HUMBOLDT COUNTY HEALTH AND HUMAN SERVICES

Mental Health Outpatient Documentation Manual

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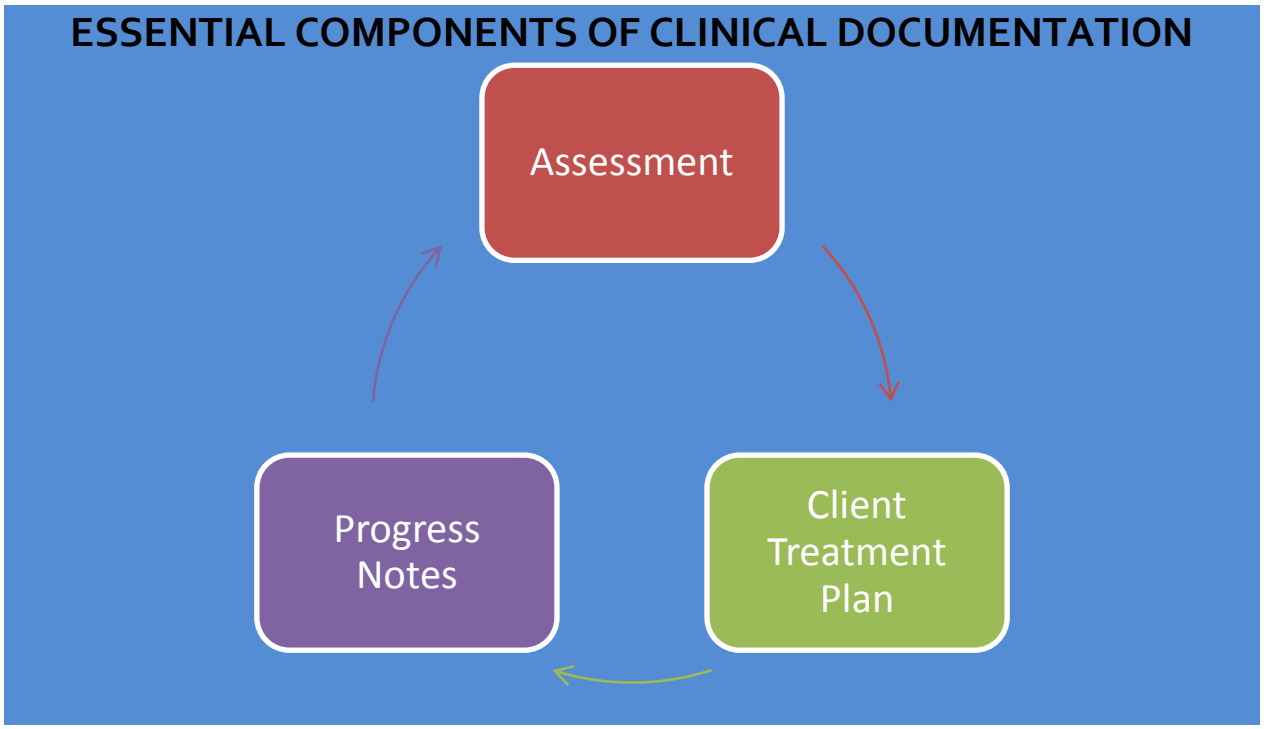
Introduction

Welcome to the Department of Health and Human Services - Mental Health's Documentation Manual. The information contained in this manual provides guidelines and standards for documenting Specialty Mental Health Services for Medi-Cal billing according to Title 9 as well as other contractual and regulatory requirements.

Referring to this manual will assist you with answering questions about documentation and claiming.

When questions or concerns emerge that are not addressed in this manual please consult your supervisor. It is important that supervisors are aware of questions or concerns in order assist with providing the best orientation and training possible. If your supervisor has questions, they can contact the Quality Improvement Unit and Medical Records to seek answers. This process allows all programs to benefit from the question and answer dialogue.

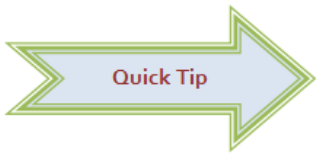
The Quality Improvement Unit provides documentation training monthly, and all staff are welcome. Your supervisor will be notified of the trainings as they are scheduled.



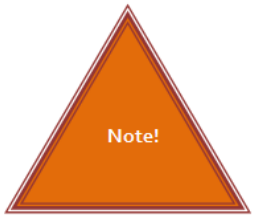
The above depicts the flow of documentation known as "The Golden Thread." Each clinical entry should demonstrate this logic. The Assessment identifies the signs and symptoms of the client's mental health condition including the functional impairments that result. The Client Treatment Plan goals focus on reducing impairments and alleviating symptoms documented in the Assessment. The Progress Notes reflect interventions used to reduce impairments

documented in the Client Treatment Plan as well progress toward the identified goals on the Client Treatment Plan.

Helpful Hints and Shortcuts

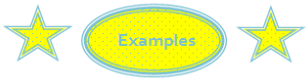


The Quick Tips symbol indicates suggestions that are provided to make this manual easier to understand.



The Notes symbol indicates warnings that must be paid attention to within this manual.

The Hyperlink symbol alerts you to a hyperlink contained within the manual. It may link to an external source or a another section of the manual. Click on the underlined blue area to open it.



The Examples symbol indicates good examples for your review.

CTRL + F = Find

If you are in search of a specific word or phrase, press CTRL + F (or click Find in the upper right hand corner of the Home ribbon), type what you want to search for in Find What, and click Find Next. After a successful Find, to find each successive occurrence, you can click Find Next. If the dialog box hides what you are re looking for, once you've specified the desired options, you can click Less to hide the rest of the dialog box. Or if the dialog box is really in the way and you have a large enough screen, you can move the dialog box completely off of the window.

CTRL + + = Zoom In

If you need to enlarge the screen you are viewing, press CTRL + + (or click the Zoom + symbol in the ribbon). This function is especially helpful in the Example section when you are viewing the Avatar screens.

CTRL + - = Zoom Out

If you need to shrink the screen you are viewing, press CTRL + - (or click the Zoom - symbol in the ribbon).

1. Scope of Practice

How To Determine Who Provides Services	It is expected that staff will only provide services based on their credential (e.g. license, education, training and experience). **However, the job classification staff is hired within determines what service activity is permissible.** Further limitations may be due to lack of experience in the specific service category or by an agency's restrictions.

Staff Who are Eligible to Provide Service	Service Activities
Psychiatric Prescribers	• Assessment • Plan Development • Crisis Intervention • Collateral • Individual Therapy • Family Therapy • Group Therapy • Rehabilitation (individual, group) / Intensive Home Based Services • Brokerage / Targeted Case Management / Intensive Care Coordination • Therapeutic Behavioral Services • Medication Support * * Including evaluation and prescribing
Nurse Practitioner with Specialty Behavioral Certification	• Assessment • Plan Development • Crisis Intervention • Collateral • Individual Therapy • Family Therapy • Group Therapy • Rehabilitation (individual, group) / Intensive Home Based Services • Brokerage / Targeted Case Management / Intensive Care Coordination • Therapeutic Behavioral Services • Medication Support * * Including evaluation and prescribing

Staff Who are Eligible to Provide Service	Service Activities
Registered Nurse with ADN or BSN **(Interim Permitee require RN co-signatures on all services provided)**	• Nursing Assessment Only • Plan Development * • Crisis Intervention • Collateral • Rehabilitation (individual, group) / Intensive Home Based Services • Brokerage / Targeted Case Management / Intensive Care Coordination • Medication Support ** *Excluding developing the plan and approval ** Excluding evaluation and prescribing
Licensed Vocational Nurse & Licensed Psychiatric Technician	• Plan Development * • Crisis Intervention • Collateral • Rehabilitation (individual, group) / Intensive Home Based Services • Brokerage / Targeted Case Management / Intensive Care Coordination • Medication Support ** * Excluding developing the plan & approval * *Excluding evaluation & prescribing
Behavioral Health Clinicians (BBSE Registered Interns and Licensed)	• Assessment* • Plan Development* • Crisis Intervention • Collateral • Individual Therapy • Family Therapy • Group Therapy • Rehabilitation (individual, group) / Intensive Home Based Services • Brokerage / Targeted Case Management / Intensive Care Coordination • Therapeutic Behavioral Services *Co-signature by licensed staff are required for Assessment, developing the plan and approval for registered interns

Staff Who are Eligible to Provide Service	Service Activities
Staff *with* BA / BS in Mental Health related field *or* *with* two (2) years experience in Mental Health	• Plan Development + • Crisis Assessment and Intervention (when accompanied by licensed staff) • Collateral • Rehabilitation Services (individual, group) / Intensive Home Based Services • Brokerage / Targeted Case Management / Intensive Care Coordination • Therapeutic Behavioral Services . + Excluding developing the plan and approval
Staff *without* BA / BS in Mental Health related field *or* *without* two (2) years experience in Mental Health	• Crisis Intervention* • Plan Development *+ • Collateral* • Brokerage / Targeted Case Management / Intensive Care Coordination* • Rehabilitation Services (individual, group) / Intensive Home Based Services* *All services require a co-signature by licensed staff. + Excluding developing the plan and approval
2nd Year Graduate Student Intern (ex. MSW 2nd year, MFT Trainee) & One-year program Graduate Student Interns	• Assessment* • Plan Development* • Crisis Intervention* • Collateral* • Individual Therapy* • Group Therapy* • Family Therapy* • Rehabilitation Services (individual, group) / Intensive Home Based Services * • Brokerage / Targeted Case Management / Intensive Care Coordination * *All services require a co-signature by licensed staff

Staff Who are Eligible to Provide Service	Service Activities
1st Year Graduate Student Intern	• Plan Development* + • Crisis Intervention* • Collateral* • Rehabilitation Services (individual, group) / Intensive Home Based Services * • Brokerage / Targeted Case Management / Intensive Care Coordination * + Excluding developing the plan and approval *All services require a co-signature by licensed staff
Undergraduate Student Interns	• Plan Development*+ • Collateral* • Rehabilitation Services / Intensive Home Based Services * (individual and group**) • Brokerage / Targeted Case Management / Intensive Care Coordination * + Excluding developing the plan and approval *All services require a co-signature by licensed staff **Group Rehabilitation Services can only be provided with a Humboldt County Clinical Staff co-leader

2. Informed Consent

What is Informed Consent?	Clients will be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in client preferences and encourage shared decision making.[1]
Does a Client have the right to refuse Consent?	Adults, including those receiving mental health treatments, have the right to give or refuse consent to medical diagnostic or treatment procedures. California Health and Safety Code § 7185.5(a) states that "the legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care..." California Code of Regulations, Title22 § 70707(b) (6) provides that a patient has a right to "participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment."

The range of services provided shall be discussed prior to admission with the prospective client or an authorized representative (one holding legal privilege to consent to treatment) so that the program's services are clearly understood. As Mental Health practitioners, there is an obligation to inform clients of the risks and benefits of treatment. At the initiation of outpatient services, we must ensure that clients understand the content of not only the Informed Consent form and all of the Informing Materials Form 1196 prior to the client agreeing to services and signing these forms. This includes ensuring that minors who are able **to consent for their own services without a parent are fully educated about the similarities and** differences in the types of services they can receive. In addition, although we do not need to have client's re-sign Informed Consent forms when they transfer from program-to-program, it is important we inform them of the specific risks and benefits of each particular services when they initially transfer.

