroom with the beneficiary.	Assisting the beneficiary with his/her homework. OR Teaching a typing class at an adult residential treatment program.	Sitting with the beneficiary in a community college class to help reduce the beneficiary's anxiety and then debriefing the experience afterward.
Recreational Situation Going to a community location together.	Teaching the beneficiary how to lift weights.	Introducing a beneficiary to a Friendship Center and debriefing about the visit.
Vocational Situation Interacting with the beneficiary at their work place.	Visiting the beneficiary's job site to teach them how to cook hamburgers. OR Teaching a beneficiary how to use a cash register.	Responding to the employer's call for assistance when a beneficiary 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 beneficiary to decrease their anxiety enough to concentrate on the task of learning the new skill.
Accessing Resources Situation Meeting with the beneficiary to fill out paperwork for housing.	Staff waits while the beneficiary fills out the forms. OR Staff fills out the form for beneficiary, periodically asking beneficiary to provide information for the form.	Beneficiary reports that they are unable to complete paperwork due to high level of anxiety about writing down the "wrong" information. Staff sits with beneficiary and coaches beneficiary to use relaxation techniques and cognitive coping to support beneficiary's ability to work through their anxiety to complete paperwork.

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PROGRESS NOTES

General Information

Progress notes are an essential component of clinical work. They serve as a legal record of the services provided to a beneficiary. It is the legal and ethical duty of all providers to write clear, complete, and accurate progress notes after every service provided to or on behalf of a beneficiary. **If it's not documented in writing, it did not happen**.

Additionally, progress notes serve as bills to various funding sources which provide reimbursement for the services provided to our beneficiaries. These funding sources verify that adequate and timely progress notes are written for the services provided and that the progress notes include all required elements, have sufficient content, and are legible and signed by the service provider. The content of progress notes should be easily understandable, without requiring additional context or information, and should provide a clear ongoing record of the beneficiary's condition, clinical interventions and intended next steps.

Progress notes are also an essential way to facilitate communication and coordination of care between providers and are read by other treating providers to better understand the beneficiary's condition, needs and course of treatment. It is important to remember that progress notes may also be read by the beneficiary or their family members, and that progress notes may be used in legal proceedings.

Please note that the information included in a progress note may vary based on the service type and the beneficiary's clinical needs. Some notes may contain less descriptive detail than others. If information is located elsewhere in the clinical record (for example, the Assessment or Treatment Plan), it does not need to be duplicated in the progress note. Use clinical judgement to determine if the information is adequately provided in another area of the medical record.

The following sections highlight important aspects of progress notes in further detail. If you ever have questions regarding the content of your progress note or other documentation related questions, please reach out to your supervisor or BHRS Quality Management for support.

DOCUMENTATION REMINDER

Certain information should **never** be included in a progress note, such as information about a **grievance investigation** or a **critical incident report** involving the beneficiary.

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Timeline for Documenting Services

Providers MUST complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which MUST be completed within one (1) calendar day. The day the service was provided is considered day zero (0). Progress notes should never be completed in advance of a service.

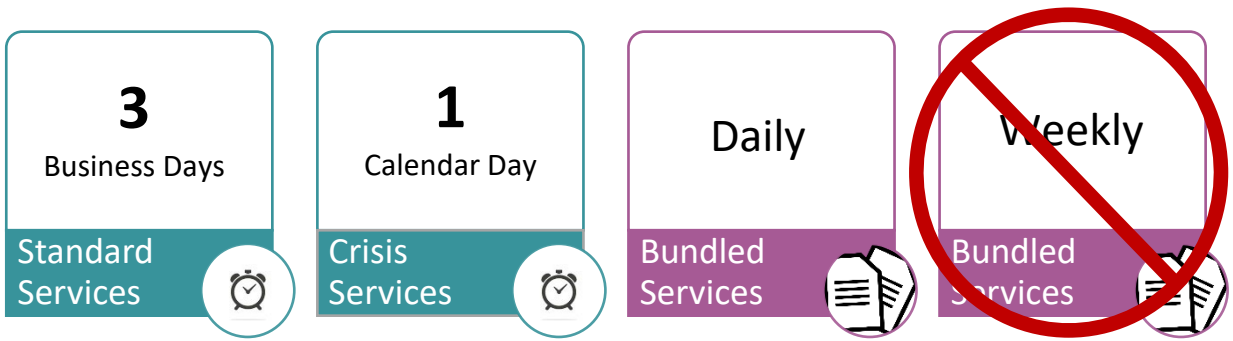
If a Progress Note is submitted outside of 3 business days, it is good practice to **document the reason the note is delayed in the body of a Progress Note. Late notes remain billable and should not be withheld from the claiming process.** However, if your note is *significantly* late, please consult with your supervisor or QM to determine the best service code to use. Please note that state regulations may require stricter timelines for completing progress notes depending on the program/facility type (e.g., STRTP, other DHCS regulations).

- Crisis services: Documentation should be completed within one (1) calendar day.
- A daily note is required for documentation of some residential services*
    - Crisis Residential Treatment
    - Adult Residential Treatment
    - DMC/DMC-ODS Residential Treatment
    - Day Treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation), and other similar settings that use a daily rate for billing (i.e., bundled services).

Compliance Reminder

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse within the service provision and claiming system. Disallowances in audits will occur when there is evidence of fraud, waste, or abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this guide are necessary steps to promote compliance.

**In these programs, weekly summaries are no longer required.* If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.



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Progress Note Fields

Independent Note vs. New Service

In most cases, "New Service" should be selected when completing a Progress Note.

An "Independent Note" is only selected in rare instances when a beneficiary has been discharged from all open episodes and a progress note must be written to document an event related to this beneficiary. **Independent notes do not get billed** and do not include dedicated data fields to indicate the date of service, duration of service, etc. Staff should write any relevant information such as date, time, location, and type of contact or service that was provided in the body of the note.

Service Time

The Service Time field is used to document time spent providing direct patient care. This includes time that a provider directly spends with a beneficiary in-person, on the phone, or via video conference to provide a billable service. Direct patient care also includes time spent with the beneficiary's support persons or other providers/care team, to deliver a billable service.

DOCUMENTATION REMINDER

Direct patient care does not include travel time, documentation, administrative activities, chart review, utilization review, quality assurance activities or other activities a provider engages in either before or after a beneficiary visit.

