Quality Assurance Documentation Manual

Behavioral Health Division

Acknowledgments

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Clinicians: Shannon Clymer, LCSW, Laurie LaQuey, LMFT, and Bev Shoopman, LPCC

Behavioral Health Specialists: Rose Jones, Lori Keyser-Boswell, and Robert Wallace

Leslie Zane, LMFT, Quality Assurance Manager

Joe Krzesni, LMFT, Consultant

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Introduction

The purpose of this manual is to provide guidance to providers on documentation standards for Medi-Cal billing.

There are many regulations and funding sources that impact the provision of mental health services. The requirements for documentation and billing are governed by stringent federal and state mandates which are sometimes modified by counties and referred to as the Mental Health Plan (MHP). The majority of our clients are Medi-Cal recipients, but the requirements for documentation apply to all individuals served, regardless of Medi-Cal status.

The Department of Health Care Services (DHCS) requires the county mental health plan (MHP), or in other words the Siskiyou County Behavioral Health Division, to certify that the following criteria have been met for every claim submitted to Medi-Cal for payment:

- An assessment of the client was completed.
- The client is eligible to receive Medi-Cal services at the time the service was provided.
- Services claimed were actually provided.
- Medical necessity was established including the client having an eligible diagnosis.
- A treatment plan was developed and maintained with no lapses in coverage.
- Service authorization requirements were met for children's services performed by organizational and contract providers.

Benefits of Good Documentation

- Spend less time on paperwork procedures
- Increases compliance with third-party payers and ensures audit survival
- Encourages that the treatment objectives remain on target
- Increases effective communication with other professionals
- Demonstrates the effects and outcomes of therapeutic procedures
- Serves as a defense against malpractice claims and protection in the event of litigation
- Contributes to the provision of quality mental health care
- Provides the client an accurate record of treatment to read or share with other health providers

What must be **excluded** from documentation?

- Information that is hearsay or could prove embarrassing to a client/provider/third party.
- Negative characterizations of the client and collaterals
- Information that has no real impact on the course of treatment and could easily be misinterpreted by outside sources
- Personal opinions and comments about other professionals involved in the client's care
- Detailed, sensitive information such as sexual practices and fantasies and information on sexually-transmitted diseases
- Names of collaterals and other service providers, in other words, names other than the client's name.

Reimbursement Guidelines

- Services must be medically or therapeutically necessary.
- Services must be directed toward a MediCal eligible diagnosable psychiatric disorder which results in a functional impairment.
- Services must be consistent with the diagnosis and degree of impairment.
- There must be documentation of reasonable progress consistent with the treatment of the disorder. When an intervention does not result in progress in a reasonable time, that approach must be stopped and a new approach tried.
- Services must be specifically directed toward the diagnosis and impairment.
- To receive continued services, there must be documented evidence of continued impairment.
- The progress notes must clearly relate to the measurable treatment plan goals and objectives as they apply to the functional impairment. If not, a reason for exceptions should be explained.
- Services must be coded correctly so check to be sure to enter the correct service code from the Anasazi keying guides (see appendix 14 for Anasazi resources).
- Two services may not be claimed for in the same note e.g., case management and individual rehabilitation. If more than one service is delivered during a session, write a note for each.

Some Billing Do's

DO write a progress note for each service billed.

DO include and write out (ex, MFT Intern not MFTI) your licensure status on signature line. (Your job title is not a substitute for this information). This applies to handwritten documents only. Anasazi will enter your credentials automatically.

DO include your job title on the signature line for staff without a license or license waiver.

DO get a co-signature for all documentation as directed by your supervisor.

DO bill for documentation and travel time connected with a billable service provided to a client. See the documentation of travel time description in appendix 2.

DO bill only for mental health services that are provided within your scope of practice.

DO bill for completing outcome measures if it is part of an assessment or used in conjunction with a client visit.

DO document time spent performing utilization review or quality improvement activities. See the quality improvement claiming procedure in appendix 3.

BILLING TIPS

Documentation needs to include, at each visit, information that indicates that services are medically necessary. All services should be directed towards the treatment plan objectives as they relate to the client's identified functional impairments. If not, a reason for the exception should be explained in the progress note.

Some Billing Donts

DO NOT bill for mental health services (except case management related to discharge) provided while a client is admitted to a psychiatric hospital (called a lock-out).

DO NOT bill for academic or educational services (tutoring or helping with homework).

DO NOT bill for vocational services (helping someone find a job or teaching him/her how to work).

DO NOT bill for purely recreational or social activities (going to the zoo, taking a client to the movies).

DO NOT bill for transporting a client as opposed to traveling to a client's location and back (see appendix 2 for claiming travel time). If a service is provided during the trip, i.e. case management or individual rehabiliation (skill building), for example, talking to client about selfsoothing techniques and practicing this during the trip, then those services can be billed.

DO NOT bill for interpreting, but document if an interpreter is used. See appendix 4 for information about documenting language interpretation.

DO NOT bill for administrative type services (emails, appointment setting, leaving messages, etc.)

DO NOT bill for paperwork that is not directly related to a service provided (transportation requests, writing letters, report writing, e.g., CPS/APS abuse reports).

DO NOT bill for providing supervision of staff.

DO NOT bill for services provided while a client is incarcerated in jail, prison or juvenile hall (called a lock-out), unless the minor in juvenile hall has been adjudicated and is awaiting placement.

DO NOT bill for more than one staff member providing services to a client at the same time unless each staff member has provided a distinct service to the client. Staff members must document separate and distinct roles related to the services provided.

If one progress note is done for a group session it may be signed by one provider, but the progress note must clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements must also be met.

Furthermore, when services are being provided "by two or more persons at one point in time, each person's involvement shall be documented in the context of the mental health needs of the beneficiary." (Cal. Code Regs., tit. 9 § 1840.314(c))

DO NOT bill for time spent preparing for sessions.

Documentation Process

The course of clinical documentation begins with an initial assessment. Assessment data provide the information for creating the client's treatment plan. The objectives from the treatment plan then guide the course of treatment and resultant progress notes. Cultural and human diversity issues must be addressed when discussing client's behaviors, needs, concerns, strengths, responses, etc. and integrated into treatment and documentation.

When a service is provided in a language other than English, the language used and if an interpreter is present must be documented in all progress notes (see appendix 4 for documentation of interpretation services). Other accommodations should be documented such as providing large format documents for visually impaired clients or services such as TDD for hearing impaired clients.

It is also important to remember that you must use standard abbreviations in all documentation. First, spell out the words you intend to abbreviate: then use the abbreviation thereafter e.g., Northern Valley Catholic Social Services (NVCSS). In clinical documentation do not include names other than the client's name. For example, when referring to the teacher Mr. Smith at Yreka High School, document "client's teacher at Yreka High School" and not the teacher's specific name. The only exception to this rule is when in the course of obtaining an opinion from CPS or APS regarding an abuse complaint, record the contact person's name in the informational note.

The assessment, treatment plan and progress notes are integrated items, each affecting and dependent on the other. Although they are independent documents, they should represent a continuous process of treatment. There are regulatory and agency timeline standards for each of these three elements.

TIP: Documentation Completion Timelines

- The assessment must be completed within the first 30 days from the initial intake appointment. Assessments are updated every year before the previous assessment expires in CSOC and two years prior to expiration in ASOC and Medical Services. Updates for assessments are linked to the episode of care date. The treatment plan must be completed within the first 60 days after intake. Treatment plans are updated every year before the current plan expires and when there is a significant change to the client's condition (e.g., suicidal ideations, hospitalization, objectives attained, transfer from one clinician to another). The end date of the treatment plan coincides with the episode of care date. For example, if the episode of care date is 10/14/14, then the end date would be on the same date for the following year e.g., 10/14/17, etc. Notifications are set for 30-days prior to expiration. Until the treatment plan is completed, the only services that can be billed are assessment, plan development and services that address an urgent condition where a client's condition may worsen if not treated such as medication support, and crisis intervention. Case management and intensive care coordination (ICC) may be provided for assessment, plan development, and referral/linkage to assist clients to obtain needed services including medical, alcohol and drug treatment, social, and educational services.

- It is expected that progress notes will be completed within 6 business days from the day of service delivery If a progress note cannot be written by the end of the 6th business day including the day of service, a late entry progress note must be written. Specify "late entry" on the progress note.

- The reason for exceptions to required timelines must be documented in progress notes, e.g., "due to client cancellations, the development of the treatment plan was delayed."

Assessment

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

Standard required elements of a mental health or psychiatric assessment which must be documented in the Anasazi form:

- Presenting Problem - The beneficiary's chief complaint, history of the presenting problem(s), including current relevant family history and current family information;
- Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;
- Mental Health History - Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
- Medical History - Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
- Medications - Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
- Substance Exposure/Use - Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications, over-the-counter, and illicit drugs;
- Client Strengths - Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- Risks - Situations that present a risk to the beneficiary and/or others, including past or current trauma;
- Mental Status Exam;
- Diagnosis - A complete diagnosis from the most current Diagnostic and Statistical Manual, or a diagnosis from the most current International Classification of Diseases-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data;
- For Children, the assessment should indicate that the client was assessed for eligibility and the need for ICC/IHBS services; and
- Additional clarifying formulation information as needed.

ASSESSMENT TIP: If you are unable to determine information for the assessment areas, do not put n/a. Write the reason for the lack of information. **Remember,** that you may obtain releases to talk with collaterals and gather more assessment data after your session with the client or conduct a second session if you need more time.

Staff who may bill for an assessment: Assessments can be provided by licensed, waivered, registered staff (MD, NP, Ph.D., LCSW, LPCC, and LMFT), and master's student trainee (with licensed LPHA co-signature)

The disposition of the assessment:

The assessment should "paint a picture" of the client and determine whether or not mental health treatment is needed. If medical necessity is met, the assessing clinician, with the client's participation and input, makes a decision to proceed to develop a treatment plan. If medical necessity is not met, referrals and a *Notice of Action (NOA-A)* form should be given to the client. NOAs are required to be issued within 3 working days of the assessment. If the client is being referred to Beacon due to low to moderate acuity, promptly fax a screening form to them and document the referral in the assessment progress note.

Timelines for completion of an assessment and billing:

Initial assessments are to be completed within 30 days. Assessment updates are completed every 2 years in ASOC and every year in CSOC, or when a significant change occurs and should be completed within 30 days of the episode of care date anniversary. Notifications via the treatment plan are set for 30-days prior to the expiration of the treatment plan and to coincide with the episode of care date anniversary. Bill for each session and phone call that you conduct to complete the assessment plus the documentation time as outlined in the assessment progress note template section. Remember, you cannot bill any service other than crisis before the initial assessment is completed.

ASSESSMENT TIPS FOR CLINICIANS

A completed assessment includes:

1. An Anasazi form for MH Adult Intake Assessment or a MH Children's Assessment; MH Medical Necessity Determination; CANS or ANSA depending on service unit; and a Diagnosis Review form.
2. Releases of information for primary care provider, pertinent collaterals, referrals and providers.
3. Internal release of information for exchange of protected health information between MH and AOD.

Standard Elements of the Assessment Progress Note when client is present:

- Start Time

- A note is a "late entry" if it is entered more than six working days from the day of service. If that is the case, document this statement "This is a late entry progress note for service provided on the date above."

- Document that you completed the assessment or part of the assessment today and provided the client with required information regarding their rights, confidentiality, etc. (informed consent).

- Document if more information needs to be obtained through other sources to complete the assessment.

- Document whether the client meets medical necessity for services.

- Document the plan for continuing services to the client if applicable. Document if referrals to community resources and other agencies are given.

Standard Elements of the Assessment Progress Note when client is NOT present:

- Start Time

- Document in the progress note that today's assessment documentation is a continuation of the client's assessment which began on _____ (date).

- Gather additional assessment information from collaterals or other service provider face-to-face or over the phone; or from the client over the phone if applicable.

- Document about any plans, medical necessity determinations, outcomes, etc. not mentioned in the previous assessment note.

TIP FOR CLAIMING THE ASSESSMENT WRITE-UP

Service Time **=** Time spent on clinical interviewing, gathering information and entering the assessment, medical necessity form, diagnosis review form and a CANS or ANSA in Anasazi.
Documentation Time **=** Time spent documenting the progress note.

Medical Necessity

Medical necessity is defined as the need for professional services due to the existence of a mental disorder that has resulted in significant functional impairments.

Medical necessity is the principal criterion Medi-Cal uses to determine payment and authorization for covered services. To be eligible for reimbursement, medical necessity for specialty mental health services must exist before and during on-going treatment.

To qualify for treatment or service reimbursement, symptoms must be documented so that a reviewer or any other health care provider understands the impact of the symptoms and resulting functional impairment of the client. Medical necessity evidence is a required element of all clinical documentation including on-going progress notes. Medical necessity is documented at the assessment in the MH Med Nec Determination form in Anasazi. This form should be updated at every assessment.

All three components listed below are required to justify medical necessity for specialty mental health services:

1. Presence of an included diagnosis: The beneficiary must have **one** of the following diagnoses from the most current Diagnostic and Statistical Manual, or a diagnosis from the most current International Classification of Diseases, consistent with the presenting problems, history, mental status examination and/or other clinical data. This diagnosis will be the primary focus of the intervention being provided.

NOTE: The current lists of included and excluded diagnoses published by the Department of Health Care Services (DHCS) continue to be from the DSM IV-TR as the state has not changed over to DSM V so the practice of entering diagnoses in Anasazi is a combination of the two.

- Pervasive Developmental Disorders, except Autistic Disorder
- Attention Deficit and Disruptive Behavior Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnosis

The list of diagnoses below often reflect problems that are more organic or physical than mental in nature, and therefore are not billable to Medi-Cal as primary diagnoses. However, excluded diagnoses

may be secondary or tertiary diagnoses. Appropriate referrals should be made to agencies who treat these disorders or to the client's primary care physician.

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorder
- Autistic Disorder (Other Pervasive Developmental Disorders are included)
- Tic Disorders
- Delirium, Dementia, and Amnesia and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related/Induced Disorders
- Sexual Dysfunction
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions That May Be a Focus of Clinical Attention (except Medication Induced Movement Disorders, which are included).
- V-Codes

> ***TIP:*** *A client may receive services for an included diagnosis that is primary when an excluded diagnosis is also present.*

2. Impairment Criteria: The client must meet at least **<u>one</u>** of the following criteria due to the mental disorder:

- Impairment in an important area of life functioning due to the mental disorder.
- Probability of significant deterioration in an important area of life functioning.
- Probability that the client will not progress developmentally as appropriate due to the mental disorder. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or improved.

> ***TIP:*** *Impairments must be documented in the assessment form and the treatment plan.*

3. Intervention Related Criteria: The client's treatment must meet **ALL** of the following criteria:

- Focus is to address the condition identified
- Client will benefit from the intervention which will do **one or more** of the following:
  1. Significantly diminish the impairment
  2. Prevent significant deterioration
  3. For children, will allow individually appropriate developmental progress
- In order to meet medical necessity, the client's condition will not respond to physical health based treatment alone (e.g., cannot be met by primary care physician alone)

Diagnosis Review Form

The diagnosis review form is completed in Anasazi at the time of the assessment and is used to open the client's case. DSM V

The diagnostic formulation must be consistent with the presenting problems, history, mental status evaluation, and other assessment data. An example follows:

Axis I: F33.2 Major Depression, Recurrent Episode, Severe

Treatment Plan

After the mental health assessment is completed and medical necessity for specialty mental health services is met, the clinician works with the client to develop the client treatment plan.