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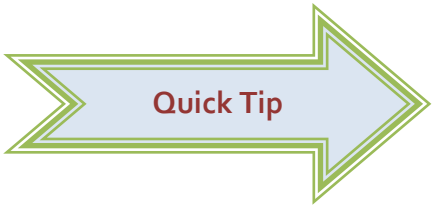
Informed Consent for Outpatient Services

Informed Consent for Treatment must be obtained prior to providing services (first face-to-face contact) to a client and is the first step to be completed between the Clinician* and the means that a consumer grants, refuses or withdraws consent to treatment after the mental health provider presents the consumer with information about the proposed mental health

[1] *Institute of Medicine Committee on Quality of Health Care in America (2001). Crossing the Quality Chasm: A New Health System for the 21st Century.*
Washington, DC: National Academies Press

services, mental health supports, or treatment, in language and manner that the consumer can understand". At Department of Health and Human Services-Mental Health, we obtain written informed consent at the initial admission (first face-to-face contact) to services. This consent covers both outpatient and inpatient services and is valid unless the consumer withdraws the consent. Discussion about informed consent must be documented in the consumer's clinical record. If a consumer is unwilling or unable to provide informed consent, the reason as well as attempts to obtain informed consent must be documented in the consumer's clinical record.

For treatment with psychotropic medications there are additional documentation requirements for informed consent. The 1042 Outpatient Medication Advisement Form must be completed by the medical staff prescriber and the consumer or the consumer's parent / guardian. This documentation shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to consumers taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the consumer. Medication consent must be obtained prior to prescribing medication and whenever a new medication is prescribed.



During a crisis on an unopened consumer, it is advisable for a practitioner to obtain informed consent during the face-to-face contact.

3. Request for Access to Services

What is RAS?

RAS stands for the "Request to Access Services." Request for services can be made by telephone, in writing or in person.

Why do we record RAS?

The State Department of Health Care Services (DHCS) requires all county Mental Health Plans to maintain a log of initial requests to access services. Timely access to our services throughout our county is a required element in our contract with DHCS.

Where is a RAS call recorded?

Humboldt County Mental Health (HCMH) staff records the contacts as well as all requests for information by consumers in an electronic database called the "RAS Log." All requests for information and initial requests for access of services are logged in the RAS database.

If this is part of your role, your Supervisor will contact DHHS IS and request that a shortcut be installed on your desktop in order to gain access to the RAS log. See "Who has to Record RAS?" below for more details.

The RAS log is located here if you have been granted access with a NARF: C:\Program Files\Humboldt County Health and Human Services\RASPhoneLog\

Where is RAS training?

hyperlink

The RAS Training is located here:

http: / / dhhsbulletinboard / sites / enterprise / OpsDocs / DocsRef / Mental Health / **RAS** Phone Log Training Manual.pptx

If additional training is needed please request this from your Supervisor who will contact the QI Training Unit to schedule a training.

What are we monitored for?

1. How long do consumers have to wait from the initial request for services to the actual Assessment appointment? Reports from the RAS Log are generated to determine if consumers have timely access to requested services. These are reported to DHCS.
2. Are the requests for Services logged? Logging requests for services in

the RAS Log allows our department to track timely access of services to our consumers as well as to track the number of calls our department receives from around the county over time.

3. Is there access to a toll free statewide number 24 / 7 line that clients can call on how to access mental health services?
4. Is there access to a toll free statewide number that has the capacity to respond to those whose primary language is not English?

Aside from being a state requirement, the RAS Log benefits consumers and staff. When calls are logged, staff can refer back to the entry when following up with a consumer. This way, consumers don't need to repeat information already relayed to HCMH staff. Staff is able to work more efficiently by having the background information when addressing a consumer's needs during follow-up. Other staff that comes in contact with the same consumer for future follow-up will have historical information to help them meet the consumer's needs. The RAS Log allows for time-efficient continuity of care and is a core element of HCMHs standard of care.

What happens when we cannot provide services within 14 days of first contact?

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When HCMH is unable to provide services within 14 days of contact then a Notice Of Action E is issued by staff. Notice of Actions provides consumers with information about their rights regarding accessing mental health services among other things (see 0704.500 Notice of Action). HCMH analysts collect data to measure these time frames to ensure compliance with "timely access to services."

What information is logged?

All requests for information and initial requests for access of mental health services (new clients) need to be logged in the RAS log during, or immediately after, handling the request. The following situations are examples of requests requiring logging into the RAS log:

Examples of telephone requests are:

- Parent calling for help with child exhibiting behavioral concerns
- Consumer calling in emotional distress, asking how to get into counseling services
- Consumer who wants to be evaluated for psychotropic medications
- Consumer who is new to the area and wants mental health services

- Family member with concerns for their loved one wants to know the process to get them in

Examples of written requests (generally faxes) are:

- Primary care doctor referring their patient to HCMH for psychiatric evaluation
- Primary care doctor referring their patient to HCMH for counseling
- School staff requesting services for a child with behavioral issues at school
- CSU staff requesting follow up care for a stabilized client
- HCMH Intra-agency referral requesting additional services (AOD, Case Mgmt, etc)
- Community agency (RCAA / YSB) linking their clients with mental health services
- Calls received after-hours by answering service faxed into reception
- Requests for a list of mental health providers who speak other languages

Examples of in-person requests are:

- Consumer with no telephone initiating the process to be seen at HCMH
- Family members in distress over loved one's mental health signs and symptoms
- Referent accompanying their consumer to begin the process of being seen at HCMH

Pertinent information about the interaction with the consumer is documented in the RAS. The **consumer's name** (alias, John / Jane Doe is permissible), **date of birth, phone number, acuity (emergent, urgent, routine)**, use of **Language Line** (if applicable), **type of request** (information, services) and **location** being referred to are required elements of an entry (see 0100.600 Request for Access to Mental Health Services). Helpful information staff can enter in the "**Disposition**" box includes what the **purpose of the contact** was, what **follow-up** was needed, what **referrals** were given and **how staff assisted** in accessing services.

hyperlink

It is important that staff **document the first available appointment in the RAS Log follow-up**. If a client declines that first available appointment due to a scheduling conflict or other reason and chooses a later date, our data will reflect how soon HCMH was able to accommodate the client.

Who has to record RAS?

All of these scenarios would be entered into the RAS log by the first staff in communication with the consumer or receiver of a written request. During business hours, **reception** would often be the first point of contact that enters a RAS for follow-up by **Access Team staff**. Other units who will receive requests for services to be added to the RAS Log would be **Same Day Services, Crisis Stabilization Unit** and **Sempervirens**. In addition, calls coming into HCMH's answering service will be faxed to reception the next business day for entry into the RAS Log.

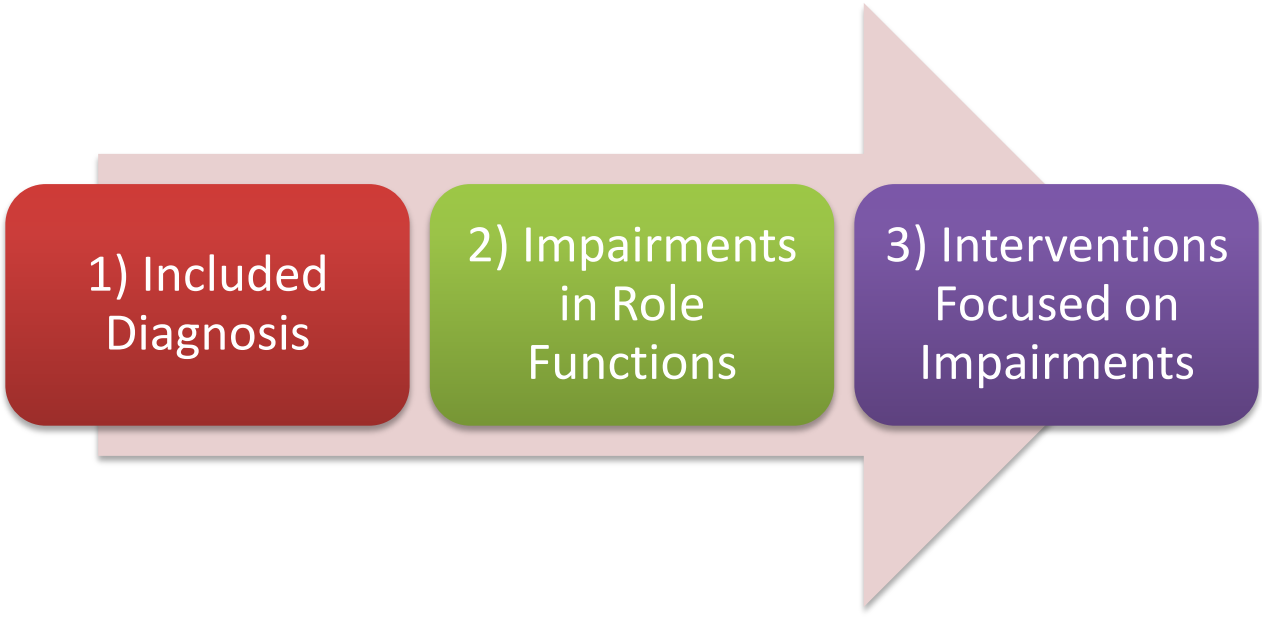
4. Medical Necessity

How To Determine Medical Necessity

1. The client must have an "included" DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnosis. Please refer to list on next page.

2. The client must have either a serious impairment or the probability of significant deterioration in an important area of life functioning; children also qualify if there is a probability they will not progress developmentally as appropriate.

3. The focus of the proposed intervention(s) is to address the impairment, and it is expected that the client will benefit from the treatment. For children, it is probable the child will not progress developmentally as appropriate without the treatment, or it is expected that the condition will be corrected or ameliorated. *Note: The impairment would be non-responsive to physical healthcare-based treatment solely.*



Included Diagnoses

The following DSM-IV-TR disorders qualify for a primary diagnosis:

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

Excluded Diagnoses

The following DSM-IV-TR disorders do not qualify for a primary diagnosis:

- Autistic Disorder
- Learning Disorders
- Motor Skill Disorders
- Communication Disorders
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Other conditions that may be a focus of clinical attention, except Medication-Induced Movement Disorders
- Mental Retardation (Axis II)
- Antisocial Personality Disorder (Axis II)
- 799.9 Deferred diagnosis
- V71.09 No diagnosis

Levels / Global Assessment of Functioning

Adults

Purpose	This is an attempt to categorize a client's acuity or level of need. The Levels system is three tiered, and is completed at the same time as the Assessment: • Level 1: the most acute need / serious impairment • Level 2: the medium acute need / moderate impairment • Level 3: the least acute need / mildest impairment

Adult Level 1: GAF 1 to 50

1. The client meets medical necessity criteria.
2. Client has a Serious Mental Disorder

   To qualify for the category of Serious Mental Disorder, all of the following three criteria are required:

   a. At a minimum, one of the included diagnoses based on Medical Necessity Criteria, and most typically, a severely disabling mental disorder, such as schizophrenia and other serious psychotic disorders, or major mood and anxiety disorders.

   b. As a result of the mental disorder, has substantial impairment in at least one of the following areas of life functioning:

      i. Health
         1. Difficulty managing basic needs [Activities of Daily Living (ADLs)]
         2. Health is seriously at risk due to noncompliance with medication or healthcare
         3. Serious to moderate substance abuse

      ii. Daily Activities
         1. No employment, training program or school
         2. No interest in leisure activities

      iii. Social Relationships
         1. No support system and / or unable to access support
         2. No friends and / or significant other

      iv. Living Arrangement
         1. Seriously at risk of losing current living arrangement due to behavior (e.g. aggressive incidents, suicidal / self-harm behavior, etc.)
         2. Homeless
         3. Unable to secure alternative living arrangement

   c. Likely to become so disabled as to require public assistance, services, or entitlements.