For information on Service Codes please see Service Code section of this Documentation Manual.

Service Duration

Avatar NX auto-populates the Service Duration time with the same minutes that are inputted into the Service Time field. This is because the Service Duration field does *not* include documentation/travel time/other billable service time. **DO NOT UPDATE/CHANGE THE TIME THAT AVATAR NX AUTO-POPULATES IN THE "SERVICE DURATION" FIELD.** *The function of this field is primarily for the billing department.*

Other Non-Billable Time

This field should be used to enter time spent providing services that do not fall into the categories of service time, documentation time or travel time. For instance, time spent talking with a beneficiary to schedule an appointment would be included here. **For a list of Non-Billable Services, please see the Coding section of this Documentation Manual.**

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Documentation and Travel Time

Under CalAIM Payment Reform, DHCS no longer *directly* reimburses for time spent on non-direct patient care, such as documentation and travel time.

However, in an effort to streamline claims processing, DHCS has updated their reimbursement rates for direct patient care services to account for documentation and travel time. Time spent on travel and documentation should still be recorded in the respective fields of the Progress Note form in Avatar, as this information may be used for future rate setting.

DOCUMENTATION TIME

Refers to time spent writing. These services are not considered direct patient care. Some examples include: Time it takes to write a progress note, time to write up an assessment or treatment plan without the beneficiary's participation, any time spent documenting where you are not providing a direct service to the beneficiary.

TRAVEL TIME

Refers to the time spent traveling round-trip to provide a billable service. All travel time is applicable when it is tied to a billable service provided directly to the beneficiary or on the beneficiary's behalf, including to the beneficiary's support persons or with other treating providers.

Below is a guide to help you understand when it is generally acceptable to include travel time in the "Travel Time" field in a progress note:

May I Include Travel Time in the "Travel Time" field?	
Travel from your usual worksite to another clinic to provide a billable service	**Yes***
Travel from your usual worksite to community location to provide a billable service	**Yes***
Travel from your usual worksite to client's home to provide a billable service	**Yes***
Travel between multiple clinics in a day to provide billable services	**Yes***
Travel from your personal residence to your usual worksite at the start of your workday	**No**
Travel from your usual worksite to your personal residence at the end of your workday	**No**

* Not ALL the time spend traveling is allowed to be included in the "Travel Time" field. The next page includes additional instructions on how to determine the **amount** of time that is allowed to be included in the "Travel Time" field.

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Determining the Amount of Time To Include in "Travel Time"

The time it would usually take you to commute to and from your regular worksite is not considered travel time. However, there may be some scenarios where you would document travel time when traveling from or to your personal residence at the start or end of your workday.

Travel time should NOT be included in a progress note if it took you less time to travel to or from your appointment than it would have from your regular worksite.

For Example:

- Usual travel time from your personal residence to your regular worksite = 20 minutes
- Travel from your personal residence to a beneficiary's home for your first appointment of the day = 10 minutes
- This travel time would not be included in the progress note because it is less than what your usual commute time would have been to your regular worksite.

- Usual travel time from your personal residence to your regular worksite = 20 minutes
- Travel from your personal residence to a beneficiary's home for your first appointment of the day = 35 minutes
- Only add 15 minutes of travel time to your progress note (you can only claim the travel time that was in excess of your usual commute time).

- Usual travel time from your regular worksite to your personal residence = 20 minutes
- Travel from an appointment at a beneficiary's home to your personal residence at the end of your workday = 30 minutes
- Only add 10 minutes of travel time to your progress note (you can only claim the travel time that was in excess of your usual commute time).

- Usual travel time from your regular worksite to your personal residence = 20 minutes
- Travel from an appointment at a beneficiary's home to your personal residence at the end of your workday = 15 minutes
- This travel time would not be included in the progress note because it is less than what your usual commute time would have been to the office.

A reminder that, i**f you are traveling to complete administrative tasks, this is not considered Travel Time.** This is because administrative tasks are not billable services. Time spent travelling for non-billable services is not entered into this field. Instead, please put this time in the "Other Non-Billable" service time category.

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FREQUENTLY ASKED QUESTION ABOUT DOCUMENTATION AND TRAVEL TIME

What if the beneficiary no-shows?

Travel time to meet the beneficiary, even if they no-show, should still be documented in the Travel Time category. This is because you intended to provide a billable service. When the beneficiary no-shows, include your travel time in the "Travel Time" category and use the Location Code of "Missed Visit."

What if I provide a service while transporting the beneficiary? Is this considered Travel Time?

Under certain circumstances, it may be possible to provide billable services while transporting a beneficiary. Use clinical judgement to determine whether it is safe and reasonably possible. If you are unsure, please consult your supervisor or reach out to QM for additional support.

If appropriate, you would use the service code that best describes the billable service that you provided and enter the service minutes to a progress note as follows:

- **Service Time:** Enter the minutes you spent providing an intervention/billable service while transporting a beneficiary.
- **Travel Time:** Enter the minutes of travel time that you spent providing a billable service.
- **Other Non-Billable Time:** Enter any additional minutes you spent transporting the beneficiary while not providing an intervention/billable service.

Do you add the Travel Time for Non-Billable Services?

Document travel time related to non-billable services in the "Other Non-Billable Time" category. For example, if you are traveling to complete administrative tasks, or simply transporting the beneficiary without any therapeutic interventions, this is not included in Travel Time. Please put this time in the "Other Non-Billable Time" category. For a list of Non-Billable Services, please see the "Blocked Billing and Non-Reimbursable Services" subsection in the "Coding Services" section of this manual.

Beneficiary (Client) Participation Field

This field asks the question "**Did client participate in this service?**" Participation as used for this question includes participation in-person, participation via phone, or participation over a video-conferencing platform. Mark "**Yes**" if the beneficiary participated in the session, and mark "**No**" if they did not participate in the session.

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Collateral Participation Field

Since there are longer collateral-specific service codes, BHRS Progress Notes include a field titled "**Did Collateral participate in service?**" to allow our system to better capture the provision of collateral services.

If the Collateral participated in the service, mark "**Yes**." If a collateral did not participate in the service, mark "**No.**"

A collateral may participate in the service in-person, over-the-phone, or via videoconferencing.