The Treatment Plan timeline indicates that it must be completed:

- Within 60 days of initial assessment appointment.
- Before billing a mental health service outside of assessment, plan development, and crisis intervention.
- When the client's condition changes, the client achieves goals and/or a need for new goals arise, and if additional or different services are needed.
- Completed 30 days prior to the end of the existing plan, if continued services will be needed.

> ***CASE TRANSFERS TIP:*** When the case is transferred to another clinician, the plan should be reviewed for viability. by the newly assigned clinician.

The following elements are required to be present on the Treatment Plan:

- Specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis..
- Proposed type(s) of intervention(s)/modalities, including a detailed description of the intervention to be provided.
- Proposed frequency and duration of the interventions.
- Have interventions that focus and address the identified functional impairments as a result of the mental disorder; have interventions that are consistent with the treatment plan goals.
- The Treatment Plan must be consistent with the qualifying diagnoses.
- The Treatment Plan must be signed (or electronic equivalent) and dated by either:
    - The person providing the services;
    - A person representing a team or program providing services; or
    - A person representing the MHP providing the services.
- In addition to a signature by one of the above, the plan must be co-signed by one of the following providers, if the Treatment 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 Treatment Plan is not one of the categories of staff listed below:
    - A physician
    - A licensed/waivered psychologist
    - A licensed/registered/waivered social worker
    - A licensed/registered/waivered marriage & family therapist
    - A licensed/registered/waivered professional clinical counselor
    - A registered nurse, including but not limited to nurse practitioners and clinical nurse specialists.

SIGNATURES TIP: Authorization begins on the date the LPHAand co-signer if applicable sign and dates the plan. Once the signatures are obtained, billing of the full range of services can commence However, it is in keeping with best practices that the client and legal guardian (if applicable) should sign the plan demonstrating their involvement in the treatment planning process, as soon as possible.

The Treatment Plan must also have the following clinical elements:

- Must be consistent with the diagnosis and symptoms.
- The focus of the interventions must be consistent with the objectives.
- Should be realistic and meaningful with objectives that are achievable, observable, measurable, and appropriate to the client's age and abilities.
- Should be written in easily understandable language for clients, family, and staff to comprehend.
- Should provide measurable indicators of progress.
- Should support the client's need for level and length of care being provided.
- Should support interdisciplinary collaboration.
- Should be revised when there are significant changes in the client's condition e.g., suicidal ideations, hospitalization, objectives attained, transfer from one clinician to another.

Documenting Treatment Plan client participation:

- Evidence of the client's degree of participation and agreement with the treatment plan as evidenced by the client and/or guardian's signature must be documented.
- **Provide the treatment plan in the client's (parent/guardian's) preferred language.**
- If client and/or guardian is unavailable or refuses to sign the treatment plan, a written explanation in the progress notes why the signature could not be obtained is necessary.
- Follow-up efforts to obtain a signature and evidence of client participation must be documented regularly in the progress notes if the client is initially unavailable or unable to sign.
- A copy of the treatment plan must be offered to the client and/or guardian.
- Electronic signatures should be obtained whenever possible because this eliminates the risk of losing a hard copy client signature.

CHILD/YOUTH TREATMENT PLAN TIP: Explaining a treatment plan to a young child can be challenging. If the clinician believes that the child is able to comprehend the goals and objectives, then the client should be asked to sign the plan, but only if the client is old enough to write their name legibly. Parents and guardians are required to sign any CSOC client's plan, regardless of age of the client. If the client is reluctant to involve the parent/guardian in the treatment planning process, the clinician should consult their supervisor for direction on how to proceed with obtaining signatures.

Foundation of the Treatment Plan

The foundation of the treatment plan is the symptoms and behaviors which are causing the client distress and significantly impairing his/her home, school, and/or community functioning. The more accurately the behavioral symptoms, frequency and duration are documented will determine, to a degree, whether or not the treatment plan will be of use and will have a significant impact on the client's impairments.

SAMPLE TREATMENT PLAN TIP:
See appendix 5 for a sample treatment plan.

Examples of a client's strength: (Clients strengths that support success in achieving goals, achieving objectives and accepting interventions)

- Client is easily engaged and willing to learn new skills.

Example of a Problem (medical necessity): (Justification for services. What is the diagnosis, functional impairment, and behavioral symptomology?)

- Client is diagnosed with Major Depression, Recurrent, Severe. She reports feeling sad most of the day, nearly every day. She sleeps restlessly nearly every night and has noticed a decrease in her appetite, eating only one meal a day for the past two weeks. Client states that she no longer enjoys activities that she used to like to do with her friends and has been spending more time isolated in her room. She states that this has caused impairment with her family relationships as evidenced by her isolating, and not participating in family meals and activities. Her symptoms are also causing school impairment as she is unmotivated to do her school work and hasn't been able to concentrate in class resulting in poor grades.

Example of a Goal: (Describe the client's long term goal related to the symptoms of the mental health diagnosis)

- Client will learn coping skills to manage depressive symptoms. Can include client's own words "I don't want to feel so sad."

Objectives for the Treatment Plan

The objectives in the treatment plan are a good gauge to determine if the interventions are working. The objectives must be specific, observable, with baseline and desired outcome measurements which relate directly to the symptoms and behaviors gathered during the assessment process. The documentation of these symptoms and behaviors must include frequency and duration.

Objectives are NOT:

- To attend mental health services.
- To come to medication appointments.

Examples of objectives in specific and measurable terms: (Quantifiable and measurable short-term goals that the client will accomplish to help reach long-term goal. Must include a target date)

- Client will decrease the frequency of being sad for most of the day everyday to no more than four days per week by participating in family meals, attending social functions, and completing homework, as measured by self-report, parent report, and teacher report.

- Client will increase her coping skills by using "I statements" and journaling when wanting to isolate, skip a meal, and/or avoid school work from 0 x per week to 3-4 x per week. As measured by self-report, review of journal, and parent report.
- Objectives also can be stated in outcome measures related to the CANS, ANSA or scales such as the Beck's Depression Inventory.

TIP: TRIGGERING NOTIFICATIONS IN ANASAZI In order to trigger Anasazi to notify the clinician that the plan needs to be updated, a "target date" must be entered into the problem, goal, and objective sections on the treatment plan.

Interventions

Specific interventions focus on how the treatment team plans to facilitate change in the identified symptom or behavior.

Examples of interventions including modality: (specific to client [not cookie cutter] and must include all service codes that will be used to provide services and meet goals)

Individual Therapy: Over the next 12 months, staff will provide individual therapy. Therapy will utilize CBT to teach coping and communication skills, and feelings identification with the focus on reducing symptoms of sadness, isolation, poor sleep/appetite as a means to improve mood, family relationships, and academic performance. **NOTE:** The narratives may be simpler. Do not list a modality that is currently beyond your competence as defined by your professional ethics.

Individual Rehabilitation: Over the next 12 months, staff will provide weekly rehabilitation services to include education, coaching, and assisting with skill building around developing a routine for completing school/homework assignments and increase participation in activities as a means to increase school performance and decrease isolation.

Collateral: Over the next 12 months, staff will provide monthly collateral services to client's parent. Collateral services will focus on psycho-education related to client's diagnosis and symptoms, and parenting skills with the focus on increasing client's natural support system to reduce her current depressive symptoms.

Case Management: Over the next 12 months, staff will provide monthly case management services to focus on access, monitoring and linking client to supportive activities and/or referrals for additional services and school support as a means to decrease depressive symptoms and increase social functioning.

Medication: Over the next 12 months, med staff will provide monthly medication services to increase medication knowledge and compliance.

Group Rehabilitation: Over the next 12 months, staff will provide a 6-8 week group series on social skills building (building friendships; self-esteem; conflict resolution; time management; organization) as a means to increase social connections with others and increase the client's ability to use positive social skills to reduce depressive symptoms and school impairments.

Group Collateral: Over the next 12 months, staff will provide a 6-8 week group series with parents which may include psycho-education, parent's skills, or consultation to assist in better utilization of services and in understanding the client's depression, isolation, and academic impairments.

Intensive Care Coordination: Intensive care coordination will be provided to ensure effective coordination of services and to assess the client's progress and current needs.

Intensive Home Based Services: Intensive home based services will be provided to improve the client's adjustment and interactions with family to maintain placement. It will also be used to prevent crisis and hospitalization from occurring.

Who may write and sign a Treatment Plan: Licensed, waivered, registered staff (MD, NP, RN, Ph.D., LCSW, LPCC, LMFT, ASW, Associate MFT, Associate PCC), and master's student trainee (with licensed LPHA co-signature)

Active Treatment Plans: Treatment plans are client specific and only one active treatment plan at a time can exist. Multiple service providers must work together to collaborate and update/revise treatment plans as needed.

PLANNED VS. UNPLANNED SERVICES TIP: All services except for assessment, plan development, and crisis services must be on the treatment plan to be billed. If Anasazi cues you that you are entering an "unplanned"service when entering a progress note, this indicates that the service is not listed on the treatment plan or that the treatment plan has expired. An informational note must be entered instead of a billable unplanned service progress note. Also, the clinician should be notified to redo the treatment plan and add the service.

Progress Notes

Progress notes are based on the treatment plan. The assessment, treatment plan and progress notes are interrelated and dependent upon each other. They represent a continuous process in treatment. Documentation is required for each service that is provided. The client record provides timely documentation of relevant aspects of the client's care. The provider uses the client's records to document provided services, including relevant clinical decisions and interventions.

Standard Elements of the Progress Note:

- Start time
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into the session must be noted.
- **Behavior/symptoms** currently reported and related to the treatment plan that meet medical necessity for the service being delivered:
    - Include current functioning/impairments affecting daily living
    - What are the client's/guardians/teachers observations, thoughts, direct quotes?
    - What does the provider observe (affect, mood, appearance)?
- **Interventions:**
    - Be specific about interventions that were done with the client to achieve symptom reduction and reduce impairment in functioning.
    - Include referrals and linkages to other agencies, treatment provided, and clinical decisions made.
- **Outcome and Response to Interventions and Progress in Treatment:**
    - Include the client's response to the interventions provided during session.
    - Indicate how treatment is progressing.
    - Include any impediments to treatment.
- **Plan for continued services:**
    - Identify the provider's specific activity planned for the client between this and the next session.
    - Must relate to treatment plan goals and identified interventions.
    - Include plans for referrals and continuation or change of the treatment plan. Do not simply write, "Plan is to meet with the client next week."
- **Safety:** If safety concerns are brought up in the session, please add the following information to the progress note.

- Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

Corrections to the electronic record:

- *Non-Final Approved:* Can make changes to service indicators, date, and content of note
- *Final Approved but not yet billed to Medi-Cal:* Can make changes to service indicators only.
- *Final Approved and billed to Medi-Cal:* Complete billed in error form (see appendix 6).

Corrections to the hard copy chart:

- Draw a line through the erroneous documentation
- Initial and date
- Add correct documentation
- Never use white-out

Standard timeline for progress note entry:

BHD's policy is that progress notes are to be entered and signed by the service provider within 6 business days including the day of service. A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document “late entry” at the top of the progress note.

Progress notes for multiple services during a client session:

There are occasions when a client receives more than one service during a session. An example is when case management and therapy are provided in the same contact.

If one progress note is done for a group session it may be signed by one provider. In addition, while one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note must clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements must also be met.

Furthermore, when services are being provided “by two or more persons at one point in time, each person’s involvement shall be documented in the context of the mental health needs of the beneficiary.” (Cal. Code Regs., tit. 9 § 1840.314(c))

Billing lockouts:

Staff cannot bill for therapeutic services when the client is in an acute inpatient hospital, PHF, crisis stabilization unit, day treatment program during program hours, jail or juvenile hall unless the juvenile has been adjudicated and is awaiting placement.

Reasons for Disallowance

The primary reasons for disallowance (dollar loss) during a Medi-Cal audit are:

- No valid assessment or treatment plan for the service being claimed
- No progress note was found for the service claimed
- The time billed to Medi-Cal was greater than the time documented.
- The progress note indicates that the service was provided while the client resided in a setting where the client was ineligible for Federal Financial Participation (FFP), such as Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts.
- The progress note indicates that the service provided was one of the following:
  1. Academic educational service
  2. Vocational service that has work or work training as its actual purpose
  3. Recreation
  4. Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.
  5. The claim for a group activity was not properly allocated to all clients present.
  6. The progress note does not contain the signature of the person providing the service.
  7. The progress note indicates that the service was solely transportation.
  8. The progress note indicates that the service provided was solely clerical (appointment confirmation, appointment scheduling).
  9. The service claimed is not supported by the documentation (ex: collateral service code used, but the service provided is case management).
  10. The service is solely to complete programmatic, administrative, fiscal, or MHSA forms or paperwork.
  11. Two providers claimed the same service at the same time, and the time was not split between the two. However, intensive care coordination (ICC) service allows for multiple service providers to claim their active participation in ICC meetings.
  12. The treatment plan objectives were not observable or measurable.
  13. The services were not related to the client.
  14. No mental health service was provided.
  15. "Proximity" support or "observation" are not billable.

Case Management

Case Management is defined in regulations as “services that assist the beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services pertaining to a beneficiaries treatment plan. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development" (as distinct from plan development described on page 37). Case Management may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law. **PLEASE NOTE: Case management services may now be provided to clients prior to treatment planning.** Examples include, helping the client to obtain needed resources through referral or linkage that will help them to stabilize or prevent deterioration.

Interventions that may be provided using this code can include one or more of the following as it pertains to client’s mental health needs, and medical necessity:

Linkage

- Assisted a client by communicating on behalf of the client with community providers in order to obtain a needed service related to the client's treatment plan. Transportation provided by case managers does not count as a billable linkage service, but the time the case manager spends traveling to and from the client's location is billable.

Brokerage

- Located and arranged for services on the client's behalf that are related to the client's treatment plan.

Monitoring

- Overseeing that the client has accessed and is receiving services by a provider, and that the services are effective.
- Monitoring the client's progress towards the client's treatment plan goals and objectives.

Advocating

- Advocating that the client obtain needed services related to their treatment plan and/or that their service is improved.

Access to services

- Assisting clients to access needed medical, vocational, educational, social, rehabilitative, or community services as those services pertain to the client's treatment plan.

Referral

- Assisted client with a referral to needed services through consultation and coordination with a provider.

Staffing Requirements: Case management services can be provided by licensed, waivered, registered staff (Ph.D., LCSW, LPCC, and LMFT), Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and Other Qualified Provider.

Service Location: Case management services can be provided at the program site, in the field, or over the telephone.

Case Management versus Rehabilitation Service:

The process of deciding what type of service you are providing can start with a question, **"Am I connecting the client with services or am I providing skill-building, training or assisting the client?"** If your answer is "connecting," you are providing case management. Case management assists with access to services. It can be done with another provider or support person. The client does not need to be present. Case management involves linkages, monitoring progress, advocating, brokering or ensuring access with or on behalf of the client.