3. And / or at risk for highest levels of care (e.g. CSU, PHF, jail, IMD)

a. Dangerous / destructive behavior
b. Suicidal ideation / plan; self injurious behavior
c. Unable to provide for basic needs
d. History of CSU / inpatient admissions
e. Clients existing in an Institute for Mental Disease (IMD) facility

Adult Level 2: GAF 51 to 60

1. Client meets Medical Necessity Criteria and has a significant impairment in at least one of the following four areas of life functioning (or probability of significant deterioration):
    a. Health
        i. Requires encouragement and / or assistance for basic needs (ADLs)
        ii. Has difficulty maintaining compliance with medication or healthcare
        iii. Moderate to severe substance abuse
    b. Daily Activities
        i. Unable to initiate and / or maintain daily activities on a regular basis
    c. Social Relationships
        i. Lack of a support system and / or difficulty accessing support
        ii. Lack of friends and / or significant other
    d. Living Arrangement
        i. Has difficulty managing money
        ii. Some risk of losing current living arrangement due to behavior (e.g. aggressive incidents, suicidal / self-harm behavior, etc.)
        iii. Homeless
        iv. Difficulty securing alternative living arrangement

Adult Level 3: GAF 61 to 70

1. Client meets medical necessity criteria.
2. Without mental health treatment, there is a reasonable probability of deterioration in at least one important area of life functioning.

Minors

Purpose	This is an attempt to categorize a client's acuity or level of need. The Levels system is three tiered, and is completed at the same time as the Assessment: • Level 1: the most acute need / serious impairment • Level 2: the medium acute need / moderate impairment • Level 3: the least acute need / mildest impairment

Minors Level 1: GAF 1 to 50
Severely Emotionally Disturbed (SED) Child / Adolescent (under age 18), or SED Transition Age Youth (age 18-20)
1. The client has a primary DSM Mental Health Disorder which meets Specialty Mental Health criteria, and
2. Displays a significant and substantial impairment in at least two of the following areas:
a. Self care
b. Ability to function in the community
c. School functioning
d. Family relationships
e. An important area of life functioning, which must be specified.
3. Has at least one of the following risk factors applies:
a. The child is at risk of removal from the home or has been removed from the home.
b. The mental disorder and impairments have been present for more than one year or are likely to continue without treatment.
c. The child / adolescent displays one of the following:
i. Psychotic features
ii. Risk of suicide
iii. Risk of violence due to a mental disorder
d. The child / youth meets Special Education eligibility requirements under Education Related Mental Health Services (ERMHS).

Minors Level 2: GAF 51 to 60
SED Child / Adolescent (under age 21)
1. The client has a primary DSM Mental Health Disorder which meets Specialty Mental Health criteria.
2. And displays at least one of the following impairment criteria:
a. A significant impairment in an important area of life functioning, which must be specified
b. A probability of significant deterioration in an important area of life functioning, which must be specified.

Minors Level 3: GAF 61 to 70
Child / Adolescent (under age 21)
1. The client has a primary DSM Mental Health Disorder which meets Specialty Mental Health criteria.
2. And displays the following impairment criteria: There is a probability that the child / adolescent will not progress developmentally as individually appropriate as a result of a mental health disorder which can be corrected or ameliorated.

F.A.Q.

Q1.How does 'Medical Necessity' tie into 'Specialty Mental Health Services,' and why is it important?

A1. 'Specialty Mental Health Services' is a Medi-Cal term for specific types of services that are reimbursable. In order for a client to receive such services, they must meet 'Medical Necessity' which establishes the reason why the client is being seen and how their life is impacted by their mental health issues. 'Medical Necessity' justifies the need the client has for services and why it should be covered by Medi-Cal. If a client no longer meets 'Medical Necessity' then services would be discontinued.

Q2. How do I document 'Medical Necessity' on clients who have an excluded diagnosis?

A2. A client must have an included diagnosis in order to qualify for Specialty Mental Health Services. Clients who have been assessed and are determined to have an excluded diagnosis as their primary diagnosis would be provided a NOA-A packet which explains that they do not meet criteria and are given referrals to other types of services. The client's excluded diagnosis can be a secondary diagnosis and still meet Medical Necessity if the primary is an included diagnosis. The DSM describes a Primary diagnosis as the 'reason for the visit' or 'the main focus of attention or treatment.' The assessor will include diagnostic criteria for the secondary diagnosis in the Assessment and the assigned Clinician will address the related impairments on the Client Plan. However, the focus of the interventions should not constitute more than 50%

Medical Necessity - 1

of the overall service provision.

Q3. If Levels 1,2 and 3 all meet Medical Necessity, what is the purpose of rating them?

A3. The Levels are used to categorize a client's acuityor level of need. By categorizing, assessors and Access staff can determine if urgent, in-house services (Level 1) or referrals to Org Providers or Beacon (Levels 2, 3) are appropriate to meet the client's needs. Similar to the GAF of a 5 axis diagnosis, the information is also useful in planning treatment and measuring it's impact. If a client entered treatment as a Level 1 and moved down to a Level 2 or 3 that's a good indicator of improved functioning. If a client who is a Level 3 moved to a Level 1, the treatment team would consider adding services, increasing frequency of services or updating the Client Plan to address crisis intervention or high-risk behaviors.

Q4. How do Mental Health providers determine that the client's condition 'would not be responsive to physical healthcare based on treatment?'

A4. A thorough Assessment includes a discussion with the client about their medical history and current physical symptoms, so this determination is made with the client's input and the assessor's clinical judgment. A mental disorder caused by a general medical condition would require "evidence from the history, physical examination or laboratory findings that the disturbance is the direct physiological consequence of a general medical

condition" per the DSM. If the client reports physical medical symptoms that have gone unchecked by their medical provider the assessor will note a recommendation of "follow up with primary care physician."

Q5. Why do we have to authorize services internally within Mental Health?

A5. Since the Medical Necessity / Levels / Authorization form is considered a component of the Assessment, only licensed staff operating within their scope of practice can authorize services internally or through an Org Provider. Authorization is signed by the assessor which indicates client has met Medical Necessity and is recommended indicated services. The authorization expiration date can be referred to by all staff as an indicator of annual updates needed.

Q6. If original levels has all services authorized, is new levels required for added service?

A6. No. If the assessor authorized all available Specialty Mental Health Services, providers are free to begin any of these upon receipt of an Intra Agency Referral. Keep in mind that added services require a Client Plan within 30 days of opening them to that particular service.

4. Assessment

The Assessment serves as the foundation for the client's plan of care. It reinforces eligibility to receive outpatient Specialty Mental Health Services (SMHS), drives the treatment planning process, and provides the basis for ongoing changes in treatment delivery and discharge planning.

Purpose	1. To determine if the client meets medical necessity for SMHS. 2. To assist with formulating a clinical diagnosis. 3. To assist with forming the foundation for the client plan.
What is the Time Frame for Assessments?	Initial Assessments should be completed during the first session. (Please see Quick Tip below if this is not possible.)
When must Assessments be updated?	Assessments **must** be updated on an annual basis for clients who continue to receive SMHS. For example: If I complete an intake and Assessment on a new client today, August 1, 2014, my "annual due date" would be August 1, 2015. Let's say I am able to complete next year's Assessment on July 27, 2015 – a few days prior to the due date, the following year's Assessment would be due on or before July 27, 2016. The due date is determined by the date the Assessment was started, **not** the date the Assessment was submitted.
What if my client's symptoms or impairments change?	Assessment may be updated earlier than the annual date if symptoms or impairments change.
What if I provide SMHS but the annual Assessment has expired?	The MHP Contract with the Department of Health Care Services requires Assessments to be updated annually. Providing SMHS past the annual due date will result in a disallowance!
What must be included in an Assessment?	1. A description of the client's current symptoms and behaviors that supports the required DSM criteria for each diagnosis (including severity, frequency and duration of symptoms).

2. All sections must be completed. It is not acceptable to leave questions or sections blank. Use N / A if not applicable.

3. A detailed description of the client's functional impairment(s).

4. A list of the client's strengths in achieving client plan goals:
    a. Abilities and accomplishments
    b. Interests and aspirations
    c. Recovery resources and assets
    d. Unique individual attributes

5. A description of the client's cultural / spiritual / linguistic factors.

6. Substance Exposure / Substance Use. Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications (CAM), over-the-counter (OTC), and illicit drugs.
    a. If the client uses or has used drugs and a dual diagnosis may be present, the full Substance Use History Option must be completed; if there is no indication of a dual diagnosis, only the mandatory areas of the Substance Use History Option need to be completed.

7. Both the numerical code and full clinical name of the diagnoses, based on the latest DSM is completed. For example, "Axis I: 313.81, Oppositional Defiant Disorder."
    a. Please note Alcohol and Drug Diagnosis shall be listed as a Secondary Diagnosis; if the Alcohol and Drug Diagnosis is the client's primary diagnosis, the client does not qualify for specialty mental health services and the client should be provided a referral to Alcohol and Drug Services!

8. A full Five Axis Diagnosis must be completed.

9. Any updated diagnosis must be accompanied by a progress note in order to document the change, and the diagnosis option in Avatar must be completed with the updated information. In the event of a new / updated diagnosis, a new Client Treatment Plan may be needed.

Assessment Content Areas

Quick Tip

Both the Assessment (1096) and Medical Necessity / Levels (1038 / 1039) forms should be completed at the end of the first assessment interview. If unable to complete the assessment at that time, you must document the rationale for not completing it and a Five Axis diagnosis in your Progress Note, and consult with your Supervisor. You must then complete the Assessment and the Levels forms no later by the end of the client's next visit.

Assessment Timelines

The Initial Assessment:

- The initial mental health Assessment is required for all clients meeting medical necessity who are not currently opened or are new to the outpatient mental health system (or are returning for services after being discharged from all outpatient services for more than thirty (30) days). This Assessment shall be completed upon the first visit. Assessments are **valid** only when signed by a **LPHA and finalized in the EHR** (the date of validation appears by the LPHA staff signature). Please refer to the **Document List and Timelines for Completion –Outpatient Services** in the Appendix for timelines and due dates for each item required in the clinical chart.

hyperlink

Updated Assessment:

- An updated Assessment must be completed annually on or before the date of the initial
- Updated Assessments are required to be comprehensive and complete. In other words, the updated Assessment must stand alone and not simply be the same as the initial assessment
- Updated Assessments must clearly state why the client continues to require services in the presenting problem section of the Assessment (e.g. this is what establishes continued medical necessity)
- Updated Assessments must contain a summary of the treatment provided in the past year and the response to that treatment in the mental health treatment history section of the assessment

Assessments when client transfers to, or are opened to a new program:

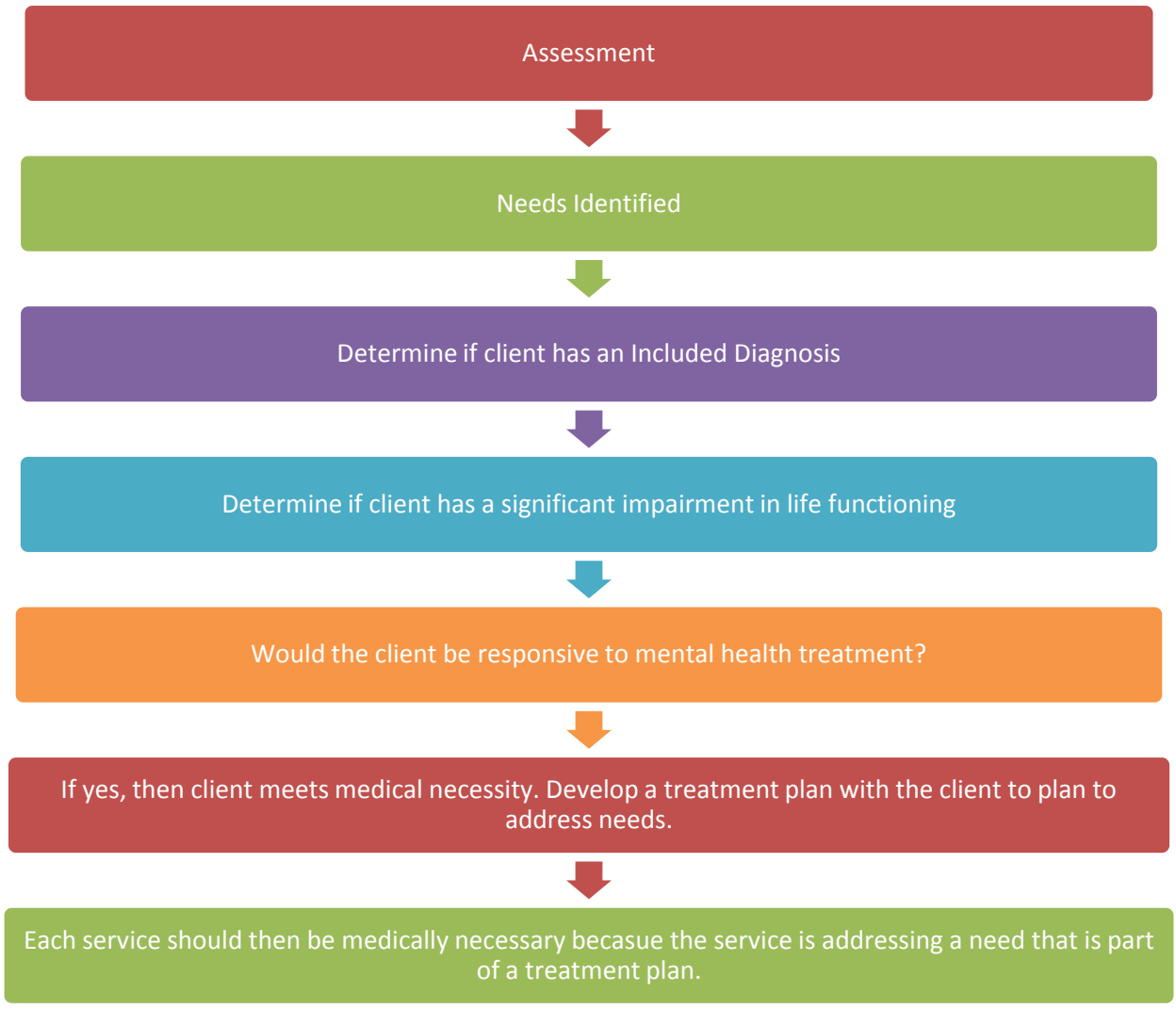
If a currently open client transfers to a new program or is added to a new program, the Clinician may use one of the following three options:

1. Complete a new Assessment within 30 calendar days of opening in the new program, if indicated.
2. Accept the prior Assessment, if satisfactory, as long as it was completed within the past year. This Assessment must be updated within a year of the existing annual Assessment date and be accompanied by a progress note stating the clinical rationale for accepting the prior assessment.
3. Accept the prior Assessment, but if there are incomplete sections the Clinician must update and complete these sections **within 30 calendar days** in the Assessment.

Note!

CSU and SV Transfers to Outpatient Services require a new Outpatient Assessment to be completed because the client presented in Crisis, but this Assessment may not accurately reflect their baseline mental health condition. It is permissible to utilize information from the Inpatient (CSU and SV) Assessments to complete the Outpatient Assessment.

Logical Flow = Assessment→Medical Necessity→Functional Impairment→Treatment Plan



F.A.Q.

Assessment

Q1. If a rule out is given, what is the process for staff to determine if criteria is met at a later date?
A1. A rule out and a provisional diagnosis are not to be left unresolved. Once a clinician has obtained enough information through ongoing assessment a revised diagnosis is recorded in the Diagnosis Form in Avatar and an accompanying progress note is required.

Q2. When non-licensed staff do evaluations with diagnostic impressions (rather than Assessments with diagnoses), what does this mean and does it affect anything other than a co-signature?
A2. Please see Scope of Practice.

Q3. When a provider is unable to complete the Assessment and documentation on the same day, is it okay to claim documentation time the next day?
A3. Yes, two notes will need to be written. One on the first day, which must include the actual service duration, and one on the second day, which references the note on the first day and includes only the duration of documentation for the second day.

Q4. When a Clinician does an Assessment, do they need to list the 5 Axis diagnosis on the Progress Note for that service?
A4. No, staff do not need to list the 5 Axis diagnosis on the Progress Note as long as it is included on the Assessment in the chart. The only time it would

be in the Progress Note would be if the Assessment was not fully completed and the Clinician was documenting a provisional diagnosis.

5. Client Treatment Plan

Whereas the Assessment documents the current mental health condition and functional impairments of the client, *the Client Treatment Plan is the guiding force behind the delivery of care*. The plan helps the client and the clinical staff collaborate on the client's recovery goals. Ultimately, treatment should result in services provided at the lowest level of care needed, or through discharge to the community.

Client Treatment Plan Basics

- The Treatment Plan is an agreement between the client and the Clinician that states which mental health problem(s) will be the focus of treatment. The Client Treatment Plan consists of specific goals, objectives, and the treatment interventions that will be provided. See Signatures.
- There needs to be a flow from the DSM diagnosis and functional impairments in the assessment to the problem, goals, objectives, and interventions.
- A Client Treatment Plan is expected to be written in both the client's preferred language and English.
- A Client Treatment Plan is required to be completed with required signatures. The Treatment Plan shall be used for all service activities.
- A client receiving both general mental health and medication support services will have an "integrated client treatment plan." Integrated plans include both general mental health interventions and medication interventions and **must be signed by a prescriber (Psychiatrist or Nurse Practitioner) and the client for medication support services to be valid.**
- The Client Treatment Plan is only valid from the date in which both the LPHA and the client have signed the plan. In the event of a new diagnosis, a new Client Treatment Plan may be needed if clinically appropriate. Please consult with your clinical supervisor if needed.
- The effective date for a Medication Support Service Plan is the date the prescriber co-signs it.
- A minimum of two goals / objectives and two interventions per goal on each Client Treatment Plan are required.

Quick Tip

The only services that can be provided prior to the completion of a Client Treatment Plan are the Assessment, Plan Development, Linkage and Brokerage (TCM) and Crisis Interventions.

Client Treatment Plan Timeline

The completion of the Client Treatment Plan is subject to specific deadlines and signature requirements, as described below:

- **Initial**: The Client Treatment Plan is due within 60 days of the Assessment, which is considered the day the client is opened to Outpatient (OP) Services.
- **Updates and Revisions**: A new or revised plan is due within 30 days from opening a client to new services.

A plan must be updated on an annual basis, and must be done before the anniversary date when the client is continuing with OP services. The anniversary date is the original Assessment date of the current episode. An annual Client Treatment Plan must be complete on or before the expiration of the current Assessment start date.

- For example, the initial Assessment was completed on 5 / 2 / 13, the initial Client Treatment Plan is completed on 6 / 30 / 13; the annual Client Treatment Plan will be due on or before 5 / 1 / 14
- Subsequent Client Treatment Plans will be due prior to the expiration of the most recent assessment date

Each Client Treatment Plan can be authorized for up to one year, however many clients achieve goals prior to a year, and plans shall be updated prior to a year based on goal achievement. A plan should not be the same year after year. If our current plan did not help the client achieve his or her goals, the plan must change.

hyperlink

For a complete list of all documentation timelines please see the **Document List and Timelines for Completion –Outpatient Services** in Appendix.

- **Late Renewal:** If the renewal period passes and the next Client Treatment Plan is completed late, there will be unauthorized days that should not be claimed. (e.g. the renewal date is July 1st but the Plan is completed on July 7th, then July 1st through 6th would be unauthorized for all services, except crisis intervention, during that time period).

Quick

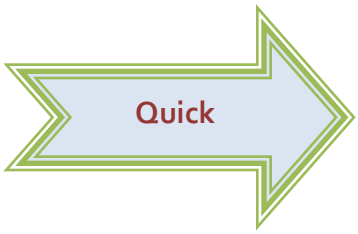
Check the content and the dates of the plan to be sure the services you will deliver are covered in the plan. If you do not agree with the current plan, update it with the client and treatment team!

Client Treatment Plan Components

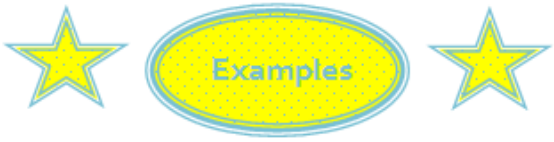
The Client Treatment Plan contains the following components to identify the needs and services of the client.

Problems

The problem is the focus of treatment based on the mental health diagnosis, which includes symptoms, behaviors and life functioning.



Perfecting the Problem statement is easy. An excellent statement must include the client's impairment in life functioning as it relates to the symptoms that support the diagnosis.



- Due to Schizoaffective Disorder, client has symptoms of disorganized thinking, paranoia, auditory hallucinations, intense sadness, thoughts of suicide, insomnia and social withdrawal. These symptoms are interfering with their ability to maintain a job, maintain stable housing and have a positive relationship with others.

- Due to Post Traumatic Stress Disorder, client has symptoms following exposure to a traumatic event which threatened death or serious injury. Symptoms include experiencing intense fear or hopelessness, recurrent and intrusive distressing recollections of the event and recurrent distressing dreams of the event. In addition the client is avoiding activities and places associated with the traumatic event, they are experiencing insomnia, avoiding leaving the home and irritability. These symptoms are negatively affecting their school performance, employment and person relationships.

Bad Example of a Problem:

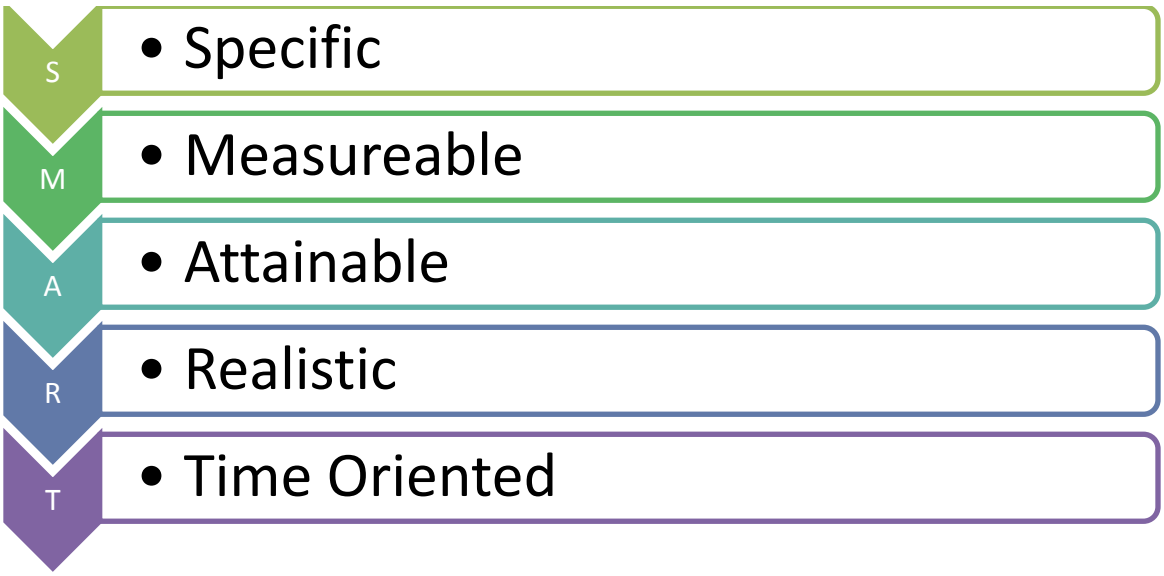
"Client has symptoms of major depressive disorder."