DEFINITION OF "COLLATERAL"

A collateral is a significant support person who supports the beneficiary in a non-professional capacity. The purpose of a collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Restricted Notes

This section describes the different restricted note types available for BHRS Avatar NX. Notes in Avatar NX allow staff to indicate when a note should be restricted and to allow for the tracking of disclosures. Contracted agencies who use their own EHR may or may not have similar categories for restricted progress notes.

All notes should be reviewed prior to release, regardless of whether or not the note is flagged as restricted. Restricted notes indicate that a the writer of the note determined that a higher level of scrutiny should be applied when reviewing the restricted note.

Important Reminder

Do not assume that only notes marked as flagged contain sensitive information. There is always the chance that a note was not flagged to be restricted even though it should have been.

WHAT MARKING A NOTE AS "RESTRICTED" DOES AND DOES NOT DO:

- ✓ Marking a note as "restricted" serves as a "flag" to let staff know that those notes should be carefully reviewed to determine if it is appropriate to release to the parties requesting the record.
- ✖ Marking a note as "restricted" does NOT automatically remove the notes from being released.

Staff who require co-signature should use the versions of the restricted type that state "(Co-Sign Required)."

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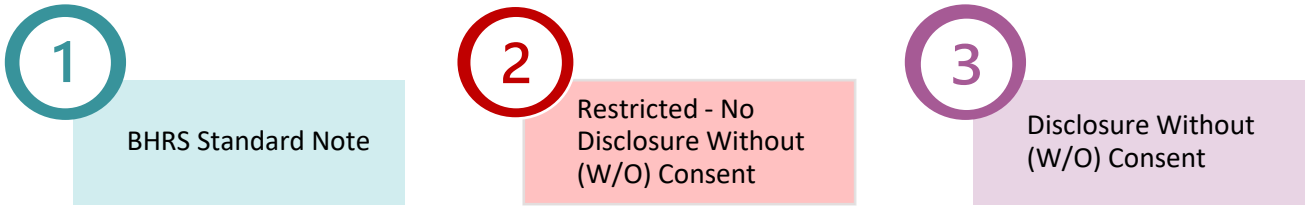
HOW TO MARK A NOTE AS RESTRICTED



1) BHRS Standard Note

Selecting this option does **not** flag a note as restricted. This is the type of progress note for documenting most services. These notes should be reviewed prior to release, but do not indicate that there is particularly sensitive information in the note that requires more scrutiny beyond a standard clinical review before release.

2) Restricted – No Disclosure Without Consent

Marking a progress note using this category is how you "flag" a note as restricted. These notes **should not be disclosed** unless there is a RELEASE /CONSENT from the BENEFICIARY. Selecting this type for a progress note means information will be flagged as restricted and the clinician/clinical team will review and determine if release is necessary and if so, get a release from the beneficiary prior to releasing it. Use ONLY FOR progress notes containing information:

- About HIV status.
- Given in confidence by a family member/significant support person who requests that it not be shared with the beneficiary.
- That, if disclosed to the beneficiary, might result in serious risk to the person who provided the material (even if the person disclosing did not request restriction).
- If a youth beneficiary requests information in the note be restricted – such as sexual behavior (not abuse), AOD use/treatment, HIV fears and other private or personal information. Use with caution in these situations.

3) Disclosure Without Consent (Not Treatment)

Can be disclosed **without** a beneficiary release/consent; note does not contain restricted information or information related to Treatment/Payment or Operations.

Information in this note type can be released without the consent of the beneficiary:

- To the family/significant other in an urgent, safety/crisis situation (e.g., a current threat of harm to others or death reporting);
- To the police/other law enforcement;
- To CPS or APS, even if the reporting is mandated by law;
- To the DMV for lapses of consciousness.

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Same Day, Same Service Progress Notes

Same Day, Same Service Decision Tree

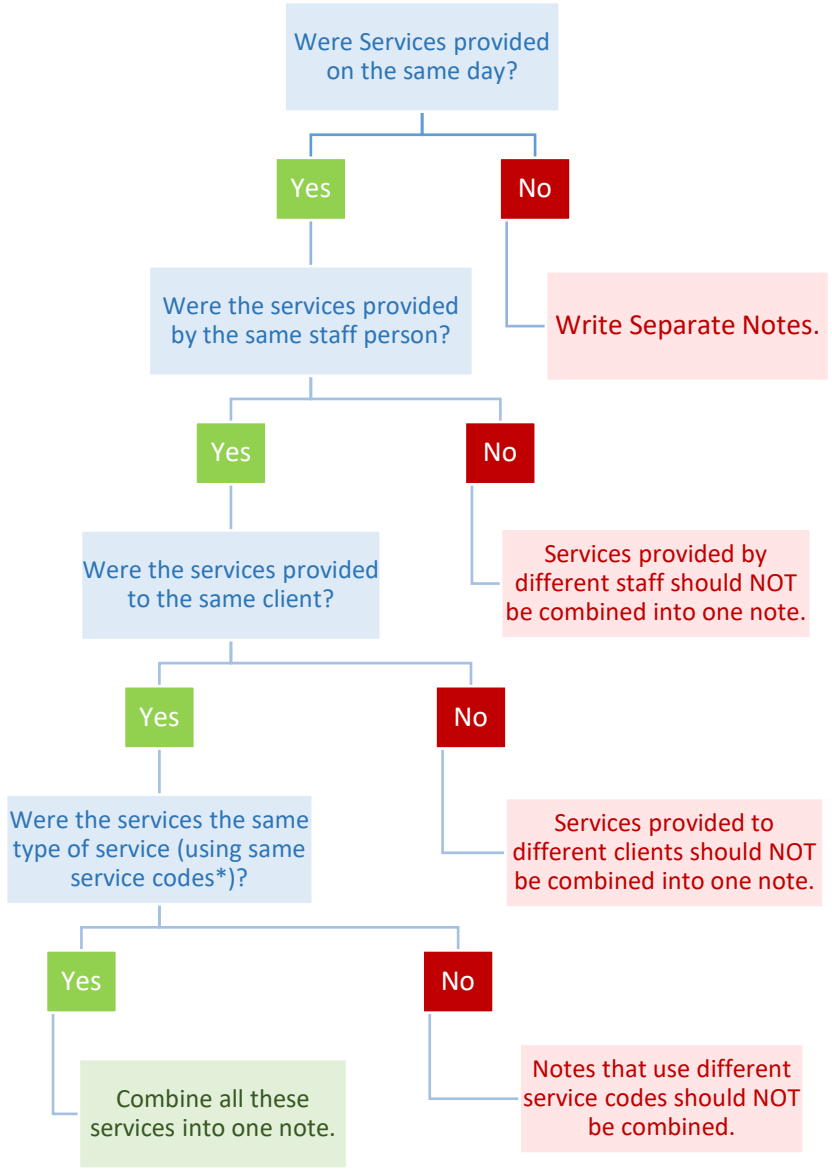
Under CalAIM Payment Reform, all claims for the same beneficiary, that are provided under the same service code, by the same provider, on the same day, **MUST** be combined into one progress note. If you provided multiple services to THE SAME CLIENT, ON THE SAME DAY, please follow the decision tree to the right to determine if you should combine all notes written on that day into one note.