If you answer "providing training," you are providing rehabilitation services. Rehab activities are done with the client to educate, teach, coach, or assist with a skill needed by the client to manage mental health symptoms and reinforce daily living skills.

Charting Tips for Case Management:

- Tie service into the identified symptoms on the treatment plan.
- Use a verb that describes the case management activity (for example, linked, monitored, collaborated, consulted, and advocated for)
- Comment on client functioning in one of the following areas: living arrangement, social support, health, daily activities as it relates specifically to the treatment plan goals.
- Document plan for future services and explain how information from the case management session will impact future plans for the client's care.

Case Management Progress Note Format WITH the Client Present:

- Start time
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into session must be noted.
- **Behavior:** Symptoms currently reported and related to the treatment plan that meet medical necessity for the service being delivered:
    - Describe the current symptoms/impairments that require a case management intervention
- **Intervention:** Provide a concise description of what service was provided to address the client's medical necessity symptoms/impairments. Include the following:

- Identify the case management intervention (linkage, monitoring, referral, etc.)
- Provide specific and individualized description of interventions implemented to address the problem
- Statement tying the client's need/problem and the intervention provided to the client's symptoms/impairments

- **Outcome:**
  - Include the client's response to the interventions provided.
  - Include any barriers to the client or others following through.

- **Plan:** (outline the plan/next action steps needed to assist client with linkage of supportive services)
  - Specific plan for follow-up and the next action steps that are needed to eventually lead to recovery and becoming independent from mental health services. In this section, also include follow-up for the client and/or their family/significant support person.

- **Safety:** If safety concerns are brought up in the session, please add the following information to the progress note.
  - Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

Example Case Management Note

B - Client continues to struggle with physical aggression and defiance that results in hitting, inability to control his anger, and communicate his feelings effectively. This continues to interfere in client's relationships both at home and at school and impacts his level of functioning.

I - This writer facilitated referral and linkage between the client and the agency that provides a 6-week anger management group. The group topics focus on effective communication, appropriate expression of feelings, and conflict resolution skills. These topics will aim to assist client in meeting his goals and objectives in order to reduce physical aggression.

O - The client said that "I have to go because of probation" and admits to not wanting to go. Client accepted the referral and seemed to comprehend how to follow through.

P - Will follow-up with client to confirm enrollment in group, obtain an authorization to release information to the referral agency, and will consult with group facilitator regarding client's progress in group. Will encourage client to attend and participate in all group sessions.

<u>Case Management Progress Note Format WITHOUT the client present</u>:

Use this format for case management services performed over the phone; by staff only on behalf of the client; or to a collateral or service provider. **Should not be in the BIOP format but be sure to include these elements.**

- Start time

- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document “late entry” at the top of the progress note.

- If applicable anywhere in the progress note, record any pertinent cultural or human diversity issues that are impacting the client and what efforts are being made to adapt treatment to these issues (e.g., language interpretation service needed, large format materials, culturally relevant referral).

- Document what prompted the need for the case management services.

- Briefly explain how the case management interventions provided specifically address the client's functional impairments and the treatment plan objective.

- **Intervention:**

    - Identify the case management intervention (linkage, monitoring, access to care, referral, advocacy, brokerage)
    - Provide specific and individualized description of interventions implemented to address the problem

- If the case management service is a formal meeting between the behavioral health specialist and the clinician or other providers directly involved in the client's care, only bill when there have been significant changes to the client's symptoms or impairments. **Routine staffings are not billable services under case management.** If there are significant changes, document what was discussed in terms of the client's service needs, and the action plan. Document only for your unique contribution to the meeting and the time it took.

Rehabilitation Services

Rehabilitative mental health services are services recommended by a physician or other licensed mental health professional within the scope of his or her practice under State law, for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a beneficiary's functional level. Rehabilitative mental health services allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention. Rehabilitative mental health services include services to enable a child to achieve age-appropriate growth and development. It is not necessary that a child actually achieved the developmental level in the past. Rehabilitative mental health services are provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency.

Rehabilitation services may include any or all of the following and must tie to the treatment plan, diagnostic symptoms, and functional impairments:

- Organizing, arranging and conducting activities that provide assistance in restoring or maintaining a client's functional skills, living skills, social skills, grooming/personal hygiene skills, meal preparation skills, medication compliance, and support resources related to the client's treatment plan objectives.
- Assisting the client and/or significant support persons (when the client is present) with skill building and psychoeduation as a means to decrease or manage behaviors/symptoms and achieve goals.
- Training in activities needed to achieve the client's goals/desired results/personal milestones.

Staffing Requirements: Rehabilitation services can be provided by licensed waivered, registered staff (Ph.D., LCSW, LPCC, and LMFT), Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and Other Qualified Provider.

Service Location: Rehabilitation services can be provided at the program site, in the field, or on the telephone. Rehabilitation can be provided individually or in groups.

Individual Rehabilitation Progress Note format:

- Start time.
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into session must be noted.
- **Behavior:** Symptoms currently reported and related to the treatment plan that meet medical necessity for the service being delivered:
    - Describe the current symptoms/impairments that require a rehabilitation intervention
- **Interventions:**

- Describe how the practitioner intervened and assisted, and use words such as encouraged, modeled, taught, roleplayed, discussed, and suggested.
- Be specific about the skills being taught to the client to achieve symptom reduction and reduce impairment in functioning.

- **Outcome and Response to Interventions and Progress in Treatment:**
  - Include the client's response to the interventions provided during session
  - Indicate how treatment is progressing
  - Include any impediments to treatment

- **Plan for continued services:**
  - Identify the provider's specific activity planned for the client between this and the next session.
  - Include plans for referrals and continuation or change of the treatment plan interventions. Do not simply write, "Plan is to meet with the client next week."

- **Safety: If safety concerns are brought up in the session, please add the following information to the progress note.**
  - Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

TIP: REHABILITATION SERVICES KEY PHRASES

- Offered assistance with, to, or on behalf of ...
- Offered training to/taught client (and significant support person)
- Offered encouragement to, for, in regards to ...
- Modeled, roleplayed, described, demonstrated (a skill)
- Assigned homework for client (and significant support person) to practice the skill we worked on today.
- Provided psychoeducation/information regarding ...

Example of Individual Rehabilitation Progress Note

B - The client continues to have difficulty with acting out his anger by hitting and kicking. The client has not spit since the last session and over the last week has only become physically aggressive 2 times. Behaviors continue to cause risk to self and others.

I -This writer met with client and utilized anger management activity (Stop, Think, Act) which helped the client to focus on thinking about consequences of his behaviors so that he will minimize his physical hitting and kicking. This writer engaged client in roleplay and role reversal of anger management, conflict resolution, and communication skills as a means to improve client's self-regulation and decision-making skills.

O - Client was able to show appropriate use of the skills in session; however, he had difficulty when trying to incorporate some of the skills across different situations. In general, client appears to be

showing overall progress toward meeting objectives as evidenced by his decrease in physical aggression.

P - Will meet again in one week to work on breathing and progressive muscle relaxation in order to help client further his ability to stay calm and rational with decision-making therefore choosing more appropriate behaviors when angry.

Example of Individual Rehabilitation Progress Note with Family

B - The client continues to have difficulty with acting out his anger by hitting and kicking. The client has not spit since the last session and over the last week has only become physically aggressive 2 times. Behaviors continue to cause risk to self and others.

I -This writer met with client and parent and utilized anger management activity (Stop, Think, Act) which helped the client to focus on thinking about consequences of his behaviors so that he will minimize his physical hitting and kicking. This writer engaged client and parent in roleplay and role reversal of anger management, conflict resolution, and communication skills as a means to improve client's self-regulation and decision-making skills and to assist parent with prompting client to use the skills when becoming angry or aggressive.

O - Client was able to show appropriate use of the skills in session; however he had some difficulty when trying to incorporate some of the skills across different situations. Parent also participated in session by practicing prompts from therapist during roleplay with client. In general, client appears to be showing overall progress toward meeting objectives as evidenced by his decrease in physical aggression and parent reports that learning new skills will allow her to continue to help client.

P - Will meet in one month to work on breathing and progressive muscle relaxation in order to help client further his ability to stay calm and rational with decision-making therefore choosing more appropriate behaviors when angry.

TIP: STEPS TO HELP A CLIENT LEARN A SKILL

Understanding the steps involved in helping the client learn a new skill makes teaching the skill and documenting the skill easier.

1. Describe the skill and discuss it with the client
2. Demonstrate the skill and answer questions that the client might have
3. Have the client demonstrate the skill step and provide feedback to the client.
4. Homework of practicing the skill step
5. Demonstrate as needed, incentivize as needed (prompt, reward)

The skill building process can take a number of sessions of demonstrating steps, prompting, modeling and reinforcing/rewarding. Report in the progress note if building a specific skill takes place over a number of sessions. Be specific about the process involved and the client's response in your notes.

MHSA Services

Not all of the services that we provide to clients are billed to Medi-Cal. The following are additional codes that should be utilized through the Mental Health Services Act (MHSA) program, for activities on behalf of unserved, underserved community members; and clients who are full-service partners (FSPs) with open cases.

115: MHSA CSS Outreach and Engagement
Provided assistance or activities to reach, identify, and engage *unserved* individuals and communities in the mental health system and reduce disparities identified by the County. "Unserved" means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved. **If there is a client number, document the service in an informational note. If there is not an open case, then document the service time in the individual client services record in Anasazi.**

116: MHSA PEI Access and Linkage to Treatment
Activities to connect individuals with severe mental illness to medically necessary care and treatment (FQHC, Beacon, Behavioral Health, Indian Health Services), improving timely access to services, and facilitating prevention groups for underserved populations. Provide prevention and early intervention services to consumers who are not open to Behavioral Health.
PLEASE NOTE: This code is restricted (at this time) to use by case managers who are providing prevention and early intervention (PEI) services at a supervisor's request. **Document the service time in the individual client services record in Anasazi.**

117: MHSA Support
Provided to FSP clients, the "whatever it takes" services to reduce the risk of homelessness, use of the emergency room, incarceration or hospitalization. In addition for youth, providing services to FSP clients aging out of foster care or juvenile justice to reduce the same risks. These services might relate to the client's diagnosis and impairments but it is not required that they are identified on the treatment plan. Examples may include securing housing in more intensive means then usual by helping clients to complete rental applications, taking them to see properties and talking with landlord; to purchase items such as food on CalCards or taking clients to food banks. **Document the service in an Anasazi progress note.**

Collateral

Collateral is a service activity involving a significant support person (e.g., family member, caregiver or guardian) in a client's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this activity. Remember, that appropriate releases of information must be completed prior to sharing information.

Collateral services may include any or all of the following:

- Training of a significant support person to increase understanding of the client's mental illness.
- Training a significant support person in assisting the client in managing his mental health symptoms or training the significant support person in managing the symptoms and behaviors.
- The service must show how the collateral intervention helped the significant support person improve, maintain or better understand the mental health of the client.

Significant Support Person:

A significant support person is defined as someone who has, or could have, an influential role in the successful outcome of treatment. A significant support person may be the parents or legal guardian of a client who is a minor, relatives, a person living in the same household as the client, or other adult person who has the ability to influence treatment success through their interaction with the client.

Staffing Requirements: Collateral services can be provided by licensed, waivered, registered staff (Ph.D., LCSW, LPCC, and LMFT), Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and Other Qualified Provider..

Service Location: Collateral services can be provided at the program site, in the field or by phone. Collateral groups cannot be provided by phone.

Collateral Progress Note format:

- Start time
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into session must be noted.
- Tie the service into the identified behaviors or symptoms on the client's treatment plan. Do not focus on the significant support person's behavioral issues.
- Describe how the interventions help a significant support person improve, maintain or better understand the mental health status of the client (e.g., putting together behavioral chart with a

parent, teaching how to better reinforce appropriate behaviors, discussing the mental health disorder with the care provider). Interventions include:

  - Providing psycho-education to collaterals about the client's mental illness
  - Provide specific skills training to collaterals to help them aid the client to achieve a client plan goal/objective.
  - In order to address the client's goals and objectives through therapy when the client is not present.

- Document the collateral's response to the intervention.

- Document the plan for continuing services to the collateral and/or client. Document alternative approaches for future interventions if applicable. Document if referrals to community resources and other agencies were given.

TIP: Collateral versus Case Management Services

Collateral: Collateral is a service where the practitioner educates, informs, trains a significant support person (family member, caregiver or guardian). When providing a collateral service, the provider educates the support person on how to assist with the client's treatment plan goals or better understand the mental health condition.
Case Management: Case management is a service that monitors symptoms or progress toward treatment goals or a service that involves consultation or coordination with other treatment providers (including teachers and school personnel) for the purpose of coordinating care or linking to needed service. Case management usually involves monitoring, coordinating, linking and consulting as well.

Example of Collateral Progress Note

B-Parent reports that the client continues to have difficulty with acting out his anger by hitting and kicking. Over the last week, it's reported that the client has been physically aggressive 2 times. Behaviors continue to cause risk to self and others.

I-This writer provided psycho-education to parent about client's diagnosis and how it is manifested in his behaviors. This writer used CBT techniques to teach the connection between thoughts, feelings and behaviors and how to identify client's triggers so that she can better anticipate and respond to them. This writer helped the parent to generalize these interventions across client's home and community environments so that she can apply them effectively and prompt the client to use these skills in order to reduce physical aggression. This writer taught behavioral management techniques and developed a behavior chart/contract to increase consistency and follow through on consequences for physical aggression.

O- The parent was able to show an understanding of the skills by being able to verbalize how to apply them in different scenarios that are triggers for client. The parent participated in the development of the behavioral chart/contract and provided feedback on what has worked in the past and what has not

worked. It appears that parent is utilizing interventions as there is a reported decrease in escalation of his negative behaviors when parent intervenes and parent states that client is "making progress."

P- To continue to work with parent on behavior management techniques, consistency and implementation of behavioral chart/contract as a means to reinforce appropriate behaviors and decrease impulsivity and aggression.

Therapy

Medi-Cal's definition of therapy is "therapeutic interventions that focus primarily on symptom reduction as a means to reduce functional impairments." Therapy can be provided individually, with a family or in groups. The service can be provided in person, and to a group.

Staffing Requirements: Therapy services can be provided by licensed, waivered, registered staff (Ph.D., LCSW, LPCC, and LMFT) and masters student trainees (with co-signature).

Service Location: Individual therapy services can be provided at the program site, on the phone, or in the field. Group therapy services cannot be provided by phone but can be provided at the program site or in the field.

Charting Tips for Therapy Services:

- Tie service into the identified symptoms on the treatment plan
- Include specific interventions used.
- Focus documentation on symptom reduction.

Individual Progress Note format:

- Start time.
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into session must be noted.
- **Behavior:** Describe the current symptoms/impairments, improvement or deterioration of symptoms, results of assignments and any other pertinent info that occurred since the last contact with the client.
- **Interventions:**
    - Tie interventions into the identified symptoms on the treatment plan
    - Include specific interventions used
    - Focus documentation on symptom reduction
    - Document if any relevant clinical decisions were made
- **Outcome and Response to Interventions and Progress in Treatment:**
    - Include the client's response to the interventions provided during session.
    - Indicate how treatment is progressing.
    - Include any impediments to treatment.
    - Document quantitative or measurable progress towards the objectives on the treatment plan.