Note! The specific symptoms / functional impairments are missing.

Goals

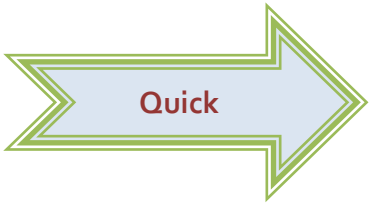
A Goal is a description of what the client will do to show progress toward a goal.

SMART goals are:

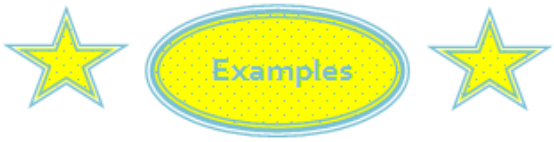


Goals need to be realistic and achievable. Smaller and more reasonable steps can assist in successes in the client's life and motivate towards goal achievement.

It is important to track and document client progress on goals closely. Update the Client Treatment Plan as needed or begin transitioning client to a lower level of treatment or discharge when goals have been met or functioning returns.



The 'Goal Template' below can assist in writing a simple yet excellent goal.

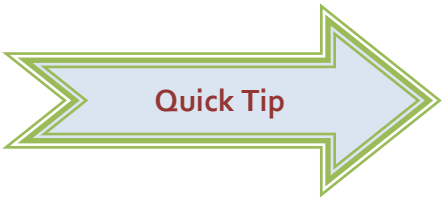


- Goal = Billy will decrease physical altercations with his roommates from 5 days a week to 2 days a week or less.
- Goal = Patty will increase her positive self statements at work from zero times weekly currently to 3 times a week or more.

Bad Example of a Goal:

"Decrease psychiatric symptoms."

Note! The goal lacks specificity with symptom or functional impairment and is difficult to measure objectively.



Do not use percentages (%). They are difficult to quantify and track.

Interventions

Interventions are the therapeutic activities provided by staff to assist the client in attaining the objective in each goal. In other words, how can staff provide a clinical service to assist the client to meet his / her goals?

Interventions also include what the client or client's support person is going to do to work towards the goal (e.g. therapeutic homework, attending a social skills group, wellness group, etc.).
Interventions must address the objectives and **must include duration and frequency**. All services must be included in this section. The following template provides a simple way to write an excellent intervention:

- Clinician will provide cognitive behavioral techniques weekly for one year to assist client in reducing symptoms of suicidal ideations.
- Client will attend the social skills group weekly for 12 months to improve social skills by interacting with same aged peers.
- Staff will provide rehabilitative services 2 x a week for 6 months to model and practice social skills.
- Clinician will use structured play therapy (Stop, Think and Listen Game) weekly for 3 months to increase impulse control skills.
- Medical staff will provide medication education (side effects, medication efficacy) every 3 months to support adherence to medications and reduce symptoms.

Signatures

The client's participation and understanding of all elements of the plan is essential, is expected by our auditors, and is mandated by state regulations. W&I Code Sec. 5600.2. (a) (2) which states (Persons with mental disabilities) "Are the central and deciding figure, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. Planning should also include family members and friends as a source of information and support." This regulation indicates that unless a person has a legal status that removes the client's decision making power, the client must fully participate in the Treatment Plan. At a minimum, client participation is documented by obtaining the signature of the client / parent / guardian. Additionally, the signature of the Clinician who is developing the plan is required. The prescriber's signature is required for Medication Treatment Plans. A copy of the plan must be offered to the client / family member.[2] For plans that do not involve medication support services the provider with the highest licensure is required to sign the plan. It the plan is exclusively for case management services a LPHA signature is required.

[2] CCR, title 9, sections 1840.314 and 1810.440(c)

F.A.Q.

Q1. Does each provider type need to complete their own plan?

A1. No. It is beneficial to develop an integrated plan with client involvement as well as input from other providers who are working with the client. This ensures that the plan activities are relevant to the provider's scope of practice, and this practice reduces confusion for the client.

Q2. Are Case Managers able to cover any other discipline?

A2. Case managers may assist in the creation of goals within the ClientTreatment Plan related to client support activities that are within the scope of practice of the case manager. See Scope of Practice.

Q3. California minor consent laws say some minors can sign their own plans. Exactly when is this possible?

A3. Each case is different. If you have a minor that you believe should be able to sign his / her plan without a legal guardians signature then consult your supervisor.

Client Treatment Plan

6. Progress Notes

Progress notes are a summary description of what was accomplished or attempted at the time of service that was delivered to a client. Progress notes mark progress towards a client's identified goals and are a required element of good clinical documentation.

How to Write a Good Progress Note	Progress notes should be written objectively. Refrain from using negative language about clients. Also refrain from providing long narratives to describe what happened during the service. Good progress notes may also explain clinical judgment that is relevant to the course of treatment.

Progress Notes Basics

1. Every service activity must have a separate, corresponding note (whether claimable or not).

2. All progress notes need to include the following items:

    a. Date of each service

    b. Duration of service in exact minutes

    c. Specify Goal being charted to

    d. Specify clinical intervention and / or decisions

    e. Client response to the service

    f. Record any therapeutic assignments (homework) for the time between sessions

    g. Must be legible

    h. Service provider's handwritten or approved electronic signature

    i. Signatures must include: staff's professional degree, license or job title

    j. Duration of documentation time, when not done concurrently

    k. Duration of travel time (when appropriate)

    l. Duration of face-to-face time

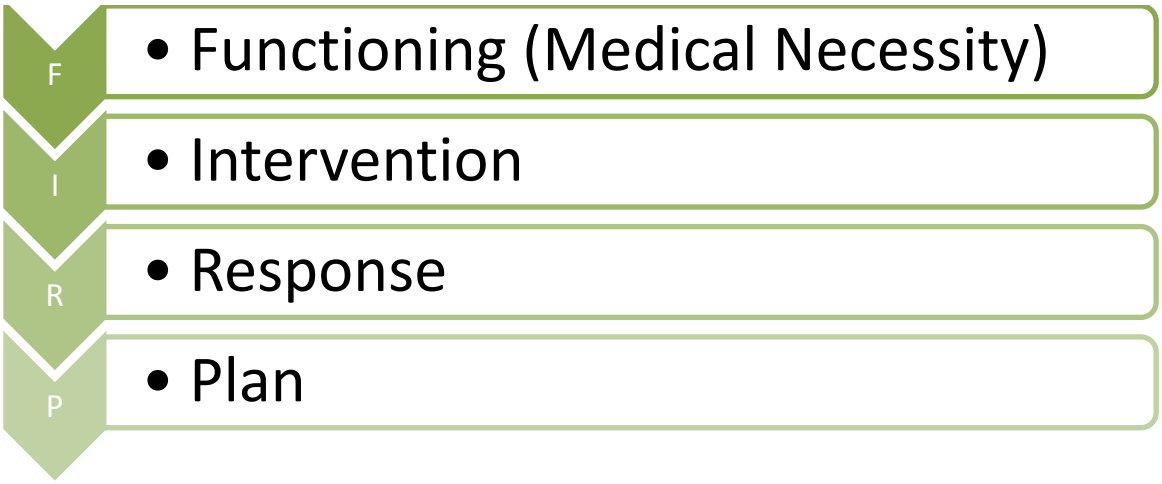
3. Every service is expected to be documented in a timely manner. Our standard of good clinical practice calls for notes to be written on the same day of the service delivery or by the end of the next business day. All staff are encouraged to use concurrent documentation (write your note with the client present) to write notes in real time, eliminate post service documentation time, and increase the client's involvement in his or her clinical record.

4. When two staff provide the same service to a client, they both must write a progress note. Documenting the reason more than one staff was necessary is essential.

5. When more than one staff member participates in a group service for a client, one staff will write the note identifying the other staff member by name and discipline as well as explaining their contribution to the service.

FIRP

FIRP format must be used when writing progress notes. FIRP is an outline of what should be included in a progress note. Each section of FIRP should be identified by its corresponding label.



Functioning	1. What was the reason or purpose for the encounter? • Start by describing the type of service e.g. individual, collateral, etc. 2. What was the content or topic discussed? • Factual, brief, and relevant to the goals and objectives if possible 3. What clinical observations were made? • Should be objective, factual, and non-judgmental 4. What is the current medical necessity of services? • Must document continued medical / service necessity to justify all services provided. • Was the service provided appropriate to address the client's service need? 5. What was said, done or requested by the consumer? • This is a good place to address requests for linguistic services

Intervention	1. What did you do in the context of the encounter? • **Example:** Address what was done about the request for linguistic services cited above 2. What therapeutic interventions or techniques were employed? • These must reflect the strategies listed in the client plan, if not, address why there was a deviation from the plan 3. What progress or setbacks occurred? • Describe in measurable, behavioral terms the progress toward the goal(s) and address possible reasons for lack of progress 4. What referrals were made? • If referrals were made, please note them here
Response	1. What was the consumer's response to the intervention? • Address this in specific terms based on behavior and / or client report 2. How was the intervention effective or ineffective? • Describe in terms of measurable or observable changes in behavior whenever possible 3. What signs or symptoms of the diagnosis are present or no longer present? • This links to medical necessity and appropriateness of current treatment 4. What was done outside the session? • If homework was given at the previous session this is a good place to address what the consumer did or did not accomplish • If the consumer self-initiated any interventions, report them as well (e.g. joining a self-help group) 5. What are the consumer's current impairments and strengths? • Again, this addresses medical and service necessity and should describe • current levels of functional impairments **and** strengths to overcome them
Plan	1. How did the session address Client Treatment Plan objectives? • Based on what was described above, describe how you helped the consumer's the recovery process 2. What will be done outside the session?

	• Describe any activities that will occur before the next contact, e.g. planned, referrals, etc. 3. Was there homework assigned? • Did you teach the consumer a new adaptive skill and is there an expectation that it will be practiced before the next session 4. What type of follow-up will be made? • Similar to above, could consist of planned collateral contacts. State the planned time for the next contact with the consumer

Point of view—Remember that you are an agent to help improve the client's condition, so you will address:

Goal: Reason for service and how they presented

Intervention: What you did to contribute?

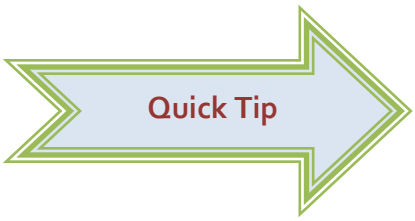
Response: Client's progress toward goal

Alerts: Warning signs and actions taken to minimize

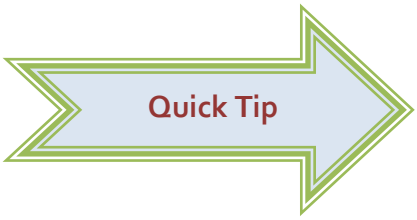
Plan: What approaches will be taken in future to make change?