*Example: A clinician provides 14 minutes of Case Management services by phone and 17 minutes of Case Management services at the office, on behalf of the same beneficiary, on the same day. The clinician should complete **one** progress note for all Case Management services provided and select the location as "Office".*

Note: Services that were provided in *different locations* but were provided on the same day using the same procedure code by the same provider **must** be combined. The place of service where the **majority of the service** occurred should be reported. Within the body of the progress note, document that the service was provided in two different locations.

Exception

Group services provided on the same day to the same client by the same provider do NOT have to be bundled. Each group session may be documented separately.



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Individual Progress Notes

Progress Notes for Individual Services (non-group) should include the following minimum elements:

- ✓ *Type of service provided*
- ✓ *Date of service provided*
- ✓ *Duration of direct service provided*
- ✓ **Location/place of service*
- ✓ *A typed or legibly printed name, signature of the provider, and date of signature.*
- ✓ ***A brief description of how the service addressed the client's behavioral health needs** (e.g., activities or interventions used, any issues discussed, progress toward goals).*
- ✓ ***A brief summary of next steps** (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, referral, discharge planning).*
- ✓ *Next Appointment (Include earliest offered appointment date for next appointment).*

PROGRESS NOTE TEMPLATES

Please use the progress note templates provided in Avatar to assist you with including all the required elements of a progress note.

Select the template that best describes the service you are providing.

The Avatar Progress Note form already includes some of the required elements in designated categories, while other elements are required in the body of the progress note.

Co-Practitioner Progress Notes (Non-Group)

The guidance under CalAIM regarding the use of a co-practitioner states that should more than one provider provide a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service.

As of July 2023, due to changes in the claiming structure that interfered with our ability to correctly bill for co-practitioners in group notes, adding a co-practitioner's services through the co-practitioner field in a progress note is no longer an option in BHRS' Avatar NX. The Co-Signature section of progress notes was also removed as of October 13, 2023

As a result, in order to successfully bill for services that occurred on or after 7/1/2023, each provider must complete a separate progress note when more than one provider will be billing for the same appointment for any service type (including group) provided to or on behalf of a beneficiary.

Example: When two providers co-facilitate a group therapy session, each provider will submit a separate progress note for each member of the group, documenting the providers specific role in the group and the specific amount of time they provided direct patient care.

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Group Progress Notes

Group Progress Note Requirements

A new progress note must be written for each group session accurately documenting the events that took place during the group that day. It is NOT sufficient to repeatedly copy and paste the same information into each progress note, group after group.

For each member of the group, an individual progress note must be written in their medical record documenting the service that was provided to them and their attendance in the group that day. Additionally, progress notes for Group Services should include the following minimum elements:

- ✓ *Type of service provided*
- ✓ *Date of service provided*
- ✓ *Duration of direct service provided*
- ✓ **Location/place of service. (See note under "Additional Requirement for Remote Service Notes" regarding documenting the location of the client for Remote Services as this also applies to group services provided remotely).*
- ✓ *A typed or legibly printed name, signature of the service provider, and date of signature.*
- ✓ ***A brief description of how the service addressed the member's behavioral health needs*** *(e.g., this may include activities or interventions, any issues discussed, progress toward goals).*
- ✓ ***A brief description of the member's response to the service*** *(e.g., effectiveness of the intervention, progress or barriers, other info relevant to member's participation).*
- ✓ ***A brief summary of next steps*** *(e.g., any action steps, collaboration with client or providers, goals, steps to address client's needs, referral, discharge planning).*
- ✓ ***When more than one provider is facilitating a group, each provider must describe their (1) specific involvement and (2) their specific amount of time of involvement in the group activity, in each of their respective progress notes.*** *(If there is only one provider facilitating the group, this information is not required).*
- ✓ *Next Appointment (Include earliest offered appointment date for next appointment).*

Under CalAIM, the entire duration of a group should be added to each group participant's progress note, unless they arrived late or left early. Please also add the number of clients that participated in the group that day in the designated field in the Mental Health Progress Note form.

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Co-Facilitated Groups

It's important to note that not every group needs more than one facilitator.

However, when necessary, ***each provider must describe their (1) specific involvement and (2) their specific amount of time of involvement in the group activity, in each of their respective progress notes*** based on the group members' needs, not the provider's needs.

DOCUMENTATION EXAMPLE

"An additional facilitator was needed to help manage the behavioral needs of members in this group and provide support to the client when they became agitated and required assistance with implementing coping skills. The additional facilitator actively participated for the entire group session of 60 minutes."

Billable Groups vs. Non-Billable Groups

BILLABLE GROUPS

Group services vary based on the primary focus of activities and interventions. Billable groups are structured group activities, led by a provider, that address the behavioral health needs and goals of the clients in attendance.

All group providers must be eligible to bill the service type. For example, if the group is Therapy, all group co-facilitators must be able to provide therapy under their scope of practice and according to billing rules in order to bill for the group session.

All members of the group must be current clients (or collaterals of current clients) of BHRS or a contractor providing the service.

NON-BILLABLE GROUPS

Non-billable groups are comprised of BHRS beneficiaries (or collaterals of current beneficiaries), but the service provided in the group **does not** address the behavioral health needs and goals of the beneficiaries in attendance. While these groups are non-billable, they should still be documented via progress notes in the beneficiary's chart. For example, a socialization group with no interventions that address the behavioral health needs of the beneficiary is not billable. For support in determining if a group is billable or non-billable, please consult your supervisor or contact QM.