- **Plan for continued services:**
    - Identifies the provider's specific activity planned for the client between this and the next session.
    - Include plans for referrals and continuation or change of the treatment plan interventions. Do not simply write, "Plan is to meet with the client next week."
- **Safety: If safety concerns are brought up in the session, please add the following information to the progress note.**
    - Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

Example Individual Therapy Progress Note

B - The client continues to have difficulty with acting out his anger by hitting and kicking. The client has not spit since the last session and over the last week has only become physically aggressive 2 times. Behaviors continue to cause risk to self and others.

I - This writer used CBT techniques and roleplaying in order to help the client identify his triggers so that he can better anticipate and respond to them. This writer worked with the client on being able to verbalize his feelings and process his thoughts that lead to his physical aggression. This writer helped the client to generalize these interventions to his home and school environments so that he can apply them effectively.

O - The client was able to show an understanding of the skills by using them in roleplays and being able to verbalize what he should do when given different scenarios that are triggers for him. Client appears to be showing a reduction in target behaviors and is making progress toward meeting objectives.

P - Will meet in one week to continue to work towards treatment plan objectives and introduce decision-making and critical thinking concepts (Stop, Think, Act) and further work on feeling identification and expression as a means to decrease impulsivity and aggression.

Example Individual Therapy Progress Note with Family

B - Parent reports that the client continues to have difficulty with acting out his anger by hitting and kicking. The client has not spit since the last session and over the last week has only become physically aggressive 2 times. Behaviors continue to cause risk to self and others.

I - This writer used CBT techniques and roleplaying with client and parent in order to help the client identify his triggers so that he can better anticipate and respond to them. This writer worked with the client and parent on being able to verbalize his feelings and process his thoughts that lead to his physical aggression in order to assist with his ability to verbalize his feelings to his parents and others when angry as opposed to acting them out. This writer helped the client to generalize these interventions across client's home and school environments so that he can apply them effectively and coached the client's parent in how to prompt the client to use these skills when in these situations.

O - The client was able to show an understanding of the skills by using them in roleplays and being able to verbalize what he should do when given different scenarios that are triggers for him. The parent was able to appropriately prompt client during the roleplays without being a catalyst to client's anger escalating. It appears that client is utilizing interventions as there is a reported decrease in his negative behaviors and parent states that client is "making progress."

P - To continue to work towards treatment plan objectives and introduce decision-making and critical thinking concepts (Stop, Think, Act) and further work on feeling identification and expression as a means to decrease impulsivity and aggression.

Groups: Rehab, Therapy, Collateral

Group treatment is a method of service delivery which is conducted by one or two facilitators to more than two clients pertaining to a topic that is related to and can impact the clients' functional impairments, symptoms and treatment plan goals. Rehab skill building groups, collateral groups designed to educate and teach skills to significant support persons, and therapy groups specific to a diagnoses like anxiety, depression or psychosis, are all examples of billable groups.

Staffing Requirements: Group therapy can be provided by licensed, waivered, registered staff (MD, Ph.D., LCSW, and LMFT), master's student trainees (with LPHA co-signature if a therapy group) or Behavioral Health Specialists.

Group rehabilitation can be provided by licensed, waivered, registered staff (MD, RN, Ph.D., LCSW, and LMFT), Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and Other Qualified Provider.

Collateral groups can be provided by licensed, waivered, registered staff (MD, RN, Ph.D., LCSW, and LMFT), Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and Other Qualified Provider. The staffing requirements depend on whether the service activity is therapy or rehabilitation, but if the focus is on teaching skills to assist the client, it is considered rehabilitation.

TIP: BILLING FORMULA

For those billing in Anasazi at the Behavioral Health Division, Anasazi creates a billing formula for groups within the software. For contracted providers, formulas are required to be recorded on invoices and progress notes submitted for billing.

EXAMPLE: Group with one facilitator

Billable Time: 120 minutes of group + 45 minutes of documentation; + 30 minutes travel time = 195 minutes total divided by 6 clients = 32.5 minutes billed for each client.

EXAMPLE: Group with two facilitators

Billable Time: 120 minutes of group x 2 staff = 240 minutes; + 45 minutes of documentation + 30 minutes of travel time = 315 total minutes divided by 6 clients = 52 minutes billed for each client.

Service Location: Group services can be provided at the program site or in the field.

Charting Tips for Group Services:

- If only one person attends a group, the billing should be for individual therapy, rehab or collateral, etc.
- Make sure that the group topic ties to the individual's diagnosis and functional impairments, and document the relationship between the two.

- Bill only for clients who attend the full amount of the group's time. For any others, document an informational note.

Group Progress Note Format:

- Start time
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document “late entry” at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into session must be noted.
- **GROUP NOTE SECTION:** Document about the group topic, specific interventions used and group process.
- **INDIVIDUAL NOTE SECTION:**
    - **Behavior:** Describe the current symptoms/impairments, improvement or deterioration of symptoms, and any other pertinent info that occurred since the last contact with the client.
    - **Intervention:** Document how the group relates to the client's symptoms, impairments and diagnosis
    - **Outcome and Response:** Document about the client or collateral's response during the group, e.g., response to the topic, feedback and participation.
    - **Plan:** Document the plan for the client, if a new approach is needed or referrals are given.
    - **Safety: (If safety concerns are brought up in the session, please add the following information to the progress note.)** Identify safety issues and include a specific safety plan when the client presents with safety concerns.

Plan Development

Plan Development is defined as a service activity that consists of development and approval of treatment plans.

Staffing Requirements: Plan Development services can be provided by licensed, waivered, registered staff (MD, RN, Ph.D., LCSW, and LMFT), Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and Other Qualified Provider.

Service Location: Plan Development services can be provided at the program site, on the phone, or in the field.

Charting Tips Plan Development Services:

- Indicate who participated in the creation of the treatment plan.
- If client and/or guardian is unavailable or refuses to sign the treatment plan, a written explanation in the progress notes why the signature could not be obtained is necessary. This should also be documented as a client non-signature in Anasazi.
- On-going efforts to obtain a signature and evidence of client participation must be documented regularly in the progress notes if the client is initially unavailable or unable to sign.

Plan Development Progress Note Format when the Client IS Present:

- Start time.
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document “late entry” at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into session must be noted.
- Document medical necessity such as current symptoms and impairments discussed or observed at the session.
- Document the plan development session in terms of the discussion of the client's functional impairments, measurable objectives, what interventions would make the most impact, and the frequency of those interventions.
- Document the client's participation in the treatment planning and that of collaterals and other service providers.
- Document when you will meet with the client to review the written treatment plan. Offer a copy of the plan at the time it is completed.

Plan Development Progress Note format for staff when the client IS NOT present to document the plan in Anasazi:

- Start time.
- The service today is a continuation of the plan development meeting with the client on ____ (date).
- The client would like to work on _____ (general statement) or is unwilling/unable to participate in the planning process.
- Based on the client's diagnosis and functional impairments, (or progress towards previous plan goals and objectives if an update), a new plan will address _____ (general statement).
- **REMEMBER,** when claiming time when the client is not present for plan development:
    - **Service Time =** The time spent formulating and entering the plan into Anasazi.
    - **Documentation Time =** The time spent documenting the progress note.

Example of Plan Development Progress Note

This writer met with the client and parent in order to identify client and family strengths/goals, reviewed presenting problems, and developed the treatment plan goals and measurable and observable objectives. Client currently presents with anger displayed as physical aggression, hitting, kicking and spitting towards family members. The client displays these behaviors 4 times per week with moderate severity, and the duration has been over 3 months. Intervention modalities and frequencies along with time frames were established in order to address the client's behaviors and minimize risk factors and the current level of impairment. The client and parent participated fully in developing the client's goals and agreed to participate in interventions and keep appointments. The client's parent was offered free language services in her preferred language of Spanish for today's session which were delivered by an agency interpreter. The interpreter will translate the treatment plan to Spanish for the mother to review at the next session. Plan is to continue to work toward established treatment objectives and have weekly sessions with the client in order to reduce symptoms and negative behaviors of physical aggression. Will meet with the client and parent in one week to review the written treatment plan.

TIP: Combining obtaining treatment plan signatures with other services

Only in this one instance can clinical staff combine services in one progress note. If you obtain a client's signature and the time it takes is brief, document in the progress note that the signature was obtained and combine it getting the signature with whatever service you are billing afterwards (individual, rehab, medication management, case management, collateral).

Katie A. Services

Katie A. subclass members are children/youth who are members of a class of children in out-of-home care who meet medical necessity covered by a settlement agreement in a lawsuit Katie A. v. Bonta. These members have significant needs and by receiving Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) in their own home, family setting, foster home or the most homelike setting, will be most likely to improve their safety, performance and well-being. Therapeutic Foster Care (TFC) will also be available to children and youth when there is an individualized determination of need.

ICC, IHBS and/or TFC through the EPSDT benefit to all children and youth under the age of 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services. BHC will make individualized determinations of each child's/'youth's need for ICC, IHBS and TFC based on the child's/youth's strengths and needs. Neither membership in the Katie A. class nor subclass is a prerequisite to consideration for receipt of ICC, IHBS and TFC and therefore a child does not need to have an open child welfare services case to be considered for receipt of these services

Eligibility Requirements

Children/youth (up to age 21) are considered to be a member of the Katie A. subclass if they meet the following criteria:

- Are full-scope Medi-Cal eligible;
- Have an open child welfare services case; and
- Meet the medical necessity criteria for Specialty Mental Health Services (SMHS)

In addition to:

- Currently in or being considered for: wraparound, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive services, including but not limited to therapeutic behavioral services or crisis stabilization/intervention; or
- Currently in or being considered for high-level-care institutional settings, such as group homes, Short-Term Residential Therapeutic Programs (STRTPs), a psychiatric hospital or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs. In coordination with county child welfare agencies.

TIP: Katie A. MANUALS

Details are available for clinical staff who deliver ICC, IHBS and TFC in the following manuals:

- Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care for Medi-Cal Beneficiaries, 3rd Edition (January 2018)
- California Integrated Core Practice Model For Children, Youth and Families

Intensive Care Coordination

Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Core Practice Model (CPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems. 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 individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:

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

While the key service components of ICC are similar to TCM, a difference between ICC and the more traditional TCM is that ICC is intended for children and youth who:

- Are involved in multiple child-serving systems;
- Have more intensive needs; and/or
- Whose treatment requires cross-agency collaboration.

ICC also differs from TCM in that there needs to be a Child and Family Team (CFT) in place, to provide feedback and recommendations to guide the provision of ICC services. A key element of ICC is the establishment of an ICC coordinator.

ICC service components and activities are:

Assessing

- Assessing client's and family's needs and strengths
- Assessing the adequacy and availability of resources
- Reviewing information from family and other sources
- Evaluating effectiveness of previous interventions and activities

Service Planning and Implementation

- Developing a plan with specific goals, activities and objectives
- Ensuring the active participation of client and individuals involved and clarifying the roles of the individuals involved
- Identifying the interventions/course of action targeted at the client's and family's assessed needs

Monitoring and Adapting

- Monitoring to ensure that identified services and activities are progressing appropriately
- Changing and redirecting actions targeted at the client's and family's assessed needs, within 90 days

Transition

- Developing a transition plan for the client and family to foster long-term stability including the effective use of natural supports and community resources

Charting Tips for Intensive Care Coordination:

- Clinical staff, including the ICC coordinator, each claim the actual amount of time participating during the CFT meeting including active listening time.
- Each staff may claim up to the length of the meeting plus documentation and travel time.
- Participation time claimed (which may include active listening time) must be supported by documentation showing what information was shared and how it will be used in planning for client care or services to the client (e.g., how the information discussed will impact the treatment plan).
- Document your unique contribution to the meeting.

ICC Progress Note format:

- Start time

- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.

- Translation services or other culturally relevant assistance or interventions provided or integrated into session must be noted.

- **Example #1** Attended a CFT meeting, with client, his parents, ICC Coordinator and IHBS worker. We learned from the IHBS worker that Sam continues to isolate during recess because his peers do not like how he acts (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let him play with them. The IHBS worker and ICC coordinator review with the family different interventions to apply. Based on this information and discussion, the IHBS worker will focus interventions to strengthen Sam's pro-social behaviors while playing with peers by teaching, modeling and reinforcing behaviors such as listening rather than interrupting, waiting his turn, playing more gently and appropriately, and initiating social interaction with peers.

- **Example #2** Attended a CFT meeting with client, parent partners, CPS worker, ICC Coordinator and IHBS worker. During the CFT meeting, the team discusses the effectiveness of various

interventions intended to improve Sam's pro-social behaviors during recess at school. Sam's IHBS worker asks Sam to talk about how he has been practicing to wait his turn, and otherwise actively listens and learns how things have been going for Sam from the perspective of his teacher and his mom. The ICC coordinator shares that when she spoke to the recess monitor, the monitor said that Sam goes off by himself during recess when his peers do not like how he acts (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let him play. Mother is upset because she feels that the school staff are not following through with the support that they promised Sam. The IHBS worker and ICC coordinator review with the family different interventions to apply and how to keep track of progress.

- **Plan:** Identifies the CFT's specific interventions planned to address the client and family's needs/goals between this and the next CFT meeting. Document plans for referrals and continuation or change of the treatment plan interventions. **Example:** Based on the information and discussion at the CFT, the IHBS worker will focus interventions on strengthening client's pro-social behaviors through teaching, modeling and reinforcing behaviors such as listening rather than interrupting, waiting his turn, playing more gently and appropriately, and initiating social interaction with peers. The CFT will meet again in approximately one month.

- **Safety: If safety concerns are brought up in the session, please add the following information to the progress note.**
  Include a specific safety plan when the meeting includes a discussion of safety concerns and/or safety plan.

Intensive Home Based Services

Intensive home based services (IHBS) are intensive, individualized strength-based interventions activities designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the Core Practice Model (CPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities 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 the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

The difference between IHBS and more traditional outpatient Specialty Mental Health Services (SMHS) is that IHBS is expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the child's or youth's client plan, and will be predominantly delivered outside an office setting, and in the home, school, or community.

Intensive Home Based Service activity includes, but is not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant others to assist them in implementing the strategies.
- Development of functional skills to improve self-care, self-regulation, or other functional impairments. IHBS targets decreasing non-functional behavior that interferes with daily living tasks. IHBS is expected to be of significant intensity to address the intensive mental health needs of the child/youth; be consistent with the plan and the California Integrated Core Practice Model For Children, Youth and Families; and predominantly be delivered outside an office setting and in the home, school or community.
- Development of skills or replacement behaviors that allow the child/youth to fully participate in the CFT.
- Improvement of self-management of symptoms, including self-administration of medications as appropriate.
- Education of the child/youth and/or their family or caregiver about, and how to manage the child/youth's mental health disorder or symptoms.
- Support of the development, maintenance and use of social networks including the use of natural and community resources.
- Support to address behaviors that interfere with the achievement of a stable and permanent family life.
- Support to address behaviors that interfere with seeking and maintaining a job.
- Support to address behaviors that interfere with child/youth's success in achieving educational objectives in an academic program in the community.
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

Service Settings:

IHBS may be provided in any setting where the child/youth is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, child care centers, and other community settings. IHBS are typically provided by paraprofessionals under clinical supervision. IHBS may not be provided to children/youth in group homes except when children/youth that are transitioning to a permanent home environment to facilitate the transition and when delivered outside of the group home.