Quick Tip

For a Crisis Intervention, state the imminent client crisis that led to the unplanned service, what intervention you provided to stabilize the crisis and what the next steps are for follow-up and continued stability.



For Case Management notes, there may be times when there is not a response to the intervention. In this case the "R" section of the FIRP can be omitted. This would mean a Case Management note such as coordination of a client's medication refill would contain only a "FIP," or Functioning, Intervention and



When providing a clinical service without the client present, combining "I" and "R" is permissible since the client is not responding to clinical intervention.

Accounting for Time

Title 9 and the Mental Health Plan Contract with DHCS stipulate that billing for any SMHS needs to be recorded in the exact minutes of time. [3] Rounding billing time up or down is prohibited.

Total time = Travel time + Duration of SMHS time + Documentation time

- 172 minutes or 2:52 hours **(Total time)** = 140 minutes **(Travel time)** + 22 minutes **(Duration of SMHS time)** + 10 minutes **(Documentation time)**

- 65 minutes or 1:05 hours **(Total time)** = 35 minutes **(Travel time)** + 20 minutes **(Duration of SMHS time)** + 10 minutes **(Documentation time)**

Documentation of the Total time equation must always be included in the body of the Progress Note.

The amount of total time claimed is supported regardless of the disproportionate travel time in providing the direct service. **Direct service must be in the same day to claim travel time.**

You must only claim for travel time from your office. If your work day begins by going from your home to a client's house, you cannot include the travel time to the client's house, because that would be like claiming for travel time to go to work, which is not a reimbursable activity.

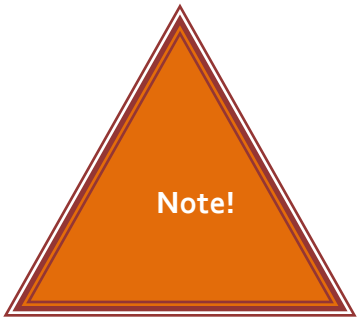
[3] Title 9 § 1840.316.

Note Due Date

When are notes due?	Our standard of care is that all notes must be written and submitted by 5:00 p.m. the next working day.

Late Entry

What do I do if I have a Late Entry?	When a service is documented on a day other than the service date, it must be noted as a "Late Entry" note. All late entry notes must document the date the note is written as well as the actual service date. All late entries are recorded in Avatar and for weekly review by Supervisors. Supervisors will monitor and report on trends of documentation timeliness.



All services must be documented regardless of the date of documentation.

Best Practices for Progress Notes

- Summarize the client's condition; quote the client, if applicable
  - During the session, the client continued to struggle with concentration and appeared to have a difficult time focusing, as evidenced by him not answering questions and being unable to stay on topic. The client stated that he has been "easily distracted at school."

- Indicate the therapeutic interventions and / or techniques that were employed and how effective they were.
  - Intervention: Family therapy to work with the client and family on improving problem solving skills and managing conflict. Used in-session role plays to teach the family how to present a problem, brainstorm possible solutions, and make a plan of action. The family initially struggled to listen to one another, but by the end of the session they were able to successfully talk through several minor issues and come up with possible solutions.

- Use active verbs to describe what you did
  - Role modeled, demonstrated, taught, etc. See samples below.

- Indicate the purpose of your intervention ("to assist client's understanding of symptoms")
  - "to assist client's understanding of symptoms"
  - "to increase the use of coping skills"
  - "to reduce outbursts of anger"

- Show how the contact or service addressed the client plan goals

- Include clinical observations about the client, including the presence or absence of signs and symptoms of the client's illness

  - During the session the client became tearful on several occasions…
  - The client presented with a flat affect…
  - The client demonstrated improved ability to express feelings…

- Summarize and be succinct; only include details as needed to communicate the goal or objective for the activity, the intervention(s) provided, the client's response, and the follow up plan.

- **Avoid "observational", "narrative", or purely descriptive notes that detail what was observed but provide no intervention or redirection or action taken. (**If you are documenting an observation or description only, most likely it should not be a claimed activity.)

Quick Tip

The interactive verb samples below may be helpful for clinical documentation.

Acknowledged	Analyzed	Assisted
Assured	Clarified	Confronted
Consulted	Demonstrated	Discussed
Encouraged	Examined	Explained
Explored	Helped	Interpreted
Offered feedback	Processed	Reality tested
Reframed	Reviewed	Role-modeled

F.A.Q.

Q1. **When documenting phone calls to or from, voice mails left or received and client complaints reported by staff, does times of day need to be included in the note?**

A1. This is not a requirement. However, if you feel the noting the time of day is relevant to the communication provided then you may note the time.

Q2. **When providers wish to add something to a previously completed note, how do they make addendums?**

A2. An "Independent Note" should be completed. At the top of this note you should write "Addendum to Progress Note dated __ / __ / __."

Q3. **Do Progress Notes need to have the "F…I…R…P" completely separated from each other in the body of the note?**

A3. Separate them to ensure that all required elements are addressed. DHCS auditors have noted how helpful it is to document in this manner.

Progress Note

7. Specialty Mental Health Services

Specialty Mental Health Services are referenced in Avatar using the term "Service Charge Codes".

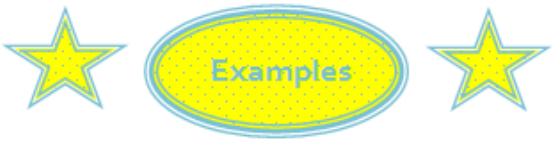
Assessment

What is Assessment?	Assessment is a service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the client's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.[4] For information on how to complete an assessment document or option, see the Assessment section.

hyperlink

Activities:

Assessment activities are usually face-to-face or by telephone with or without the client or significant support persons and may be provided in the office or in the community. An assessment may also include gathering information from other professionals.



- Interviewing the client and / or significant support persons to obtain information to assist in providing focused treatment
- Administering, scoring, and analyzing psychological tests and outcome measures such as CANS and the MORS
- In some instances, gathering information from other professionals (e.g. teachers, previous providers, etc.) and reviewing / analyzing clinical documents / other relevant documents may be justified as contributing toward the assessment
- Observing the client in a setting such as milieu, school, etc. may be indicated for clinical purposes
- Progress Note – Assessment:

[4] CCR Title 9 Division 1, §1810.204

Each assessment requires a progress note. The note should contain a brief summary of what was completed during the assessment interview / session, who was present / participated in the service delivery, and specify the exact length of the assessment time, documentation time as well as travel time

- The final assessment progress note date should match the date the assessment is finalized in the EHR. An additional progress note shall be written if an assessment is appended or updated

Plan Development

What is Plan Development?

Plan Development is a service which consists of development of client plans, approval of client plans, and / or monitoring progress related to the client plan.[5] Client plans drive services and are based on the functional impairment identified in the assessment.

Activities:

Plan Development activities may be face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. Plan Development may also include contact with other professionals.

Plan development activities can be conducted with or without the client, and include the five following items:

- Development of the Client Treatment Plan
- Approval of the Client Treatment Plan with client and their legal representative
- Updating of the Client Treatment Plan
- Monitoring the client's progress in relation to the Client Treatment Plan
- Discharge (with client present)

Progress Notes:

- Plan Development progress notes must refer to the Client Treatment Plan (e.g. development, approval, updating, or monitoring and / or discussing updating the client's diagnosis)
- Discharge summaries document the termination and / or transition of services, and provide closure for a treatment episode and referrals as appropriate

Miscellaneous:

- Plan Development is expected to be provided during the development / approval of the initial Client Treatment Plan and subsequent Treatment Plans. However, Plan Development can be provided at other times, as clinically indicated. For example, the client's status changes (e.g. significant improvement or decline) and there may be a need to update the Client Treatment Plan

[5] CCR Title 9 Division 1, §1810.232

- Plan Development may include activities without the client's presence, such as collaborating with other professionals in the development or updating of the Client Treatment Plan
- Multiple Plan Development notes for one event are at risk of disallowance, if inappropriately documented. For example, if several staff members are present at a team meeting in which a Client's Treatment Plan is discussed or approved, the only staff that can bill are those who are actively involved in that client's treatment, e.g. client's doctor and therapist

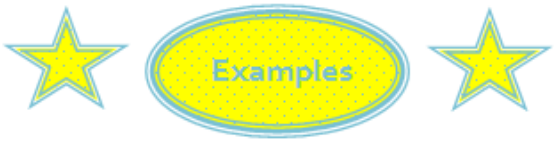
Collateral

What is Collateral?

Collateral is a service to a significant support person in a client's life for the purpose of meeting the needs of the client in terms of achieving the goals of the client'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 specialty 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). The client may or may not be present for this service.[6]

Activities:

Collateral activities are usually face-to-face or by telephone with the significant support person, and may be provided in the office or in the community. The client may or may not be present.



- Educating the support person about the client's mental illness
- Training the support person to better support or work with the client

[6] CCR Title 9 Division 1, 1810.206

Progress Notes:

- Collateral progress notes, as with all progress notes, must link the interventions to the functional impairments of the client.
- Collateral progress notes must include the staff intervention(s) identified on the client plan (examples include: educating, training, etc.)
- Collateral progress notes should include the role of the significant support person (e.g. parent, guardian, etc.)
- Documentation should substantiate that the support person is significant in the client's life
- If you are billing consultation with a significant other as a collateral service, documentation must include how the Clinician educated or trained the significant other to better understand or support the client
- Collateral groups (e.g. parenting groups) are billable with or without the client. The note must reflect how the interventions benefit the client
- An excellent collateral progress note should document the changes that occurred as a result of educating and training the significant other, e.g. show how parents learned and demonstrated new ways of dealing with their child's symptoms or behaviors

Rehabilitation

What is Rehabilitation?	Rehabilitation is a service which includes, but is not limited to assistance in **improving, maintaining, or restoring** a client's or group of clients' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, support resources, and / or medication education.[7]

Activities:

Rehabilitation activities are usually face-to-face or by telephone with the client and may be provided in the office or in the community. Rehabilitation can be done as:

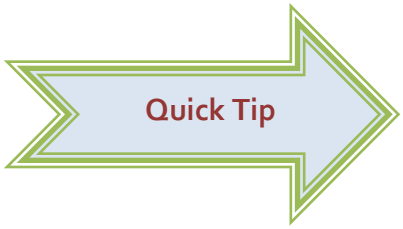
- Individual Rehabilitation
- Group Rehabilitation (for two or more clients)
- Education and / or training of, and counseling for the client in relation to the four following functional skills:
    1. Health – medication education and compliance, grooming and personal hygiene skills, meal preparation skills
    2. Daily Activities – money management, leisure skills
    3. Social Relationships – social skills, developing and maintaining a support system
    4. Living Arrangement – maintaining current housing situation

Progress notes: Group Rehabilitation

When providing Group Rehabilitation (e.g. two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:

1. Type or name of group
2. Total group time, which is the time spent in group plus documentation time and may also include travel time
3. Number of clients
4. Number of staff and their names with appropriate credentials
5. Each note must be unique to the client as well as to an intervention on their client plan.

[7] CCR Title 9 Division 1, 1810.243



If there are two staff members co-facilitating a group, document the need for more than one facilitator. Progress Notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if the "rehabilitation activity" was provided.

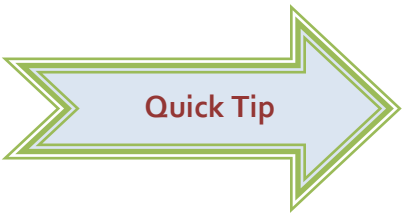
Therapy

What is Therapy?	Therapy is a therapeutic intervention focused primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group of clients and may include family therapy with the client present. [8]

Activities:

Therapy can be face-to-face, or over the telephone, or via telemedicine with the client(s) or family, and may be provided in the office or in the community.