GATHERING VS. GROUPS

Some types of gatherings, even if some clients are present, are not charted or billed. These may include: potlucks or an exclusively social events, community education class, community outreach event, gatherings in community settings open to the public, etc. These gatherings are not considered mental health groups as the staff's role is more of an educator, or the gathering is more of a class or training and not directly related to the diagnosis and mental health needs of the beneficiary.

DOCUMENTATION REMINDER

Sometimes, how the progress note is written can help justify why the service was billable, if in fact you believe you were providing a billable service.

Other times, aspects of a group may be unbillable and that's OK! These services are still very significant to the client and their experience in the group.

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GROUPS WITH BOTH BILLABLE AND NON-BILLABLE COMPONENTS

Some groups might have certain components of the group time that are considered billable, while other components of the group time are considered non-billable. Here is a sample group that contains both billable and non-billable components.

SAMPLE NOTE FOR GROUP

Anger Management Rehab Group Provided in Community Location:

A clinician facilitates a 55-minute combined rehab and socialization group focused on anger management skills for a group of teen clients. 25 minutes of the group time is spent watching a movie and eating snacks. The other 30 minutes is spent discussing how to recognize triggers and the basics of anger management coping skills.

Service Code: 70CA Rehab Group

Service Time: 30 minutes (billable service time)

Documentation Time: 8 minutes (time to write the note for one client)

Travel Time: 28 minutes (round-trip time from your usual worksite to a community location)

Non-billable Service Time: 25 minutes (time spent watching movie and eating snacks)

Additional Requirements for Documenting Group Services

Additional Documentation for Group Services

In addition to progress notes documenting the group service, there are requirements for tracking group services and verifying that group services were delivered. These include:

Group Member Listing Report

- A list of clients registered to a group in Avatar.
- Only available for staff documenting in Avatar.

Participant List

- A record of the actual attendance for each group session.

Sign-In Sheet

- A document containing signatures of participants for a particular group session.

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When a group service is provided, a list of participants is required to be documented and maintained by the provider, but the way in which the group membership and participation is documented varies based on different regulations and requirements.

The "Group Registration Form" found in Avatar NX should be used to record the full list of group members which can be printed out using the "Group Member Listing Report." This allows our system to keep track of and report on the number and frequency of group services delivered in our BHRS programs.

The Participant List is the list of group members who actually attended on a particular day. This allows for an accurate record of attendance for any particular group session.

A component of preventing FWA is through a process called service verification. This is a process by which there is direct confirmation from the beneficiary that the service was delivered to the beneficiary. A sign-in sheet can serve a dual purpose of meeting the participant list requirement as well as the service verification requirement because a sign-in sheet contains a list of all members in attendance and is signed directly by the beneficiary to confirm their attendance.

Important Reminder

Due to confidentiality standards, do NOT keep the full list of group participants in any beneficiary's medical record.

Daily Progress Notes

WHAT PROGRAMS MUST SUBMIT DAILY PROGRESS NOTES

DHCS requires providers to complete at minimum a daily progress note for services that are billed on a daily basis (i.e. bundled services). Daily progress notes are only to be completed by programs required by state or federal regulation to submit daily notes for services that are included in a bundled rate. Weekly or periodic progress notes cannot be used in lieu of individual progress notes for each unit of service.

PROGRAMS THAT REQUIRE DAILY NOTES

- ✓ Crisis Residential Treatment
- ✓ Adult Residential Treatment
- ✓ DMC/DMC-ODS Residential Treatment
- ✓ Day Treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation), and other similar settings that use a daily rate for billing (i.e., bundled services).

DAILY PROGRESS NOTE REQUIREMENTS

Providers can bill the daily bundled rate when at least one of the services included in the bundled rate are provided to the beneficiary for the date of the claim. In other words, the bundled rate for residential treatment services is only available on days in which a covered service is provided.

The progress note must support the services rendered and include all progress note requirements outlined in BHIN 23-068. At minimum, daily progress notes should include all elements of the Individual Progress Note described earlier in this manual. If Group Services are included in the daily note, then the additional group note elements of the "response to the service" and "number of clients in group" should also be included in the daily note for the group service.

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In addition to the elements noted above, the daily progress note must also include the total number of minutes/hours the client actually attended program.

These requirements apply regardless of whether the bundled and unbundled services are delivered by the same provider or by different providers.

DOCUMENTING UNBUNDLED SERVICES

There are some scenarios where a bundled service may be delivered concurrently with a second service that is not included in the bundled rate and may be claimed separately. In these cases, there must also be a separate progress note to support the second, unbundled service. This allows for those unbundled services to be billed separately from the bundled services.

WHICH STAFF CAN SUBMIT THE DAILY NOTES?

The staff submitting the claim for the bundled services must have either participated in the delivery of the service and/or was responsible for clinical oversight of the service. The staff writing the daily note may only include services in the note that are within scope of practice.

Additional Requirement for Remote Service Notes

When providing **Remote Services**, in addition to the other information outlined in this manual, you must also include the physical location of the client at the time of the service in the body of each progress note.

While the requirement to include the location of the beneficiary is not a CalAIM requirement, it is a requirement under Division 18 of Title 16 of the California Code of Regulations, which was adopted by the Board of Behavioral Sciences (BBS) of the Department of Consumer Affairs. This is a requirement that applies only for services delivered remotely to ensure the safety of the beneficiary during the remote session.

CLINICAL IMPORTANCE OF LOCATION INFORMATION

When providing a direct service remotely, it is best practice for all staff (regardless of whether they are licensed/registered with the BBS) to ascertain the beneficiary's location at the beginning of each remote service appointment. **This practice ensures that a provider can inform first responders or other crisis support service providers, of the beneficiary's location, in case of an emergency,** and also **ensures that the provider is practicing within their license by confirming that the beneficiary is located within the State of California.** If a beneficiary refuses to provide you with their specific address, staff may use cross streets, or the general city, county, and/or State in which the beneficiary confirms is their location. If the client refuses to provide any information, be sure to document the beneficiary's refusal to provide you with this information. Remember, staff may not provide services to an individual who is not located in California.

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Documenting Timely Access to Services

BHRS is required to meet State standards for timely access to care and services, taking into account the urgency of the need for services. BHRS must comply with the appointment time standards set forth in Health and Safety Code (HSC) section 1367.03 and Title 28, California Code of Regulations (CCR), section 1300.67.2.2.