IHBS Progress Note format:

- Start time.
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into the session must be noted.
- **Behavior:** Describe the current symptoms/impairments, improvement or deterioration of symptoms, and any other pertinent info that occurred since the last contact with the client and significant support persons.
- **Interventions:**
    - Tie interventions to the IHBS service activities listed in this section.
    - Document where the service was conducted
    - Include specific interventions used and intervention language like modeled, taught skill, supported, etc.

  Example #1: IHBS worker met with Sam and his mother at their home to teach Sam behavior management skills so he can gain better self-control when upset. Explained and modeled to both mother and Sam four different self-calming techniques to use when upset.

  Example #2: IHBS worker met with and observed Sam at his school during recess. Sam became upset with a peer and started banging his head on the playground climbing structure. IHBS worker prompted Sam to walk away and use one of the self-calming techniques that he has been practicing. Sam used deep breathing techniques and was able to calm himself down. IHBS worker praised him for walking away and doing the deep breathing exercises.

  Example #3: IHBS worker met with Sam's mom to assist her in ways of communicating without getting so upset. IHBS worker explained to mom how her anger impacts Sam's reaction and taught her different ways of expressing herself when she is upset.

- **Outcome and Response to Interventions and Progress in Treatment:**
    - Include the client's response to the interventions provided during session.
    - Indicate how treatment is progressing and any impediments to treatment.
    - Document quantitative or measurable progress towards the objectives on the treatment plan.

- **Plan for continued services:**
    - Identify the IHBS worker's specific interventions planned to address the client and family's needs/goals.
    - Include plans for referrals and continuation or change of the treatment plan interventions.
- **Safety: If safety concerns are brought up in the session, please add the following information to the progress note.** Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

Therapeutic Foster Care

Therapeutic Foster Care (TFC) Services model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized 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. The TFC parent will provide trauma informed interventions that are medically necessary for 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).

TFC may be provided under 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.

Membership in the Katie A. subclass is not a prerequisite to receiving TFC. It is not necessary for a child or youth to have an open child welfare case, or be involved in juvenile probation, to be considered for TFC.

BHD will make individualized determinations of need for TFC based on each child's or youth's strengths and needs. TFC is appropriate for children and youth with more intensive needs, or who are in or at risk of placement in residential or hospital settings, but who could be effectively served in the home and community. TFC must be provided by TFC parents who are approved by a TFC Agency that meets licensure and accreditation requirements established by the California Department of Social Services (CDSS).

Child welfare departments have an affirmative responsibility to identify, screen, and refer children and youth who are in the child welfare system, and may be in need of TFC.

Other entities, such as juvenile probation, have an affirmative responsibility to identify, screen, and refer children and youth who may be in need of TFC.

Instructions and examples for TFC documentation are provided in the Medi-Cal Manual for ICC, IHBS and TFC, 3rd Edition on pages 61-69.

Crisis Intervention

Crisis intervention is a service, lasting less than 24 hours, to or on behalf of a client for a condition which requires a more immediate response than a regularly scheduled visit. Crisis intervention services can include, but are not limited to, assessment, collateral and therapy. **Crisis intervention is defined as an intervention used to address an escalated physical or psychological state of the client.**

Staffing Requirements: Crisis intervention services can be provided by licensed, waivered, or registered staff or Behavioral Health Specialists.

Service Location: Crisis intervention services can be provided at the program site, in the field, or over the phone.

TIP: The crisis intervention service in Anasazi

For service code 104 MH-Crisis Intervention delivered in the course of day-to-day client contacts, select "crisis" under the code for "Intensity." A progress note is sufficient clinical documentation for this intensity of a crisis intervention service.

Crisis Progress Note format:

- Start time
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document “late entry” at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into the session must be noted.
- **Behavior:**
    - Describe the client's symptoms/impairments resulting in a crisis condition.
    - Identify the crisis being clear about the urgent nature of the crisis.
- **Interventions:**
    - Assess and identify safety issues and include the recommended safety interventions planned for the client (and the client's collaterals when appropriate).
    - Describe what the practitioner did to de-escalate the client and the rationale for that intervention.
- **Outcome and Response:**
    - Describe the client’s response pertaining to the interventions and safety plan.
- **Plan:**
    - Identifies the provider’s specific plan for crisis follow-up including the specific date/time, and with whom.
    - Document identify additional resources/referrals given.

TIP: Documenting Safety

Remember to be clear about the resolution of the crisis and the specifics of the safety plan!

Example Crisis Intervention Progress Note

B - Received a call from client's mom reporting that client is currently making threats to kill herself and is agitated, crying, and screaming and has locked herself in the bathroom. Mom reports that she and client had an argument earlier in the day about client's poor grades and poor choices.

I - Validated mom's concerns about the situation and asked mom to ask client to come out of the bathroom to speak with this writer. This writer coached mom in using a calm tone of voice when asking and to assure client that she was not in trouble. This writer could hear client crying and she did comply with the request with minimal prompting. The client confirmed for this writer that she wants to kill herself and continued to cry. This writer validated client's feelings about the situation, reminded her of using deep breaths as a means to calm down and stop crying, and process her current thoughts of wanting to kill herself. Developed a safety plan to include a verbal no-harm contract, the identification of two family members she can call, and provided the phone number to the 24-hour suicide hotline. Client allowed mom to participate in the conversation and safety plan.

O - Although client was resistant to talk with this writer at first, she complied and was able to de-escalate, stop crying, and include her mom in the development of the safety plan. Client verbally agreed to utilize the safety plan and contracted to not harm herself. Client reports feeling calmer and will go to mom for support. Mom confirms that client is calm and not in danger to hurt herself at this time. Mom reports that if the client needs further assistance, she will transport her to the hospital emergency room or call the police for help.

P - A follow-up contact is scheduled with the client and mom tomorrow. This incident will also be shared with the case manager for assistance in managing the client's impairments and symptoms.

S - Developed and reviewed client's safety plan, provided mom the address and phone number of the hospital, and instructed mom to call 911 as needed.

Therapeutic Behavioral Services

Therapeutic Services (TBS) are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan. TBS is a unique, intensive outpatient treatment intervention for clients provided in the home, school, or community settings. TBS provides one-to-one support in helping children/youth replace inappropriate behavior with more suitable behavior to improve the ability for clients to remain in their home placements. TBS can reduce the need for costly high-level group home placement, hospitalization or incarceration.

Entitlement Criteria the client must:

- Be age 21 or under
- Have full scope Medi-Cal
- Meet medical necessity for, and are already receiving, other specialty mental health services.
- Is a member of the "certified class":
    - The client is currently in a Rate Classification Level (RCL) 12 or higher group home, state mental health hospital or IMD
    - Or the client is at risk for placement in a RCL 12 or higher group home, hospital or IMD
    - Or the client had an emergency admission to an acute psychiatric inpatient unit in the preceding 24 months
    - Or the client has previously received TBS
    - Or is being considered for hospitalization

> ***TIP:*** *TBS services must be added to the referring party's treatment plan.*

Therapeutic Behavioral Services Progress Note format:

- Start time.
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into the session must be noted.
- **Behavior:**
    - Describe the medical necessity for services e.g., current symptoms, improvement or deterioration of symptoms, impairments, and any other pertinent info that occurred since the last contact with the client and significant support persons.
- **Interventions:**

- The interventions must be focused on resolving target behaviors or symptoms which jeopardize the existing placement as outlined in the TBS treatment plan.

- **Outcome and Response to Interventions and Progress in Treatment:**

  - Include the client's response to the interventions provided during the session.
  - Indicate how treatment is progressing and any impediments to treatment.
  - Document quantitative or measurable progress towards the objectives on the treatment plan.

- **Plan for continued services:**

  - Identifies the provider's specific activity planned for the client between this and the next session.
  - Include plans for referrals and continuation or change of the treatment plan interventions. Do not simply write, "Plan is to meet with the client next week."

- **Safety: If safety concerns are brought up in the session, please add the following information to the progress note.**

  - Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

Example TBS Assessment Progress Note

B - Client presented with behaviors including of physical aggression (hitting, kicking and spitting) when angry or when presented with triggers. Frequency of symptoms is daily and has been present for over 2 months with a severe intensity. Behaviors cause significant impairment in functioning in both home and school (poor relationships, chronic arguing, and suspensions) and present a risk to client's placement.

I - Conducted intake for TBS services. Reviewed credentials, confidentiality and its limits, informed consent, HIPAA and TBS service model. Assessed behaviors and their frequency, duration and intensity. Explored triggers and antecedents to the behaviors and how they are impairing his functioning and daily living. Assessed client's needs and strengths, risk factors, and need for further referrals.

O - Client and parents were interactive in the session, and participated in the assessment process as evidenced by being cooperative, and providing information about presenting problems.

P - Further develop rapport, collaborate with clinician. Will meet again in five days to develop the treatment plan goals.

Example TBS Plan Development Progress Note

B - Client currently presents with anger displayed as physical aggression, hitting, kicking and spitting. The client displays these behaviors 4 times per week with moderate severity, and the duration has been over 3 months. Client's behaviors pose a risk of placement and juvenile hall involvement. The client defies authorities, is disrespectful, talks back, and refuses to follow rules.

I - This writer met with the client, parents and treatment team in order to identify client and family strengths/goals, review presenting problems, and develop the treatment plan goals with measurable and observable objectives. Intervention modalities and frequencies along with time frames were established in order to address the client's behaviors and minimize risk factors and current level of impairment. Offered the family a copy of the treatment plan.

O - The client and parents participated fully in developing their goals. Client was somewhat resistant to taking responsibility for his behaviors; however feels that the next 30 days objectives are realistic and obtainable. Client agreed to participate and meet with his treatment team. Obtained client, parents and treatment team signatures.

P - Plan is to continue to work toward established treatment objectives and have sessions with the client and caregiver. Plan to reconvene in 30 days in order to review progress and/or setbacks and revise the treatment plan as needed.

Example TBS Progress Note

B - Client is having bouts of physical aggression on a daily basis but parents report that the anger is less intense and lasts a shorter period of time than last week. The client can be redirected at times by mother. Parents and client say that the client is behaving much better at school and complying with the teachers requests with the interventions that this writer showed the client at their last meeting at the school. Client says "I get mad when my dad yells at me." The client says that loud noises "set me off."

I - Met with client and his parents in the home. Discussed communication patterns in the family when client becomes upset and acts out in anger. Roleplayed with family and client communication techniques to reduce tension and escalation for all. Offered client an incentive for practicing skills until the next session.

O - Client and parents interacted well during the session, and participated in the roleplay. They discussed barriers to practicing new skills "when things are happening." They agreed to practice communication skills at family meals for the next three days. Client was enthusiastic about incentive that will be given to him by this writer, if he practices his skills.

P - Will discuss improvement with clinician and monitor client's progress towards his treatment plan goal of expressing angry feelings appropriately when communicating with family members and teachers. Will meet again in four days.

Medication Support Services

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

Medication Evaluation

Medication evaluation activities are provided by psychiatrists and psychiatric nurse practitioners and are usually performed face-to-face, or by video conferencing with the client or significant support persons, and are office-based. These services include:

- Evaluation of the need for psychiatric medication
- Evaluation of clinical effectiveness and side effects of psychiatric medication
- Medication education, including discussing risks, benefits and alternatives with the client or support persons and completion of medication consents
- On-going monitoring of the client's progress in relation to the psychiatric medication
- Prescribing, dispensing, and administering of psychiatric medications
- The maximum amount claimable to Medi-Cal for medication support services in a 24-hour period is 4 hours (240 minutes) per client
- Treatment plan development related to medical services

> ***TIP:*** Consultation with the client's primary care provider is a non-billable service and as such must be documented in an informational note. When consulting, make certain to have the unit's Health Assistant record the contact in the psychiatric consultation log.

Medication Evaluation Progress Note Format:

- Start time
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document "late entry" at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into the session must be noted.
- **Behavior:**

- Describe the current medical necessity for treatment including current symptoms, improvement or deterioration of symptoms, impairments, and any other pertinent info that occurred since the last contact with the client and significant support persons.

- **Interventions:**

  - Document what medications are being prescribed for the client's diagnosis and symptoms.

  - List the medications prescribed that the client agrees to take following the appointment.
  - Document any medications changed.
  - Document if medication consent forms are completed and signed by MD and client and/or legal guardian for any new medications (see appendix 11 for the medication consent policy and procedure).
  - Document if education about medication, side effects, etc. were provided to the client and/or legal guardian.
  - Document if a new treatment plan was developed and signed

- **Outcome and Response to Interventions and Progress in Treatment:**

  - Include the client's response to the interventions provided during the session.
  - Indicate how treatment is progressing and any impediments to treatment.
  - Document measurable progress towards the objectives on the treatment plan.

- **Plan for continued services:**

  - Identify the provider's specific plan for the client between this and the next session, e.g., lab work
  - Include any plans for referrals and continuation or change of the treatment plan interventions
  - Note the time frame of recommended return for medication evaluation.

- **Safety: If safety concerns are brought up in the session, please add the following information to the progress note.**

  - Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

Medication Management

Medication management activities are provided by RNs, LVNs and psychiatric technicians and are usually performed face-to-face or by video conferencing with the client or significant support persons and are office-based. These services include:

- Administering, dispensing and monitoring of psychiatric medications that are necessary to alleviate the symptoms of mental illness e.g., injections.

- Taking of vitals

- Instruction in the use of medication

- Treatment plan development related to medical services.

Medication Management Progress Note Format:

- Start time
- A note is a "late entry" if it is entered after the end of the 6th business day including the day of service. If that is the case, document “late entry” at the top of the progress note.
- Translation services or other culturally relevant assistance or interventions provided or integrated into the session must be noted.
- **Behavior:**
    - Describe the current symptoms/impairments, improvement or deterioration of symptoms, and any other pertinent info that occurred since the last contact with the client and significant support persons.
- **Interventions:**
    - Document if instruction or education about medication, side effects, etc. were provided to the client and/or legal guardian.
    - Document if a new treatment plan was developed and signed.
    - Document the administration, dispensing and monitoring of psychiatric medications e.g., injections.
    - Document vitals if taken
- **Outcome and Response to Interventions and Progress in Treatment:**
    - Include the client’s response to the interventions provided during the session.
    - Indicate how treatment is progressing and any impediments to treatment.
    - Document measurable progress towards the objectives on the treatment plan.
- **Plan for continued services:**
    - Include any plans for referrals and continuation or change of the treatment plan interventions if applicable.
    - Note the time frame of recommended return for service such as injections.
- **Safety: If safety concerns are brought up in the session, please add the following information to the progress note.**
    - Assess and identify safety issues and include a specific safety plan when session includes a discussion of safety concerns and/or safety plan.

Psychological Testing Services

Psychological Testing Services are formalized measures of mental functioning, and include written, visual, or verbal evaluations to assess the cognitive and emotional functioning of children and adults. They must be performed and interpreted by a clinically trained examiner who must be a licensed psychologist or psychologist intern. Psychological tests are used to assess a variety of mental abilities and attributes, including achievement and ability, personality, and neurological functioning.