- Individual Therapy
- Group Therapy (for two or more clients)
- Family Therapy with the client present



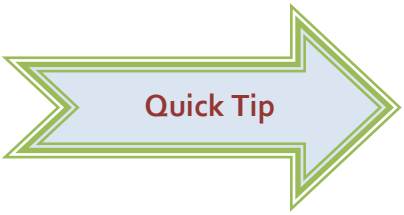
Therapy can only be provided by a LPHA or a registered intern / trainee who is supervised by a LPHA.

See Scope of Practice—Progress Notes: Group Therapy

When providing Group Therapy (e.g. , two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:

1. Type or name of group
2. Total group time, which is the time spent in group plus documentation time and may also include travel time
3. Number of clients
4. Number of Clinicians, their names (if there is more than one Clinician) with appropriate credentials, and their time spent providing the group service

[8] CCR Title 9 Division 1, 1810.250



If there are two Clinicians co-facilitating a group, document the need for more than one facilitator.

Progress notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if the Therapy activity was provided; e.g. , each note must have the problem area / clinical focus, staff intervention and the client's response. Each note must be unique to the client as well as to an intervention on their client plan.

Targeted Case Management – Linkage and Brokerage

What is Targeted Case Management?

Targeted Case Management (TCM) – Linkage and Brokerage includes a broad array of services designed to assist and support clients. These services assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service may include, but is not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development. [9]

Linkage and Brokerage – Assist clients to access and maintain needed services such as psychiatric, medical, educational, social, prevocational, vocational, rehabilitative, or other community services

- Placement – Assist clients to obtain and maintain adequate and appropriate living arrangements
- Consultation – Exchange of information with others in support of client's services

Activities:

TCM - Linkage and Brokerage activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These services may also include contact with other professionals.

- Communicating, consulting, coordinating and corresponding with the client and / or others to establish the need for services and a plan for accessing these services
- Establishing and making referrals
- Monitoring the client's access to services
- Monitoring the client's progress once access to services has been established
- Locating and securing an appropriate living arrangement, including linkage to resources; e.g. , Board and Care, Section 8 Housing, or transitional living
- Arranging and conducting pre-placement visits, including negotiating housing or placement contracts

[9] CCR Title 9 Division 1, 1810.249

Progress Notes:

A TCM Linkage and Brokerage progress note includes the focus of the assistance / intervention provided to the client (e.g. accessing medical services) and justifies the need for this service based on mental health symptoms / issues; e.g. who was spoken to, what was discussed with professional, what is the plan, was there a referral to an outside service and what is the next step needed to assist the client.

Miscellaneous:

See Lock-Out Grid

Crisis Intervention

What is Crisis Intervention?	Crisis Intervention" means a service, lasting less than 24 hours, to or on behalf of a cient for a condition that requires more timely response than a regularly scheduled visit. Crisis Intervention is an unplanned immediate emergency response that is intended to help the client cope with a crisis (e.g. potential danger to self or others; potentially life altering event; severe reaction that is above the client's normal baseline, etc.).
How does Crisis Intervention differ from Crisis Stabilization?	Crisis Intervention is distinguished from Crisis Stabilization by being delivered by providers who do not meet the Crisis Stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.[10]

Activities:

Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These include:

- Assessment of the client's mental status, acuity of symptoms and current need
- Therapeutic services for the client
- Education, training, counseling, or therapy for significant support persons involved

Progress notes:

An excellent Crisis Intervention progress note contains a clear description of the "crisis," in order to distinguish the situation from a more routine event and the interventions used to help stabilize the client.

All services provided (e.g. , Crisis Assessment, safety plan, Collateral, Individual / Family Therapy, TCM - Linkage and Brokerage) shall be billed as Crisis Intervention.

- Once the crisis is resolved, any follow-up cannot be billed as Crisis
- The maximum amount claimable to Medi–Cal for crisis intervention in a 24-hour period is 8 hours (480 minutes) per client

[10] CCR Title 9 Division 1, 1810.209

Crisis Stabilization

What is Crisis Stabilization?	Crisis Stabilization is a service lasting less than 24 hours, to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy.
How does Crisis Stabilization differ from Crisis Intervention?	Crisis Stabilization is distinguished from crisis intervention by being delivered by providers who meet the crisis stabilization contact, site, and staffing requirements. [11]
What are the contact and site requirements of Crisis Stabilization?	Crisis Stabilization shall be provided on site at a licensed 24-hour health care facility or hospital based outpatient program or a provider site certified by the MHP to perform crisis stabilization. Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All clients receiving Crisis Stabilization shall receive an assessment of their physical and mental health. If outside services are needed, a referral that corresponds with the client's needs shall be made.[12]
What are staffing requirements for Crisis Stabilization?	A Psychiatric Prescriber must be on call at all times for the provision of Crisis Stabilization Services that may only be provided by a physician. There shall be a minimum of one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times clients are present. The ratio must be a minimum of one licensed mental health or waivered / registered professional for every four client receiving Crisis Stabilization. If the client is evaluated as needing service activities they can only be provided by a specific type of licensed professional, that person must be available.[13]

[11] CCR Title 9 Sections 1840.338 and 1840
[12] W&I Code Sections 5778 and 14680
[13] W&I Code Sections5778 and 14680

Medication Support Services

What are Medication Support Services?

Medication Support Services are those services that 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; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to development related to the delivery of the service and / or assessment of the client. [14]

Activities:

Medication Support Services activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. 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
- Ongoing 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

[14] CCR Title 9 Division 1, 1810.225

Psychological Testing Services

What are 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 metal abilities and attributes, including achievement and ability, personality, and neurological functioning.

Supplemental Mental Health Services

Early Periodic Screening, Diagnosis, and Treatment

What is EPSDT?	Early Periodic Screening, Diagnosis, and Treatment (EPSDT) is a Medi-Cal benefit of individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs, both mental and physical. Based upon the identified health care need, diagnostic and treatment services are provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a client under the age of 21 may receive additional medically necessary services.

EPSDT Chart Documentation Manual

Katie A. Subclass

Who are members of the Katie A. Subclass?

Katie A. Subclass members are children / youth who are members of a class of children covered by a Settlement Agreement in a lawsuit *Katie A. v. Bonta.* These members have significant needs and by receiving ICC and IHBS in their own home, family setting or the most homelike setting, will be most likely to improve their safety, performance and well-being.

Katie A. Medi-Cal Manual

Katie A. Core Practice Model Guide

Katie A. Subclass—Intensive Care Coordination

What are ICC Services?	Intensive Care Coordination (ICC) services are provided to Katie A. "Subclass" members, who are foster care children / youth who meet the Katie A. Subclass eligibility criteria that facilitates assessment of, care planning for, and coordination of services, including urgent care services. ICC is integrated into the Child – Family Team process with Child Welfare and requires more active participation by the provider in order to ensure that the needs of the child / youth are effectively and appropriately met. They are similar to the types of services provided with Linkage and Brokerage services. The difference between ICC and the more traditional Linkage and Brokerage services is that ICC must be used to facilitate the implementation of the cross-system / multi-agency collaborative services approach described in the Core Practice Model Guide for Katie A Subclass.

ICC service components and activities are:

1. 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

2. Service Planning and Implementation

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

3. 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, not less than every 90 days

4. 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

Katie A. Subclass—Intensive Home-Based Services

What are IHBS?	Intensive Home-Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of a child / youth and his / her significant support persons and to help the child / youth develop skills and achieve the goals and objectives of the client plan. IHBS are not traditional therapeutic services.
Who are these services specific to?	These services are targeted to the Katie A. Subclass (and their significant support persons). Services are expected to be of significant intensity to address the intensive mental health needs of the child / youth, consistent with the client plan and the Core Practice Model.

Services may be delivered in the community, school, home or office settings. IHBS services includes, but not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms
- Development of functional skills to improve self-regulation or self-care
- Education of the child / youth / family / caregiver about how to manage the client's symptoms
- Support of the development, maintenance and use of social networks and community resources
- Support to address behaviors that interfere with the achievement of a stable and permanent family life and stable housing, obtain and maintain employment and achieve educational objectives

Therapeutic Behavioral Services

What are TBS?

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one to one, short-term, outpatient treatment intervention for clients up to age 21 with Serious Emotional Disturbances (SED) who are experiencing a stressful transition or life crisis that is placing the individual at risk of an out of home placement in a Rate Class Level (RCL) 12 or higher or are at risk of a psychiatric emergency.

TBS Coordination of Care Best Practices Manual

TBS Documentation Manual

Activities:

TBS activities are usually face-to-face with the client and can be provided in most settings. TBS-related activities can also be provided to significant support persons in collaboration with other professionals.

- One-to-one therapeutic contact typically models / teaches, trains or supports appropriate behavioral changes
- TBS activities may also include assessment, collateral, and plan development, which are coded as TBS
- TBS is provided only by qualified providers

F.A.Q.

Q1. What are Specialty Mental Health Services (SMHS)?

A1. SMHS include:

1. Rehabilitative services
2. Psychiatric inpatient hospital services
3. Psychiatrist services
4. Psychologist services
5. Psychiatric Nursing facility services

Q2. Who is a Specialty Mental Health Provider?

A2. A "Specialty Mental Health Provider" is a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services. Specialty Mental Health Providers include but are not limited to:

1. Clinics
2. Hospital Outpatient departments
3. Certified residential treatment facilities
4. Psychiatric health facilities
5. Hospitals
6. Licensed Mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide SMHS.

Specialty MH Services

8. Lockouts

What is a Lockout?	A lockout is a service activity that is not reimbursable through Medi-Cal because the client resides in and / or receives mental health services in one of the settings listed below. A Clinician may provide the service (e.g. targeted case management for a client residing in an IMD), but it would be reimbursable only under certain circumstances.

See Lock–Out Grid.

- Jail / Prison
- Juvenile Hall (not adjudicated)
- IMD

No service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge):

- Psychiatric Inpatient
- Psychiatric Nursing Facility
- **Exception***:* Medication Support Services or TCM-Linkage and Brokerage (for placement purposes only within 30 days of discharge) are reimbursable

No other services are reimbursable if the client resides in one of these settings (except for the day of admission & discharge):

- Crisis Stabilization

No other service activities are reimbursable during the same time period that the client is at the Crisis Stabilization Unit (Except for the day of admission and discharge, before or after).

- **Exception:** Targeted Case Management *for placement purposes only* is reimbursable while client is at the Crisis Stabilization Unit
    - **Intensive Care Coordination -** ICC may be provided solely for the purpose of coordinating placement of the child / youth on discharge from the hospital, psychiatric health facility, group home or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.
    - **Intensive Home Based Services -** Mental health services (including IHBS) are not reimbursable when provided by day treatment intensive or day rehabilitation staff

during the same time period that day treatment intensive or day rehabilitation services are being provided. Authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehabilitation services are provided. IHBS may not be provided to children / youth in Group Homes. IHBS can be provided to children / youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits outside the Group Home setting. Certain services may be part of the child / youth's course of treatment, but may not be provided during the same hours of the day that IHBS services are being provided to the child / youth. These services include:

- **Day Treatment Rehabilitative or Day Treatment Intensive**
- **Group Therapy**
- **Therapeutic Behavioral Services (TBS)**
- **Targeted Case Management (TCM)**

For more detailed information on Katie A. Lockouts, please see Katie A. Manual, Appendix D

Lockout Grid

	Type of Service		
Service Site or During the Hours of Operation	**Lockout for Outpatient Mental Health Service**	**Lockout for Outpatient Medication Support Service**	**Lockout for Outpatient Targeted Case Management Service**
Crisis Residential	Yes[1]	No	No
Crisis Stabilization Unit (CSU)	Yes[2]	Yes	No
Day Treatment Programs (Intensive and Rehabilitation)	No[3]	Yes	No
Juvenile Hall, Jail, or Similar Detention (Not adjudicated for Placement)	Yes[4]	Yes[3]	Yes[3]
Psychiatric Inpatient Hospital	Yes[1,4]	Yes	Yes[5]
Psychiatric Health Facility (PHF)	Yes[1]	Yes	Yes[5]
Psychiatric Nursing Facility	Yes[1]	Yes	Yes[5]
Physical Health Care Hospital	No	No	No

For ICC and IHBS, see Katie A. Medi-Cal Documentation Manual for Lockouts.