DHCS requires BHRS to have a system in place for tracking and measuring timeliness of care, which includes the timeliness of the initial offered appointment, timeliness to first attended SMHS appointment, or DMC-ODS appointment, and timeliness of the first offered and attended follow-up appointment for beneficiaries who begin receiving services while waiting for, or are in the process of completing, a clinical assessment.

RELATED POLICIES TO REVIEW

The following policy provides additional information regarding the requirements to provide timely access to services.

Please note that there are additional policies not listed below that may be related to a particular population, program, or situation.

Policy 18-02: Network Adequacy Standards

CLINICAL IMPORTANCE OF TIMELY ACCESS TO SERVICES

Timely access to services is not simply an administrative, regulatory requirement to gather data. Timely access is critical to health care and can increase engagement, improve prognosis, and prevent the need for a higher level of care. Delays in timely access to care can lead to a variety of negative consequences and experiences for the individual, such as distrust in the system, health care system, harm to self or others, hospitalizations, etc. that might have been avoided had timely access to care been provided. Therefore, at minimum, BHRS providers should offer appointments within a reasonable amount of time that meets Timely Access standards and the needs of the individual. In some cases the needs of the individual may warrant an appointment sooner than the required timeframe.

DOCUMENTING TIMELY ACCESS IN A PROGRESS NOTE

Providers should include in each progress note the date of the next service that was offered to the client. For instance, if a staff and beneficiary meet on April 5th and the staff person offers to meet the beneficiary the following week on April 12th, the date of April 12th **must** be documented in the progress note as the next offered appointment. If the beneficiary declines the appointment on the 12th and the staff and beneficiary agree to meet again on April 19th, it is best practice to also include the date of the agreed upon date of the next appointment in the progress note. Doing so can be beneficial to both the provider and the beneficiary. For instance, staff can easily verify the date of a beneficiary's next appointment in a note, if the beneficiary calls because they forgot their next appointment date, or in case of a missed appointment.

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Tips for Writing Progress Notes

Keep the following in mind when writing Progress Notes:

- ✓ Progress notes should be written as if an attorney and/or the beneficiary/family will read them. You should be able to explain or defend ***every statement*** that is made in the progress note. Stay objective and use quotation marks when stating what other people said.
- ✓ The content of a Progress Note should be easily understandable, without requiring additional context or information. Refrain from using clinical jargon, terminology or abbreviations that may not be widely recognized.
- ✓ Document the reports made by others involved in the beneficiary's care and who that information was provided by. *Remember that* ***if it is not documented in writing, it did not happen***. You may be asked to describe behaviors or reports from others at a later date.
- ✓ Aim for clarity, brevity, and objectivity when writing notes; lengthy narrative notes are discouraged when documenting ongoing services.
- ✓ QM has developed templates in Avatar to assist with the writing of Progress Notes. Use a template for every Progress Note written, when applicable.
- ✓ When writing a progress note that involves another Professional, use the name and role of the professional, for example, Sally Jones, Probation Officer.
- ✓ When a service is provided to two or more beneficiaries, who are also family members, write a note in each of the client's respective charts (split the time accordingly).

Confidentiality in Progress Notes

The medical record is a legal document that may be subpoenaed by a court. Please protect beneficiary confidentiality by following the below standards when completing Progress Notes:

- Do not write another beneficiary's name (e.g., classmate or sibling) in any other beneficiary's chart.
- In the unusual circumstance that another beneficiary must be identified in the record (for example, when the other beneficiary received a Tarasoff warning), do not identify that individual as a BHRS beneficiary.
- 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.

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- 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...").
- Limit what you say about family members. Remember, it's the beneficiary's chart, not the family member's chart.

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

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

Progress Note vs. Process Note

When you understand the difference between a process note versus a progress note, it becomes easier to write concise notes and reduce your documentation time which will leave you with more time to provide services to beneficiaries.

Progress Note ✓	Process (Psychotherapy) Note ✖
The following items may be included in a progress note: ✓ Persons involved (do not include names of non-beneficiaries in the note). ✓ Interventions used. ✓ Plan for next steps. ✓ If a description of a beneficiary's response is included, it should be brief and include the minimum necessary. Do not include speculation, opinions, etc. If noting statements a beneficiary made in session, it is better to quote the beneficiary directly rather than summarize or interpret the beneficiary's words in the note.	The following are typically included in process notes and should NOT be included in a progress note: ✖ Detailed narrative of what happened in session. ✖ Provider's opinion/analysis of beneficiary's behaviors/symptoms in session. ✖ Provider's reflections on countertransference, etc. ✖ Speculation regarding what transpired in session.

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Sample Progress Notes

The following Progress Note samples were developed by CalMHSA to support county documentation efforts and are included on Appendix V of the CalMHSA Clinical Documentation Guide 2023:

ASSESSMENT SAMPLE 1

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

ASSESSMENT SAMPLE 2

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

INDIVIDUAL THERAPY SAMPLE

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

INDIVIDUAL REHABILITATION SAMPLE

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

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next rehabilitation session.

CASE MANAGEMENT SAMPLE

This staff contacted Group Intervention Center and spoke with intake counselor (Susan) to obtain information about the appropriateness of their Healing Heart Program to meet client's needs. Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Healing Hearts indicated client seemed appropriate for their program group and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend this support group.

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APPENDIX A

Service Code, Location Code, Time Field Matrix

Entering Time for Reimbursable vs Non-Reimbursable Services.

	Billable (Reimbursable) Service Code	55 or 550 Service Code	Lockout Location Code	Missed Visit* Location Code
Service Time	Use for time spent providing direct service to the beneficiary, collateral, or case management services with other providers.	Use for time spent providing the actual service.	Use for time spent providing the actual service.	Zero because no service was provided.
Documentation Time	Use for time spent on documentation related to writing the progress note, assessment, treatment plan, or other clinical documentation.	Use for time spent documenting note.	Use for time spent on documentation related to writing the progress note, assessment, treatment plan, or other clinical documentation.	Use for time spent documenting note.
Travel Time**	Use for time spent traveling to/from the appointment.**	Use for time spent traveling to/from the appointment.**	Use for time spent traveling to/from the appointment.**	Use for time spent traveling to/from the appointment.**
Non-Billable Time***	Use if a non-billable service was provided during this appointment.	N/A	Use if a non-billable service was provided during this appointment.	Use if a non-billable service was provided during this appointment.