Day Rehabilitation and Day Intensive Services

Day rehabilitation and day intensive services are provided to children/youth in group homes by providers contracted with the Siskiyou County Behavioral Health Division. For a description of requirements of these services see the day rehabilitation policy and procedure in appendix 7 and the day intensive policy and procedure in appendix 8.

Missed Appointments and 10-day Letters

Following up on missed appointments is an essential step to managing potential risks associated with lapses in treatment and to reengage clients in essential services. When a client does not show up for or cancels their appointment, clinicians and health assistants should follow the procedure outlined in clinical policy 13-07 (see appendix 9). If the client misses three appointments in a row, a 10-day letter should be sent to the client (see appendix 10). ***NO SHOW AND CANCELLATION TIPS:***

Scheduled events that are no shows and cancellations should not be taken out of the Anasazi scheduler and must be documented with a zero time progress note. The exception to this rule is that no shows or cancellations of assessment appointments should be deleted from the Anasazi scheduler and documented in an informational note.

Case Closings

Discharging a client from treatment should be accomplished as part of a number of other clinical steps. For example, documenting client no shows and cancellations, and staff cancellations in Anasazi helps to track the agency's overall rates of these activities for monitoring and reporting purposes; reduces risks and keeps a record of a client's compliance with treatment. Actions such as calling clients to reengage them in services or sending a 10-day letter are essential to quality care. An essential part of the clinical process is to talk with clients about their progress in treatment, and when improvements sought are achieved to end treatment. Closing cases within established timelines manages caseloads, and avoids the appearance of mishandling the case. The timelines for closings are two to three weeks after a 10-day letter is sent if there is no contact from the client, or immediately upon a client's successful completion of treatment.

To close a case the following steps are required:

1. Complete an informational progress note summarizing the client's progress in and achievements in treatment, date of last contact, and reason for discharge.

2. Complete an assignment form so that the case can be properly closed in the Anasazi electronic health record with the discharge reason codes on page 1 of the Anasazi keying guide. The current version of the Anasazi keying guide is located in the Siskiyou Anadocs folder which you can link to from the BHS intranet web page located at this link, http://resourcecenter.hsd.lan/bhs.html

3. The clinician must end date the treatment plan with the closing date.

Appendix 1

Examples of Functional Impairments

As a result of the client's mental health behaviors/symptoms:

Family/Behavior Problems in the Home: Client is unable to maintain a positive personal relationship with siblings due to constant fighting, arguing, hitting and/or parents due to client being frequently disciplined because of defiance and/or disobedience.

Social: Client is unable to establish/maintain positive interpersonal relationships with peers that would offer social support for the client.

Academic/Behavior Problems in the School: Client is unable to maintain passing grades in school; client has many absences due to unwillingness to attend school; client is unable to refrain from peer-to-peer conflict resulting in many school suspensions.

Employment: Client is unable to establish and maintain gainful employment due to frequent absences from work; or inability to follow instructions and complete assigned jobs.

Community: Client is unable to maintain behavior in super market/other stores/shopping due to persistent tantrums and is inconsolable.

Legal: Client has persistent disregard for the law or safety of others, is destructive to property and has frequent involvement with law enforcement.

Physical Health: Client is unable to maintain a healthy lifestyle including exercise and healthy eating which would stabilize his diabetes.

Self Care/Basic Needs: Client needs assistance in obtaining housing, food, shelter, and clothing and is unable to provide these things for himself; client is unable to maintain personal care/hygiene (ADL's).

Risk Factors/Self-Harm: Client is of a significant risk of danger to self or others, self/harm gestures, suicidal or homicidal ideations, actions or behaviors that place the client at risk of death or physical injury.

Appendix 2
Documentation of Travel Time

In documenting travel time in conjunction with the provision of a mental health service, please follow the following guidelines:

- Travel time may be billed to and from the clinic to a client's home or other community location.
- Travel time may ***not*** be billed between provider sites (e.g., the Yreka and Mt. Shasta clinics).
- Travel time must be divided between clients if multiple clients are seen off site (e.g. travel time to and from Tulelake or Happy Camp should be divided between the number of clients seen at each location)
- For organizational providers, travel time may be billed from the provider's home to a client's home (or other community location) if the travel time from provider's home to the client's home is ***less*** than the travel time between the office and the client's home.
- Travel time is ***not*** billable from the provider's home to the office.
- Travel time should never be included if the location code of the services is "office".
- Travel time may not be billed to Medi-Cal by a provider stationed at a community site such as a school on a regular basis. However, if the staff member is stationed at a clinic or office, then travel time to the school can be billed and should be split between clients if multiple clients are seen.
- When a client does not show for their appointment, the travel time is *not* claimable.

Appendix 3

Quality Improvement Procedure

There are a few ways in which staff can attribute their time for quality improvement activities:

- Utilization Review: When staff spend time reviewing the form and the clinical record, make corrections, and write a response on the form that time is claimable.
- Health Information Department (HID) Chart Review: When staff spend time reviewing the form and the clinical record, make corrections, and write a response on the form that time is claimable.
- Quality Improvement Committee Meetings: When staff attend a quality improvement committee meeting or any QI subcommittee meetings, that time is claimable.

Anasazi Procedure to Claim Billable Time for Quality Improvement Activities:

1. DO NOT document the review in the client's chart.
2. Anasazi path:
    - Client Data
    - Client Services
    - Client Service Entry Menu
    - Individual Client Service Maintenance
    - Anasazi will let you use the client number if the client is currently open. If you are not using a client number then key "1" Admin client and use 900/9000 for the Unit/Subunit and following the same procedure.
    - Form# - Click on the magnifying glass for the system to assign a form number. Click on the 'Apply' button to the right of screen.
    - Fill in the date, client number and use the magnifying glass to obtain the opened Unit Assignment.
    - Next key in server ID, service (480 for licensed staff and 481 for non-licensed staff) time.
    - The following fields are auto filled:
        - Person (provided to): O other
        - Contact type: A administrative
        - Place: O office
        - Appt type: 2 unscheduled
    - SAVE

Appendix 4

Documentation of Interpreter Services

General Guidelines: When the client has limited English proficiency (LEP):

- All documentation needs to state how the language barrier was addressed.
- Documentation must include:
    - Inquiry into the client's language preference (usually done at the time of the assessment);
    - That the client is made aware of free language interpretation services provided in the client's preferred language (usually done at the time of the assessment);
    - Whenever service related personal correspondence is provided in the client's preferred language;
    - If an interpreter is used.
- If at all possible have the treatment plan translated to the client's preferred language. If that cannot be accomplished, explain how client's full participation and understanding of the treatment plan was obtained especially when the treatment plan is written in English.

Assessments: Record if the client or legal guardian wants to receive language interpretation services in their preferred language in the assessment under the section "CULTURAL AND SPIRITUAL CONSIDERATIONS"

- First question "Does the client identify with a particular cultural group?" answer yes

- If so, describe group: In this field, describe the preferred language of the client or legal guardian (parent) and the need for language interpretation services. For example:

  The client was raised in Ecuador and identifies with the indigenous mountain culture of that region. This assessment is being conducted using a Spanish language interpreter, and arrangements will be made for interpreter service for all future appointments.

Include Linguistic Factors in the Objective and Intervention Section of the Treatment Plans:

Objective: If the client requires a cultural specific approach to meeting the goal you would list it here.

Intervention: Include in each intervention that language services will be provided in person or by phone as a part of your narrative.

Include Linguistic Factors in the Objective and Intervention Section of the Progress Notes:

Intervention: Include that language services were utilized for the session. Monitor the quality of the interpretation service.

Appendix 5
Sample Anasazi Treatment Plan

Name: ADMIN, CLIENT | Case#: 1 | Page: 1 of 2
Type: MH Treatment Plan | Date: 08/10/2016 - 08/09/2017
Printed on 08/10/2016 at 04:43 PM | (Final Approved on 08/10/2016 at 04:42 PM)

Treatment Plan

Level	Type	Description	Status	Established Date	Target Date	Status Date
1	Strength	Ability to Form and Maintain Relationshps	Active	08/10/2016		08/10/2016
	At least one strength that will aid the client in attaining their goal.					
1	Problem	Emotional/Behavioral	Active	08/10/2016	08/10/2017	08/10/2016
	Client is experiencing_____diagnosis with _____ symptoms which led to_____impairments. Put in a target date that coincides with the episode of care date (see client overview tab for the EOC date).					
1.1	Goal	Stable Emotional/Behavioral Functioning	Active	08/10/2016	08/10/2017	08/10/2016
	Brief general statement of the improvement sought based on the client's problem. Put a target date that coincides with the episode of care date (see client overview tab to find the EOC date).					
1.1.1	Objective	Learn/Practice Symptom Management	Active	08/10/2016	08/10/2017	08/10/2016
	One specific, observable/measureable objective that includes a baseline and outcome measurement to address the goal. The objective must be designed to impact the client's symptoms and functional impairments due to the diagnosis. The objective defines what the client will do to meet their goal and what they are able to do now. Put in a target date that coincides with the episode of care date.					
1.1.1.1	Intervention	MH- Assessment	Active	08/10/2016		08/10/2016
	Frequency: Annually					
	Behavioral Health clinician will provide this service initially and as needed to evaluate the current status of the client's mental, emotional or behavioral health. Assessment updates will be completed at least every two years (ASOC),					
1.1.1.2	Intervention	MH-Individual Therapy	Active	08/10/2016		08/10/2016
	Frequency: Weekly					
	Clinician will provide therapeutic interventions (list whichever modality you are trained in and plan to use e.g., CBT, DBT, EMDR, play therapy) that focuses primarily on symptom reduction as a means to improve functional impairments of_____.					
1.1.1.3	Intervention	MH-Rehab Individual	Active	08/10/2016		08/10/2016
	Frequency: Weekly					
	Behavioral Health staff will assist in improving, maintaining, or restoring a client's functional skills, ADLs, social skills, obtain support resources, and/or obtaining medication education. (Personalize which skills will be focused on). Frequency = the frequency that rehab will be provided at the time of the writing of the plan or best guess.					
1.1.1.4	Intervention	MH-Plan Development	Active	08/10/2016		08/10/2016
	Frequency: Annually					
	Behavioral Health staff will develop client plans, review and approve them with clients and monitor progress. Treatment plans will be revised as needed and updated at least annually.					
1.1.1.5	Intervention	MH-Case Management/Brokerage	Active	08/10/2016		08/10/2016
	Frequency: Every two weeks					
	Behavioral Health staff will assist in planning, linking, and coordinating with others on behalf of the client. Additionally, staff will monitor service delivery to ensure the clients access to services and their progress. Frequency = the frequency that case management will be provided at the time of the writing of the plan or best guess.					

Appendix 6

Services Billed in Error

Instructions: Submit one form for *each* progress note

DATES OF SERVICE: _____

CLIENT NAME: _____

CLIENT NUMBER: _____

SERVICE CODE: _____

MINUTES: _____

STAFF NAME: _____

STAFF ID: _____

REASONS/COMMENTS: _____

SIGNATURE OF STAFF: _____

DATE: _____

SIGNATURE OF SUPERVISOR: _____

DATE: _____

*Please attach two copies of the service documentation and forward to Anita Inselman in the Fiscal unit.

_____

FISCAL COMMENTS:

_____

_____

SIGNATURE: _____

Appendix 7
Day Rehabilitation
Clin 16-09 Policy & Procedure Effective Date 5/10/16

POLICY: Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) contracts with providers for delivery of Day Rehabilitation (Day Rehab) services. The BHD Director or designee maintains a current list of providers.

Although BHD does not deliver Day Rehab services, BHD is responsible for:

1. Determining a client's need for Day Rehab services;
2. Ensuring that the client has access to these services;
3. Authorizing payment for these services; and
4. Supervising the quality of these services.

I. Assessment Criteria for Services

Clients shall be assessed for Day Rehab services through an assessment process that includes the areas required by state law, as outlined in policy CLIN 301. The assessment and supporting documentation shall be included in a provider's Service Authorization Request submitted to BHD.

II. Access to Services

BHD is responsible for arranging medically-necessary Day Rehab services for clients through its contracted providers. BHD shall review service authorization requests and assessments to determine the client's need for Day Rehab services. Clients must meet the medical necessity criteria to be eligible for services.

BHD shall ensure that organizational providers meet State standards for timely access to services through quality management and improvement activities.

III. Payment Authorization

A. BHD requires that Day Rehab contract providers request an initial BHD payment authorization for Day Rehab services. Providers are required to request prior authorization when Day Rehab services will be provided for more than five (5) days per week.

B. Payment authorization shall follow the authorization process outlined in the Provider Manual regarding medical necessity; assessments; involvement of licensed mental health professionals in the decision process; and meeting the requirements of Medi-Cal documentation standards per state regulation. In addition, supportive documentation must be submitted with invoices.

C. BHD shall adhere to the following timelines:

- Standard authorizations: BHD will provide notice of approval or denial of payment authorization within fourteen (14) calendar days following the receipt of the request for payment authorization.
- Expedited authorizations: If the standard authorization process could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, BHD will provide notice of approval or denial of payment authorization within 72 hours after receipt of the request for payment authorization.

D. BHD will authorize Day Rehab for an initial period of 30 days.

E. Upon request for continuation of BHD payment authorization for services, BHD will authorize Day Rehab for a standard period of six (6) months.

F. BHD also requires providers to request authorization for mental health services provided concurrently with Day Rehab, excluding services to treat emergency and urgent conditions.
   - These services shall be authorized with the same frequency as the concurrent Day Rehab services.

G. Notification to the client and the provider regarding denials or modified authorizations shall follow the procedure outline in the *Notice of Adverse Benefit Determination (NOABD)* policy, ADMIN 15-01. Authorized services are required to commence within 30-days of authorization or notification to the client's parent or guardian must be made by BHD and shall follow the procedure outlined in the *NOABD* policy ADMIN 15-01. Exceptions to access to services within 30-days must be reported to BHD immediately so that notification can be made.

NOTE: BHD shall not delegate the payment authorization function to its organizational providers of Day Rehab services.

IV. Quality Management

At least annually, BHD shall review the authorization process for Day Rehab through the Quality Improvement Committee (QIC). BHD shall ensure that the authorization process is consistent and meets state and federal standards. Any necessary action to improve the process shall be implemented in a timely manner.

At least annually, BHD shall review the contracted providers of Day Rehab to ensure quality of care, compliance with state and federal program requirements, and adherence to standard billing practices.

Timely review of documentation provided by contracted providers is completed retrospectively by the Children's System of Care (CSOC) Supervisor or designee to ensure the quality of services being provided. If a service is denied, the provider is notified in writing of the reason for denial and may appeal. The provider appeal process is outlined in the BHD Provider Manual.

V. Program Requirements

In order to be certified as a Day Rehab program, organizational providers must offer, at a minimum, the following components of service:

A. Hours of Operation / Claiming – as follows:
   - A *Half-Day Program* may be billed for each day in which the client receives face-to-face services that are available four (4) hours or less per day. Services must be available a minimum of three (3) hours each day that the program is open.
   - A *Full-Day Program* may be billed for each day in which the client receives face-to-face services that are available more than four (4) hours each day.
   - Although the client must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the client.