* When a beneficiary has missed their appointment/visit staff will document this by choosing the service code of the service they had intend to provide and use the location code Missed Visit. F*or example, if a beneficiary missed an individual therapy appointment (ex. 30 min), then staff would choose the corresponding CPT code for Individual therapy with the approximated time and choose the location code of missed visit.*

** See the "Documentation and Travel Time" Subsection of "Progress Notes Fields" Section in this manual to learn the amount of time to include in "Travel Time"

*** Contractors who do not use BHRS Avatar do not have the non-billable time field, so this only applies for those using BHRS Avatar.

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Entering Time for Direct Services vs No Client Present

	Individual Services	Group Services	Services Delivered without Beneficiary Present
Service Time	Entire time spent providing direct service.	Entire time spent providing the group service.	Entire time spent providing direct service.
Documentation Time	Entire time spent documenting.	Only the time it took to write the beneficiary's note.	Entire time spent documenting.
Travel Time*	Entire time spent traveling.*	Entire time spent traveling for the group service.*	Entire time spent traveling.*
Non-Billable Time	Entire time spent providing non-billable service (non-billable time other than documentation time or travel time).	Only the time it took to provide unbillable services for that particular beneficiary (e.g., time spent completing a mandated report, etc.).	Entire time spent providing non-billable service (non-billable time other than documentation time or travel time).

* See the "Documentation and Travel Time" Subsection of "Progress Notes Fields" Section in this manual to learn the amount of time to include in "Travel Time"

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APPENDIX B

General Definitions of Services

ADULT RESIDENTIAL TREATMENT SERVICES

Adult residential treatment services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential program.

The service is available 24 hours a day, seven days a week. Structured day and evening services are available all seven days.

Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a staff person of the facility on the day of service.

SERVICE COMPONENTS

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

ASSESSMENT

Assessment means a service activity designed to collect information and evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis and the use of testing procedures. Assessments are used to determine whether mental health services are medically necessary and to recommend or update a course of treatment for that beneficiary.

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CRISIS INTERVENTION SERVICES (not crisis stabilization or crisis residential)

Crisis Intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling the beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

Crisis intervention may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

SERVICE COMPONENTS

This service includes one or more of the following service components:

- Assessment
- Collateral
- Therapy

Referral Title 9, CCR, § 1840.366 states that "the maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours."

CRISIS STABILIZATION – EMERGENCY ROOM

Crisis stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the beneficiary or others, or substantially increase the risk of the beneficiary becoming gravely disabled.

Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital-based outpatient program (services in a hospital-based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization and some service components may be delivered through telehealth or telephone. Crisis stabilization may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

SERVICE COMPONENTS

This service includes one or more of the following service components:

- Assessment
- Therapy
- Crisis Intervention
- Medication Support Services
- Referral and Linkages

Medical backup services must be available either on site or by written contract or agreement with general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.

All beneficiaries receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the beneficiary's needs will be made, to the extent resources are available.

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CRISIS RESIDENTIAL

Crisis Residential Treatment Services (CRTS) are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term-3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care.

The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.

Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service.

SERVICE COMPONENTS

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation
- Crisis Intervention

DAY REHABILITATION

Day Rehabilitation is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day.

Day rehabilitation is a program that lasts less than 24 hours each day.

Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the beneficiary. Day rehabilitation services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

SERVICE COMPONENTS

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

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DAY TREATMENT INTENSIVE

Day Treatment Intensive is a structured, multi-disciplinary program which provides services to a distinct group of individuals. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living within a community setting. Services are available for at least three hours each day.

Day treatment intensive is a program that lasts less than 24 hours each day.

Day treatment intensive may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary. Day treatment intensive services must have a clearly established site for services although al services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

SERVICE COMPONENTS

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

INTENSIVE CARE COORDINATION (ICC) SERVICES

ICC is a targeted case management service that facilitates assessment of care planning for, and coordination of services to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria for these services. ICC service components include assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems. Intensive Care Coordination (ICC) Child Family Team Meeting (CFT). ICC is a specialty mental health service covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

The CFT is comprised of, as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends and clergy and all ancillary beneficiaries who work together to develop and implement the beneficiary plan and are responsible for supporting the child and family in attaining their goals. CFTs are supported by an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;
- Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;
- Supports the parent/caregiver in meeting their child's needs;
- Helps establish the CFT and provides ongoing support; and
- Organizes and matches care across providers and child serving systems to allow the child to be served in the community.

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INTENSIVE HOME BASED SERVICES (IHBS)

IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan.

- IHBS may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
- IHBS is provided to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria.

PLAN DEVELOPMENT

Plan Development means a service activity that consists of one or more of the following: developing or updating a beneficiary's course of treatment, documentation of the recommended course of treatment, and monitoring of a beneficiary's progress.

MEDICATION SUPPORT SERVICES

Medication Support Services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.

Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Medication support services may be delivered as a standalone service or as a component of crisis stabilization.

Title 9, CCR, § 1840.372 states that "the maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours."

SERVICE COMPONENTS

This service includes one or more of the following service components:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- The obtaining of informed consent
- Medication education including instruction in the use, risks, possible side effects, and benefits of and alternatives for medication
- Collateral
- Plan Development

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MOBILE CRISES RESPONSE TEAM

The mobile crises services benefit is part of the transformation of Medi-Cal reform. The intention is to help bridge the gap in the following areas of concern for DHCS:

- Many California's facing mental health or substance use crises often end up dealing with the wrong systems like law enforcement or hospital emergency rooms, without getting the help they need.
- In 2020, one out of every five people visiting emergency departments had a mental health or substance use issue.
- Mobile crises services re there to help anyone going through a mental health or substance use crises services in the community, around the clock (24/7).
- Research shows that these services can effectively handle crises in the community, steer people away from inappropriate systems, and connect them with the right ongoing support.

In San Mateo County, BHRS has selected Telecare Corp to provide the mobile crises response team services and will work with StarVista as the current provider of our Crises Line. Callers can request mobile crisis services by calling (650) 573-0350 and the specialist teams will be deployed to provide crises services to San Mateo County residents.