- The requirement for continuous hours of operation does not preclude short breaks (for example, a school recess period) between activities; a lunch or dinner may also be appropriate depending on the program's schedule. The provider shall not count these breaks toward the total hours of operation of the day program when calculating the minimum hours of service each day.

B. Community meetings – Meetings that occur at least once a day which:
   - Address issues pertinent to the continuity and effectiveness of the therapeutic milieu;
   - Actively involve staff and clients;
   - Include a staff member who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; registered nurse; psychiatric technician; licensed vocational nurse; or mental health rehabilitation specialist.
   - Address relevant items including, but not limited to, the schedule for the day; current events and/or individual issues that clients and/or staff wish to discuss to elicit support of the group; conflict resolution; planning for the day, the week, and/or for special events; old business from previous meetings or experiences; and a debriefing or wrap-up.

C. A therapeutic milieu – A structured therapeutic program with specific activities performed by identified staff and take place during the scheduled hours of operation for the program. The therapeutic milieu also includes the following:
   - Staff and activities that teach, model, and reinforce constructive interactions;
   - Peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
   - Client involvement in the overall program; for example, providing opportunities to lead community meetings and to provide feedback to peers; and
   - Behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

D. Required activities – The provider shall offer required activities during the scheduled hours of operation for the program, as follows:
   - Process groups: Facilitated by staff, these groups assist each beneficiary to develop necessary skills to help address his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day Rehab may include psychotherapy instead of or in addition to, process groups.
   - Skill building groups: Staff help clients to identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, clients become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

   - Adjunctive therapies: These therapies, in which both staff and beneficiaries participate, may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants utilize the modality to develop or enhance skills directed toward achieving client plan goals. Adjunctive therapies assist the client in attaining or restoring skills which enhance community functioning, including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings.

E. Staffing requirements – Staffing ratios and requirements are as follows:
- At a minimum, there must be an average ratio of at least one (1) person from the following list providing Day Rehab services to ten (10) clients in attendance during the period the program is open:
    - Physicians
    - Psychologists or related waivered/registered professionals
    - Licensed Clinical Social Workers or related waivered/registered professionals
    - Marriage and Family Therapists or related waivered/registered professionals
    - Registered Nurses
    - Licensed Vocational Nurses
    - Psychiatric Technicians
    - Occupational Therapists
    - Mental Health Rehabilitation Specialists

NOTE: Persons who are not solely used to provide Day Rehab services may be utilized according to program need, but shall not be included as part of the above ratio formula. BHD shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehab services and function in other capacities.

- Persons providing services in Day Rehab programs serving more than 12 clients shall include at least two (2) of the following:
    - Physicians
    - Psychologists or related waivered/registered professionals
    - Licensed Clinical Social Workers or related waivered/registered professionals
    - Marriage and Family Therapists or related waivered/registered professionals
    - Registered Nurses
    - Licensed Vocational Nurses
    - Psychiatric Technicians
    - Occupational Therapists
    - Mental Health Rehabilitation Specialists

- Program staff may be required to spend time on Day Rehab activities beyond the hours of operation and therapeutic milieu (e.g., time for travel, documentation, and caregiver contacts). BHD requires that the staffing minimums are met and available to the group in the therapeutic milieu for all scheduled hours of operation.

- BHD requires that if Day Rehab staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. BHD requires that there be documentation of the scope of responsibilities for these staff and the specific times in which Day Rehab activities are being performed exclusive of other activities.

F. Client participation – BHD expects that the client will be present for all scheduled hours of operation for each day. When a client is unavoidably absent for some part of the hours of operation, BHD will ensure that the provider receives Medi-Cal reimbursement for Day Rehab services for an individual client only if the client is present for at least 50% of the

G. scheduled hours of operation for that day. The provider will record the time that the client starts the program each day, and the time that the client leaves the program each day.

H. Minimum number of client contacts – BHD requires at least one contact per month with a family member, caregiver, or significant support person identified by an adult client; OR one contact per month with the legally responsible adult for a client who is a minor. Contact can occur face-to-face or by an alternative method (e.g., email, telephone, etc.). The contacts should focus on the role of the significant support person in supporting the client's reintegration into the community. BHD expects that this contact will occur outside hours of operation and the therapeutic milieu. Adult clients may decline this service component.

I. Written program description – The provider shall ensure that there is a written program description for Day Rehab that describes the specific activities of the service and reflects each of the required components of Day Rehab services. BHD will review the written program description for compliance before the provider delivers Day Rehab services for BHD clients.

J. Documentation – BHD requires, at a minimum, the following documentation from its organization providers of Day Rehab services:

- Organizational Provider Agreement (contract)
- Client Assessments and Annual Re-Assessments
- Client Plans
- Service Authorization Request (to request new or continuing services)
- Daily Attendance Logs: track the date, arrival time, and exit time of each service for each client, each day of service
- Weekly Progress Notes
- Discharge documentation (submitted to BHD within 30 days of last date of service)

PROCEDURES:

Service Authorization and Reauthorization Process

1. Providers must complete the BHD Service Authorization Request (SAR) form and submit it to BHD with supporting documentation, as appropriate (e.g., Assessment, Treatment Plan).
    - The SAR and supporting documentation may be faxed or emailed to BHD.

2. SARs and supporting documentation will be reviewed and approved or denied by the CSOC Site Supervisor or designee.
    - Review of SARs will be completed by licensed/waivered mental health professionals only.
    - Licensed Psychiatric Technicians and Licensed Vocational Nurses may approve or deny SARs only when the provider indicates that the client has an urgent condition.

3. Timeframes:
    - Standard authorizations: BHD will provide notice of approval or denial of payment authorization within fourteen (14) calendar days following the receipt of the request for payment authorization.
    - Expedited authorizations: If the standard authorization process could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum

function, BHD will provide notice of approval or denial of payment authorization within three (3) working days after receipt of the request for payment authorization.

4. Providers will be notified of SAR approval or denial in writing via email or fax.

5. If BHD denies the SAR, BHD will document the denial using the Service Authorization Log.

    - In addition, BHD is responsible for notifying the client of the denial by issuing the appropriate NOABD - Denial to the client and the provider within two (2) business days of the decision , or within ten (10) business days if the service was previously authorized. For more information about the NOABD, refer to the BHD policy ADMIN 15-01.

AUTHORITY: CA DHCS-MHP Contract, Exhibit A, Attachment 6; Title 9, CCR, Sections 1810.216, 1810.227, 1810.253, 1840.318, 1840.330, and 1840.352, and DMH Information Notices 02-06 and 03-03.
Referencing Policies: ADMIN 15-01, CLIN 301

Appendix 8
Day Intensive Treatment Services
Clin 16-10 Policy & Procedure Effective Date 5/12/16

POLICY: Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) contracts with organizational providers for delivery of Day Treatment Intensive services. The BHD Director or designee maintains a current list of providers.

Although BHD does not deliver Day Treatment Intensive services, BHD is responsible for:

5. Determining a client's need for Day Treatment Intensive services;
6. Ensuring that the client has access to these services;
7. Authorizing payment for these services; and
8. Supervising the quality of these services.

I. Assessment for Services

Clients shall be assessed for Day Treatment Intensive through an assessment process that includes the areas required by state law, as outlined in policy CLIN 301. The assessment and supporting documentation shall be included in a provider's Service Authorization Request submitted to BHD.

II. Access to Services

BHD is responsible for arranging medically-necessary Day Treatment Intensive services for clients through its contracted providers, who are located out of county. BHD shall review service authorization requests and assessments to determine the client's need for day treatment intensive services. Clients must meet the medical necessity criteria to be eligible for services.

BHD shall ensure that contracted providers meet State standards for timely access to services through quality management and improvement activities.

III. Payment Authorization

H. BHD requires that Day Treatment Intensive contract providers request an initial BHD payment authorization for Day Treatment Intensive services. BHD requires prior authorization when Day Treatment Intensive Services will be provided for more than five (5) days per week.

I. Payment authorization shall follow the authorization process outlined in the Provider Manual regarding medical necessity; assessments; involvement of licensed mental health professionals in the decision process; and consistent application of review criteria integral to the Utilization Management Program.

J. BHD shall adhere to the following timelines:

- Standard authorizations: BHD will provide notice of approval or denial of payment authorization within fourteen (14) calendar days following the receipt of the request for payment authorization.
- Expedited authorizations: If the standard authorization process could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, BHD will provide notice of approval or denial of payment authorization within 72 hours after receipt of the request for payment authorization.

K. BHD will authorize Day Treatment Intensive for an initial period of 30 days.

L. Upon request for continuation of BHD payment authorization for services, BHD will authorize Day Treatment Intensive for a standard period of three (3) months.

M. BHD also requires providers to request authorization for mental health services provided concurrently with Day Treatment Intensive, excluding services to treat emergency and urgent conditions.
   - These services shall be authorized with the same frequency as the concurrent Day Treatment Intensive services.

N. Notification to the client and the provider regarding denials or modified authorizations shall follow the procedure outline in the *Notice of Adverse Benefit Determination (NOABD)* policy, ADMIN15-01. Authorized services are required to commence within 30-days of authorization or notification to the client's parent or guardian must be made by BHD per the procedure outlined in the *NOABD* policy ADMIN 15-01. Exceptions to access to services within 30-days must be reported to BHD immediately so that notification can be made.

NOTE: BHD shall not delegate the payment authorization function to its organizational providers of Day Treatment Intensive services.

IV. Quality Management

At least annually, BHD shall review the authorization process for Day Treatment Intensive through the Quality Improvement Committee (QIC). BHD shall ensure that the authorization process is consistent and meets state and federal standards. Any necessary action to improve the process shall be implemented in a timely manner.

At least annually, BHD shall review the organizational providers of Day Treatment Intensive to ensure quality of care, compliance with state and federal program requirements, and adherence to standard billing practices.

Timely review of documentation submitted by contracted providers with invoices is completed retrospectively by the Children's System of Care (CSOC) supervisor or designee to ensure the quality of services being provided. If a service is denied, providers are notified in writing of the reason for denial and may appeal. The provider appeal process is outlined in the BHD Provider Manual.

V. Program Requirements

In order to be certified as a Day Treatment Intensive program, organizational providers must offer, at a minimum, the following components of service:

K. Hours of Operation / Claiming – as follows:
   - A *Half-Day Program* may be billed for each day in which the client receives face-to-face services that are available four (4) hours or less per day. Services must be available a minimum of three (3) hours each day that the program is open.
   - A *Full-Day Program* may be billed for each day in which the client receives face-to-face services that are available more than four (4) hours each day.

- Although the client must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the client.
- The requirement for continuous hours of operation does not preclude short breaks (for example, a school recess period) between activities; a lunch or dinner may also be appropriate depending on the program's schedule. The provider shall not count these breaks toward the total hours of operation of the day program when calculating the minimum hours of service each day.

L. Community meetings – Meetings that occur at least once a day which:
- Address issues pertinent to the continuity and effectiveness of the therapeutic milieu;
- Actively involve staff and clients;
- Include a staff member whose scope of practice includes psychotherapy;
- Address relevant items including, but not limited to, the schedule for the day; current events and/or individual issues that clients and/or staff wish to discuss to elicit support of the group; conflict resolution; planning for the day, the week, and/or for special events; old business from previous meetings or from previous day treatment experiences; and a debriefing or wrap-up.

M. A therapeutic milieu – A structured therapeutic program with specific activities performed by identified staff and take place during the scheduled hours of operation for the program. The therapeutic milieu also includes the following:
- Staff and activities that teach, model, and reinforce constructive interactions;
- Peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
- Client involvement in the overall program; for example, providing opportunities to lead community meetings and to provide feedback to peers; and
- Behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

N. Required activities – The provider shall offer required activities during the scheduled hours of operation for the program, as follows:
- Process groups: Facilitated by staff, these groups assist each beneficiary to develop necessary skills to help address his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems.

- Skill building groups: Staff help clients to identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, clients become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

- Adjunctive therapies: These therapies, in which both staff and beneficiaries participate, may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants utilize the modality to develop or enhance skills directed toward achieving client plan goals. Adjunctive therapies assist the client in attaining or restoring skills which enhance community functioning, including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings.

- Psychotherapy: Psychotherapy means the use of psychological methods within a professional relationship to assist the client to achieve a better psychosocial adaptation; to acquire a greater human realization of psychosocial potential and adaptation; to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions, and thinking. Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, such as medication intervention.

O. Mental Health Crisis protocol – The program must have an established protocol for responding to clients who experience a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include standard procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition. If clients will be referred to crisis services outside the Day Treatment Intensive program, the Day Treatment Intensive staff will have the capacity to handle the crisis until the client is linked to the outside crisis service.

P. Written weekly schedule – A detailed, written weekly schedule shall be made available to clients and, as appropriate, to their families, caregivers, or significant support persons. The schedule identifies when and where the service components of program will be provided and by whom. The written weekly schedule shall specify the program staff, their qualifications, and the scope of services.

Q. Staffing requirements – Staffing ratios and requirements are as follows:
- Staff shall include at least one staff person whose scope of practice includes psychotherapy.
- At a minimum, there must be an average ratio of at least one (1) person from the following list providing Day Treatment Intensive services to eight (8) clients in attendance during the period the program is open:
    - Physicians
    - Psychologists or related waivered/registered professionals
    - Licensed Clinical Social Workers or related waivered/registered professionals
    - Marriage, Family and Child Counselors or related waivered/registered professionals
    - Licensed Professional Counselors or related waivered/registered professionals
    - Registered Nurses
    - Licensed Vocational Nurses
    - Psychiatric Technicians
    - Occupational Therapists
    - Mental Health Rehabilitation Specialists

NOTE: Persons who are not solely used to provide Day Treatment Intensive services may be utilized according to program need, but shall not be included as part of the above ratio formula. BHD shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.

- Persons providing services in Day Treatment Intensive programs serving more than 12 clients shall include at least one person from each of two of the following groups:
    - Physicians
    - Psychologists or related waivered/registered professionals
    - Licensed Clinical Social Workers or related waivered/registered professionals
    - Marriage, Family and Child Counselors or related waivered/registered professionals
    - Registered Nurses
    - Licensed Vocational Nurses
    - Psychiatric Technicians
    - Occupational Therapists
    - Mental Health Rehabilitation Specialists
- Program staff may be required to spend time on Day Treatment Intensive activities beyond the hours of operation and therapeutic milieu (e.g., time for travel, documentation, and caregiver contacts). BHD requires that the staffing minimums are met and available to the group in the therapeutic milieu for all scheduled hours of operation.

- BHD requires that if day treatment staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. BHD requires that there be documentation of the scope of responsibilities for these staff and the specific times in which day treatment activities are being performed exclusive of other activities.

R. Client participation – BHD expects that the client will be present for all scheduled hours of operation for each day. When a client is unavoidably absent for some part of the hours of operation, BHD will ensure that the provider receives Medi-Cal reimbursement for Day Treatment Intensive services for an individual client only if the client is present for at least 50% of the scheduled hours of operation for that day. The provider will record the time that the client starts the program each day, and the time that the client leaves the program each day.

S. Minimum number of client contacts – BHD requires at least one contact per month with a family member, caregiver, or significant support person identified by an adult client; OR one contact per month with the legally responsible adult for a client who is a minor. Contact can occur face-to-face or by an alternative method (e.g., email, telephone, etc.). The contacts should focus on the role of the significant support person in supporting the client's reintegration into the community. BHD expects that this contact will occur outside hours of operation and the therapeutic milieu. Adult clients may decline this service component.

T. Written program description – The provider shall ensure that there is a written program description for Day Treatment Intensive that describes the specific activities of the service and reflects each of the required components of Day Treatment Intensive. BHD will review the written program description for compliance before the provider delivers Day Treatment Intensive services for BHD clients.

U. Documentation – BHD requires, at a minimum, the following documentation from its organization providers of Day Treatment Intensive services:
- Organizational/contracted Provider Agreement (contract)

- Client Assessments and Annual Re-Assessments
- Client Plans
- Service Authorization Request (to request new or continuing services)
- Daily Progress Notes: date of service; total number of minutes/hours the client attended the program; and signature and degree/title of the provider.
- Daily Attendance Logs: track the date, arrival time, and exit time of each service for each client, each day of service.
- Weekly clinical summary reviewed and signed by one of the following:
  - Physician; OR
  - Licensed/waivered/registered psychologist; OR
  - Licensed/waivered/registered clinical social worker; OR
  - Licensed/waivered/registered marriage and family therapist: OR
  - Registered nurse, who is either staff to Day Treatment Intensive program or the person directing the service.
- Discharge documentation (submitted to BHD within 30 days of last date of service)

PROCEDURES:

Service Authorization and Reauthorization Process

1. Providers must complete the BHD Service Authorization Request (SAR) form and submit it to BHD with supporting documentation, as appropriate (e.g., Assessment, Treatment Plan).
   - The SAR and supporting documentation may be faxed or emailed to BHD.

2. SARs and supporting documentation will be reviewed and approved or denied by the CSOC Site Supervisor or designee.
   - Review of SARs will be completed by licensed/waivered mental health professionals only.
   - Licensed Psychiatric Technicians and Licensed Vocational Nurses may approve or deny SARs only when the provider indicates that the client has an urgent condition.

3. Timeframes:
   - Standard authorizations: BHD will provide notice of approval or denial of payment authorization within fourteen (14) calendar days following the receipt of the request for payment authorization.
   - Expedited authorizations: If the standard authorization process could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, BHD will provide notice of approval or denial of payment authorization within 72 hours after receipt of the request for payment authorization.

4. Providers will be notified of SAR approval or denial in writing via email or fax.

5. If BHD denies the SAR, BHD will document the denial using the Access Log.
   - In addition, BHD is responsible for notifying the client of the denial by issuing the appropriate NOABD - Denial to the client and the provider within two (2) business days of the decision , or within ten (10) business days if the service was previously

authorized. For more information about the NOABD, refer to the BHD policy ADMIN 15-01.

AUTHORITY: ***CA DHCS-MHP Contract, Exhibit A, Attachment 6; Title 9, CCR, Sections 1810.216, 1810.227, 1810.253, 1840.318, 1840.328, and 1840.35, and DMH Information Notices 02-06 and 03-03.***
Referencing Policies: ADMIN 15-01, CLIN 301

Appendix 9

No Shows and Cancellations Policy and Procedure

Admin 13-07 Effective Date: 5-14-13

PURPOSE: The purpose of this policy is to create standardized procedures throughout the agency for dealing with no-shows and cancellations in a manner which addresses good clinical care, staff productivity and efficient use of agency resources.

PROCEDURES:

1. Health Assistant(s) will call all scheduled new consumers 24 hours before their scheduled appointment. The Health Assistant will only provide reminders to consumers they are able to contact directly.

   The dual purpose of this call is to remind the consumer of their appointment and to inquire as to whether they will be keeping the appointment. If the consumer indicates they were not planning to keep the appointment, the Health Assistant or clinician should schedule another consumer into the available slot.

2. In the event of a no show, the clinical staff person should immediately make every effort to contact the person by telephone or in person to determine their current status and discuss the importance of keeping scheduled appointments.

3. Clinicians will document appropriately in Anasazi; no shows and cancellations.

4. If efforts identified in No. 2 fail, the clinical staff person should spend the time now available in other service-related activities. This could include reviewing charts for purposes of case review, compliance, catching up on any late documentation, client follow-up contacts, etc.

Appendix 10

10-Day Missed Appointment Letter

For a copy of the form letter on letterhead see your Health Assistant or go to BHS all share drive > FORMS > BHS Updated forms > 10-day Missed appointment letter 7_2106

Dear

We are sorry you missed your appointment(s) with _____ on _____.
Please contact us to reschedule by calling:

___Your provider directly at _____.

___The North County Adult's Office at (530) 841-4100

___The North County Children's Office at (530) 841-4800

___The South County Adult and Children's Office at (530) 918-7200

In the event that you are experiencing a mental health crisis after our regular business hours, please call our crisis line at 1-800-842-8979. If you have already called to reschedule, please disregard this letter.

Do you have a scheduling, transportation, or other problem that is interfering with your ability to attend your appointments here? If you let us know about it, we can help.

Please remember, that you are welcome to contact us at any time you feel you need services whether now or in the future. If you would like to continue receiving services now, we ask that you please call within two weeks from the date of this letter. **After two weeks with no contact from you, we will assume that you do not want services and will close your case.** This action is based on our practice of closing cases when three appointments are missed in a row and if we have not heard from you.

Thank you for your time and immediate attention to this matter.

Sincerely,

Appendix 11

Medication Consent Policy and Procedure

Meds 16-01

POLICY: Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) Medical Services shall provide medication instruction and obtain consent from all patients receiving psychotropic medications. A medication consent form (attachment A) is completed initially for each medication prescribed to the client by the prescribing psychiatrist. The medication is listed by name, dosage, range of frequency and amount, duration, and route of administration. The reason for taking the medication, reasonable alternative treatments available, the specific psychiatric disorder, and the symptoms associated with treatment are listed on the form. The client is given brochures and verbally informed of all benefits, potential side effects, and drug interactions for each medication prescribed. The probable side effects and possible long term effects (3 months or longer) of taking the medication listed on the consent are discussed with each patient by the prescribing psychiatrist and that the consent, once given, may be withdrawn at any time by the client. Additionally, the psychiatrist instructs each patient in the administration of and proper storage of the medication, and the importance of compliance in taking the medication. A new medication consent form is completed when a new medication is ordered or the dosing range is beyond the specified range on the original form. Medication consent expires when the medication is discontinued or is withdrawn by the client, legal guardian, or court as appropriate.

Additional requirements for informed consent for antipsychotic medications include:

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

(a) The nature of the patient's mental condition;

(b) The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;

(c) The reasonable alternative treatments available, if any;

(d) The type, range of frequency, and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications;

(e) The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient;

(f) The possible additional side effects which may occur to patients taking such medications

beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.

In addition to a medication consent form, minor dependent children of Siskiyou County (foster children) require a JV 220 legal document to authorize all psychotropic medications. The JV220 document is completed by BHD Medical Services nurse and signed by the prescribing psychiatrist. This form is returned to the Child Welfare Services social worker for approval of all identified medications by a Siskiyou County Juvenile Court judge. A new JV 220 is required for any new medication added.

Clients may withdraw consent at anytime by informing any member of the Medical Services treatment team.

PROCEDURES:

- Health assistants place blank medication consent forms on the front of client charts for the prescribing psychiatrist to complete with the client and/or their legal representative/legal guardian/parent. (The medication consent form may not be completed by a nurse).
- The medication consent form is explained in writing and verbally to all clients. The form is available in English and Spanish, if requested.
- The Language Line is utilized to translate all other preferred languages to assist the patient to be informed about their medications.
- The psychiatrist, client and/or their legal representative/legal guardian/parent sign and date the form, and indicate the time it was signed.
- Client consent is documented in the progress note associated with the date of signature.
- All clients are asked to initial the form to indicate their agreement with taking a prescribed medication. If a client refuses to sign the form, consent to take a prescribed medication is indicated by client initial.
- In rare circumstances, where a client verbally agrees to take medication, but refuses to initial or sign the medication consent form, the prescribing psychiatrist uses their clinical judgment to determine the risks and benefits to the client of prescribing and/or administering said medications. **Additionally, the psychiatrist's clinical rationale MUST be documented in a progress note, printed out and attached to the medication consent form in question.**
- JV 220 forms are provided by Child Welfare Services social workers, completed by a nurse and signed by the prescribing psychiatrist. The completed JV 220 form is delivered back to the social worker for approval of all identified medications by a Siskiyou County Juvenile Court judge. The social worker informs BHD Medical Services staff once said form is approved by the court. A new JV 220 is required for any new medications added.

AUTHORITY: *CCR, title 9, chapter 4, section 851- (Community Mental Health Services Under the Lanterman-Petris-Short Act); MHP Contract, Exhibit A, Attachment 9; DHCS MHSUDS Information Notice No. 17-040*

Appendix 12
Progress Notes and Late Entry Documentation Policy and Procedure
Clin 16-06 Policy & Procedure Effective Date 2/25/16

POLICY: ***Progress Note Standards***

Siskiyou County Health and Human Services Agency, Behavioral Health Division (BHD) standards and Medi-Cal regulations require that a progress note be written for each billed service. The progress notes will include any direct services to the client or any services related to the client via family members or other service providers.

Progress notes will document the following:

- Date services were provided
- Service function (type of service delivered: assessment, collateral, etc.)
- Location of service
- Duration of service
- Contact type
- Appointment type
- Brief narrative of improvements or deterioration of symptoms as a result of assignments and any other pertinent information since last contact with client
- Description of changes in the client's medical necessity
- Relevant aspects of client care
- Rationale for diagnosis changes
- Interventions applied and client response to the interventions
- Pertinent cultural, linguistic or human diversity issues that are impacting the client and efforts made to adapt treatment to these issues
- Referrals to community resources and other agencies, when appropriate
- Follow-up services, or as appropriate, a discharge summary
- Signature of staff delivering services, including professional degree, licensure or job title, when applicable
- Co-signature by LPHA, if required

Abbreviations approved by BHD may be used to write the progress notes. See current *List of Approved Abbreviations* for more information.

Timely Documentation

It is expected that each service will be documented on the same day that the service was provided. If unavoidable circumstances necessitate a late entry progress note after the day of service delivery, the note shall be written within 6 business days including the day of service.

NOTE: The progress note completion date is the date the progress note is signed either electronically or with a handwritten signature by the staff member.

Frequency of Documentation

The frequency of documentation depends on the type of service, as indicated below:

- **Document at every contact/service**:
  - Mental Health Services
  - Medication Support Services

- Crisis Intervention Services
- Case Management/Rehab
- Therapeutic Behavioral Services: Completed each time period services are provided including significant interventions that address goals in the client plan.

PROCEDURES:

Progress Notes written on the Day of Service

1. On the day of service delivery, staff completes a progress note using the appropriate BHD form.

2. The progress note completion date is the date the progress note is signed.

3. All services as reflected in progress notes completed and administrative time entered at the end of each day must reconcile to time documented in Kronos.

Late Entry Progress Notes

If a progress note cannot be written on the same day that services were delivered, a late entry progress note will be written no later than 6 business days including the day of service.

1. On the progress note on the day of documentation, the staff member writes, 'late entry'.

2. Staff completes the progress note with a full description of the service provided.

3. The time billed for this documentation note includes the direct service time, travel time if appropriate and the time spent documenting the service.

Staff who disregard the standards set forth by BHD may be subjected to progressive disciplinary action, up to and including termination.

AUTHORITY: *CCR, Title 9, Chapter 11, Sections 1810.254, 1810.440, 1840.314, 1840.316-322, 1840.112; CCR, Title 22, Chapter 3, Sections 51458.1 and 51470.*

Appendix 13

Administrative Support Resources

COMPLIANCE

Dee Barton, Compliance Officer; and Health Information Department Supervisor

COMPLIANCE HOTLINE: Call **841-4805** or speak with Dee directly about concerns about compliance and possible violations. You may submit concerns anonymously by phone or through the suggestion box.

Information on health information; privacy and security; HIPAA; training; risk management; Notice of Action forms; Compliance Committee; Safety Committee; scheduling the Red Oak room

QUALITY ASSURANCE

Ashley Bray, LPCC, Quality Assurance Manager **841-4100**

Information on how to document clinical services; Department of Health Care Services regulations; quality of care concerns; appeals; utilization review; organizational and contract provider service review; post hospitalization review (TARs); Quality Improvement Committee, Anasazi; National Health Services Corp. loan assumption for licensed professionals

PATIENT'S RIGHTS ADVOCATE

Wendy Cheula, Health Assistant III **918-7202**

Information on how to help client's resolve grievances; appeals; state fair hearings; expediting grievances and appeals; change of provider requests

MENTAL HEALTH SERVICES ACT

Camy Rightmier, Staff Development Analyst, MHSA Program Coordinator **841-4281**

Information on full service partnerships; flex spending; Mental Health Loan Assumption and Scholarship Programs; Six Stones Wellness Center

FISCAL

Anita Inselman, 841-4742 Information on how to code services in documentation; Anasazi billing; Stage and Greyhound bus passes
Molly Smith 841-4740 Information on purchasing and supplies; business cards; fiscal intake; CalCards**Anna Powell, 2235**
Toni Van Nocker, 841-4754 Information on payroll; leave balances; time cards; Anasazi billing; Stage and Greyhound bus passes

INFRASTRUCTURE

Steve Leal, Services Manager **841-2780** Information on adaptive evaluations and equipment; building, maintenance, and safety issues; office furnishings

Appendix 14
Anasazi Support Resources

ANADOCS

"Anadocs" or Anasazi documents consist of current manuals and the keying guide. IT staff or one of the Anasazi super users will direct you to the folder initially as a part of your training.

To locate the Anadocs, go to https://www.kingsview.org/Anasazi_Manuals/ Open the Siskiyou.KSU folder on this web page. You will be prompted to enter a username and password which is the same as your Citrix login (your first Anasazi login to gain access to the electronic health record).

ANASAZI SUPER USERS

Anasazi super users are staff who have developed expertise in the Anasazi electronic software and can assist staff members in their initial orientation and with on-going questions.

AGENCY-WIDE

- **Agency Help Desk 643-7849 or via email HSD_Secure@co.siskiyou.ca.us** The agency help desk technological problems so if you have problems with the Anasazi program not working or other functional problems call or email the help desk.

NORTH COUNTY SUPER USERS

- **Christine Gannon,** Clinician I, **841-4848** Conducts Anasazi orientation for clinical staff and answers general questions
- **Anita Inselman,** Fiscal Technician, **841-4742** Information on service coding for billing
- **Toni Van Nocker,** Fiscal Technician, **841-4742** Information on service coding for billing
- **Tracie Lima**, LCSW, Deputy Director of Clinical Services, **841-2230** Information on clinical form entry and answers to general questions
- **Ashley Bray,** LMFT, Quality Assurance Manager, **841-4100** Answers questions regarding what service code to bill, documentation formatting and answers general questions

SOUTH COUNTY SUPER USERS

- **Wendy Cheula,** Program Coordinator, **918-7200** Conducts Anasazi orientation for clinical staff and answers general questions.