This specialist service has specific documentation requirements. Within our EHR, there is a unique progress note that will capture the following requirements:

- Category of the Note:
    - Crises Evaluation
    - Initial Follow-up
    - Additional Follow-up
- Service Start Time & Service End Time (Service Duration)
- Location -Where was the service provided, i.e.-street, home, shelter, school.
- Crises Category/Nature of Call -Domestic Violence, Gravely Disabled, Homicidal Ideation, Suicidal Ideation, Other.
- Crises Call Request Time
- Response Method (In-person/Not In-person)- If not in person, provide reason.
    - Arrival Time
    - Travel Time
    - Follow-up Details
    - Notes Field
    - Final/Draft

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PEER SUPPORT SERVICES

Peer Support Services are culturally competent beneficiary and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and beneficiary coaching to set recovery goals and identify steps to reach the goals.

Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Peer support may be provided as a group service or a one-on-one service.

- **Educational Skill Building Groups** means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- **Engagement** means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.
- **Therapeutic Activity** means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members or significant support persons.

PEER SUPPORT SPECIALISTS

Peer support services are provided by certified Medi-Cal Peer Support Specialists. Certified Medi-Cal Peer Support Specialists are beneficiaries 18 years of age or older who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder or both, either as a consumer of behavioral health treatment services or as a parent or family member of a consumer, and who have a current Peer Support Specialist certification in California. The Peer Support Specialist serves as part of an integrated and/or multidisciplinary treatment team and offers an invaluable perspective on the most effective.

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REHABILITATION

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

Rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings.

Rehabilitation may be provided to a beneficiary or a group of beneficiaries. For example, rehabilitation also includes assisting beneficiaries to develop coaching skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies.

THERAPY (includes beneficiary therapy, group therapy, family therapy)

Therapy means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship.

Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

TARGETED CASE MANAGEMENT (CASE MANAGEMENT/BROKERAGE/LINKAGE)

Services that assist a person in care to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of beneficiary progress; placement services and plan management. TCM services may be with the beneficiary or significant support persons.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

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

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THERAPEUTIC FOSTER CARE (TFC) SERVICES

This model allows for the provision of short term, intensive, highly coordinated, trauma informed and individualized specialty mental health services (SMHS) activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth.

TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

Special Note about Collateral Services

Under CalAIM, the way that a collateral service is billed has changed. Instead of a collateral service being its own distinct service code, the way it was previously, Collateral instead is viewed as a component of many different services. A provider working with the beneficiary's support person would select the service code that most accurately represents the service they are providing and indicate on the progress note that this service was provided to the collateral contact. Here are a few examples:

Sample Collateral Scenario	Service Code
Meeting with the beneficiary's caregiver/significant support person to gather assessment information.	Assessment
Meeting with the beneficiary's caregiver/significant support person to develop a plan for treatment.	Plan Development
Meeting with the beneficiary's caregiver/significant support person for the purpose of coaching, skill development as way to support the beneficiary with managing behavioral health needs.	Rehabilitation
Meeting with the beneficiary's caregiver/significant support person for the purpose of connecting them with resources/community supports to address the beneficiary's needs.	Case Management

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APPENDIX C

Progress Note Templates

Services Provided to an Individual (Not Group) Template

IN-PERSON SERVICE (NOT GROUP)

List people involved in the services and their role:

Service: Include how the service addressed the client's behavioral health needs (e.g., activities or interventions used, any issues discussed, progress toward goals).

Plan: Summary of plan or next steps (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, updates to problem list and/or treatment plan, referral, discharge planning).

Next Appointment: (Include earliest offered appointment date for next appointment).

REMOTE SERVICE (NOT GROUP)

List people involved in the services and their role:

Location of the client at the time of service:

Service: Include how the service addressed the client's behavioral health needs (e.g., activities or interventions used, any issues discussed, progress toward goals).

Plan: Summary of plan or next steps (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, updates to problem list and/or treatment plan, referral, discharge planning).

Next Appointment: (Include earliest offered appointment date for next appointment).

Group Services Template

IN-PERSON SERVICE (GROUP)

ONLY COMPLETE THE FOLLOWING PROMPT FOR GROUPS WITH MORE THAN 1 FACILITATOR: Describe YOUR (1) specific involvement in the group and (2) The specific amount of time of YOUR involvement in the group activity.

Service: Include how the service addressed the client's behavioral health needs (e.g., activities or interventions used, any issues

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discussed, progress toward goals).

Response: Describe the client's response to the service (e.g., effectiveness of the intervention, progress or barriers, other info relevant to member's participation).

Plan: Summary of plan or next steps (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, updates to problem list and/or treatment plan, referral, discharge planning).

Next Appointment: (Include earliest offered appointment date for next appointment).

REMOTE (GROUP)

ONLY COMPLETE THE FOLLOWING PROMPT FOR GROUPS WITH MORE THAN 1 FACILITATOR: Describe YOUR (1) specific involvement in the group and (2) The specific amount of time of YOUR involvement in the group activity.

Location of the client at the time of service:

Service: Include how the service addressed the client's behavioral health needs (e.g., activities or interventions used, any issues discussed, progress toward goals).

Response: Describe the client's response to the service (e.g., effectiveness of the intervention, progress or barriers, other info relevant to member's participation).

Plan: Summary of plan or next steps (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, updates to problem list and/or treatment plan, referral, discharge planning).

Next Appointment: (Include earliest offered appointment date for next appointment).

Crisis Intervention Services Template

CRISIS INTERVENTION

ONLY FOR REMOTE CRISIS SERVICE: Location of the client at the time of service:

List people involved in the services and their role:

Service: Include how the service addressed the client's behavioral health needs (e.g., activities or interventions used, any issues discussed, progress toward goals).

Plan: Summary of plan or next steps (e.g., action steps, collaboration with client or providers, goals, steps to address client's needs, updates to problem list and/or treatment plan, referral, discharge planning).

Specific Safety Plan (if needed):

Next Appointment: (Include earliest offered appointment date for next appointment).

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Medication Support Template

MEDICATION SUPPORT

- ✓ **Interval History**
- ✓ **Mental Status Examination**
  - General Appearance /Behavior
  - Speech
  - Mood /Affect
  - Perceptions /Thought Content /Thought Process
  - Attention /Concentration
  - Orientation /Cognition /Memory
  - Judgment:
  - Insight:
- ✓ **Risk Assessment**
  - Med Assessment:
  - Comment
  - Diagnosis:
- ✓ **Plan**