[1] Except on the day of admission
[2] No other Specialty Mental Health Service is reimbursable during the same time period the service is reimbursed
[3] Except by the same Day Treatment Program Staff
[4] Except when there is evidence that the court has ordered suitable placement (post-adjudication for placement) in a group home or other setting other than a correctional institution, jail and other similar settings.
[5] Except on the day of admission, and 30 calendar days immediately prior to the day of discharge, for a maximum of three non-consecutive periods of 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement

9. Disallowances

What is a Disallowance?	A disallowance is a claim adjustment agreed upon by the medical provider and insurance company. It is an amount of funding that is never expected to be collected, by virtue of laws, regulations, contracts or internal policies applicable to the services provided by the entity.

The most common DHCS Disallowances can be found on Reasons for Recoupment for FY 2011-2012.

10. Coordination of Care

What is Coordination of Care?	Information-sharing across providers, clients, types and levels of service, sites and times to ensure efficient and high quality care.
Who would be provided Coordination of Care?	Clients with multiple needs that cannot be met by a single Clinician, agency or organization will benefit from care coordination to help meet their needs. Multiple providers working together can share clinical information and have clear, shared expectations about their roles with the client. When documenting, each provider must include a rationale for multiple team members being involved in client care.
What is the goal of Care Coordination?	Care coordination's goal is to keep participants involved in the client's care informed and to ensure that effective referrals and transitions take place. Staff exchanging information with other participants will obtain a Release of Information prior to coordination activities.

11. Discharge Summary

When must a Discharge Summary be completed?	When a client has either met their goals and can transition to a lower level of care or discontinues specialty mental health services, a discharge bundle must be completed.
What does the Discharge Summary in Avatar include?	The discharge bundle in AVATAR includes a Discharge Summary, as well as a completed Diagnosis Form to record the client's discharge diagnosis. This bundle can also be utilized when a client discontinues services without notifying staff and fails to respond to phone calls or letters offering additional services.

Appendix A: Glossary of Words and Acronyms

These are some of the commonly used acronyms and terms that are used by Mental Health. These along with the approved abbreviations in the next section, are the only approved ways to write words and terms without spelling them out.

AA	Administrative Analyst Alcoholics Anonymous
ABHRS	Adult Behavioral Health and Recovery Services
ACT	Assertive Community Treatment
ADHC	Adult Day Health Center
Annual Plan	The documentation that must be completed on an annual basis. This includes the assessments, Client Treatment Plan and all consents. "Client Plan" or "Treatment Plan" are used interchangeably with Client Treatment Plan and describe a plan for the provision of specialty mental health services to an individual client who meets the medical necessity criteria in Sections 1830.205 or 1830.210 CCR Title 9
AOD	Alcohol or Other Drugs
ART	Aggression Replacement Therapy Alternate Response Team
ASOC	Adult System of Care
AT	Activity Therapist
Authorization to Use, Exchange, and / or Disclosure of Confidential Mental Health Information Release of Information (ROI)	Documents signed by client and provider that permits specified information to be shared among designated persons and / or agencies regarding client's services and or treatment plan, for a designated period of time.
Avatar	DHHS-MH's Electronic Health Record system
BC	Behavioral Coaching
B&C	Board and Care
BHB	Behavioral Health Board
BOS	Board of Supervisors
Bridgehouse	Adult Day Treatment; an Organizational Provider for DHHS-MH
CANS	Child and Adolescent Needs and Strengths (CANS) is an instrument used to help identify the client and family strengths and needs.
CAR	Central Access Registration
CAR Staff	Certain staff who are trained and are responsible for authorizing services for clients to see contract providers
CAST	Child Abuse Services Team
CCR	California Code of Regulations

CCT	Comprehensive Community Treatment, an intensive "WRAP" program for adults
CIF	Client Information Form
CBH	Crestwood Behavioral Health
CBHDA	California Behavioral Health Directors Association
CCP	Cultural Competency Plan
CCR	California Code of Regulations
CCDAC	Client and Cultural Diversity Advisory Committee
CFR	Code of Federal Regulations
Changing Tides	An Organizational Provider for DHHS-MH
CiMH	California Institute of Mental Health
CMHC	The computer program used by MH through March 2014 that includes client database, claiming and tracking
CMS	Centers for Medicare and Medicaid Services Case Management Services
Co-occurring Disorder	Youths, adults, and older adults are considered to have a co-occurring disorder when they exhibit the co-occurrence of mental health and substance use / abuse problems, whether or not they have already been diagnosed.
CQI	Continuous Quality Improvement
CQIC	Continuous Quality Improvement Committee
CSOC	Children's System of Care
CSU	MH's emergency room for psychiatric emergencies, located on the 2nd floor of the Main Building (formerly known as Psychiatric Emergency Services or PES)
CWS	Child Welfare Services (DHHS-SS)
C&FS	Children and Family Services
DCP	Discharge Planner
DHCS	Department of Health Care Services
DHHS	Department of Health and Human Services
Disallowance	A claim for a service which is denied or recouped due to not meeting regulatory standards
DT or DTC	Day Treatment or Day Treatment Center
EAP	Employee Assistance Program Emergency Action Plan
ERMHS	Educationally-Related Mental Health Services: Free, appropriate public education in the least restrictive environment for children with mental health challenges.
ECHC	Eureka Community Health Center
EPSDT	Early Periodic Screening Diagnosis and Treatment
FA	Fiscal Assistant
FIT	Family Intervention Team

FY	Fiscal Year, e.g. July 1, 2014 – June 30, 2015
FIT	Family Intervention Team
GR	General Relief
GV or G'Ville	Garberville
HCCF	Humboldt County Correctional Facility or Jail
HCL	Humboldt Central Lab
HCP	Henderson Center Pharmacy
HCMH	Humboldt County Mental Health
HF	Healthy Families
HFSC	Humboldt Family Service Center –An Organizational Provider for DHHS-MH
HIPAA	Health Insurance Portability and Accountability Act of 1996 refers to the protection of the privacy of individually identifiable health information. As part of this protection, release of information is required to share any information pertaining to client's care / services.
HMP	Healthy Moms Program (Perinatal MH / AOD Program)
HumWORKs	Humboldt County Work Opportunity & Responsibility for Kids (the Mental Health program in CalWORKs)
IDEA	Individuals with Disabilities Act
IHSS	In-Home Supportive Services
IMD	Institute for Mental Disease
Interventions	Refers to what the practitioner will do in order to assist client with meeting their objective and life goals. These are what drive reimbursements.
IP	Inpatient
JH	Juvenile Hall
LCSW	Licensed Clinical Social Worker
LE	Legal Entity: Each county mental health department or agency and the corporations, partnerships, or agencies, providing public mental health services under contract with the county mental health department or agency.
LPHA	Licensed Practitioner of the Healing Arts: physician, psychologist, licensed waivered MFT, LCSW, RN with Master's degree in Psychiatric Nursing
LPT	Licensed Psychiatric Technician
LVN	Licensed Vocational Nurse
MAA	Medi-Cal Administrative Activities
MAB	Management of Aggressive Behavior
MAC	Multiple Assistance Center, a residential program for homeless families
MC	Managed Care

MCO	Managed Care Organization: HCMMMHC MCO clients: clients who have Medi-Cal as their only insurance
Medi-Cal	California's Medicaid program, from which reimbursements for medically necessary services are received
Medicare	Federal Medical Aid
Meditrieve	HCMH on-line medical records system (see Sceris)
MEDS	Medi-Cal Eligibility Data System
Mental Health Medi-Cal	Another name for the program which oversees Short-Doyle / Medi-Cal claiming
MFT	Marriage and Family Therapist
MH	DHHS - Mental Health
MHB	Mental Health Advisory Board
MHP	Mental Health Plan, agreement between DHHS Mental Health and the State of California
MHRC	Mental Health Recovery Center (Crestwood Behavioral Health is an MHRC)
MHRS	Mental Health Rehabilitation Specialist: a person Who possesses either a Baccalaureate degree plus 4 years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment; a Master's degree plus 2 years of experience as above; or Associate degree plus 6 years of experience as above
MHS	Mental Health Services
MHW	Mental Health Worker
MO	Mobile Outreach
MOA	Medical Office Assistant
MORS	Milestones of Recovery is an effective evaluation tool for tracking the process of recovery for individuals with mental illness
MSW	Masters in Social Work
MTFC	Multidisciplinary Treatment Foster Care
NP	Nurse Practitioner
NPI	National Provider Identifier
NOA	Notice of Action is a letter provider sends out to communicate changes in services to clients and their families.
NSMH	Non-Specialty Mental Health (see SMH)

OA	Office Assistant
Objectives	Refer to the smaller accomplishments / steps the client makes in order to achieve their life goals
OP	Outpatient
PA	Physician's Assistant
PATH	Projects for Assistance in Transition from Homelessness- Mental Health grant program providing services to the homeless population
Peer Specialists	Services provided by clients and family members hired as program staff
PES	
PH	DHHS - Public Health
PHF	Psychiatric Health Facility – Sempervirens is a PHF as well as an acute psychiatric hospital
PHI	Protected Health Information
PHP	Public Health Pharmacy
PM	Program Manager
Practitioner	Licensed / Licensed-Waived / Trainee
Provider	A supplier of mental health services in California that are sued by county mental health programs
PRC	Peer Recovery Center
Psychiatric Prescriber	MD, DO, NP or PA
PT	Psychiatric Technician
PURT	Peer Utilization Review Team or process
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement, similar to QI and the term that DHHS-MH uses
QM	Quality Management
QIC	Quality Improvement Committee Quality Improvement Coordinator
R / A	Rite Aid Pharmacy
RAS	Request to Access Services: the form and the process, to be completed on all new clients when they request services
RCAA	Redwood Community Action Agency –an Organizational Provider
RCL	Rate Class Level set forth by Community Care Licensing
RCP	Red Cross Pharmacy
RCRC	Redwood Coast Regional Center
RF	Regional Facility
RN	Registered Nurse

ROI	Release of Information (authorization to release PHI) Documents signed by client and provider that permit specified information to be shared among designated persons and / or agencies regarding client's services and or treatment plan, for a designated period of time.
RV	Remi Vista; an Organizational Provider for DHHS-MH
RWD	Recovery, Wellness, and Discovery
SAC	Substance Abuse Counselor
SAMHSA	Substance Abuse & Mental Health Services Administration
Sempervirens	SV-MH's Psychiatric Health Facility (PHF)
Service Charge Code	Billing code used to denote service type
SCERIS	HCMH web-based on-line medical records system (see Meditrieve)
SED	Seriously Emotionally Disturbed: minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. [1]
SET	Support and Education Team
Significant Support Person	Refers to persons, in the opinion of the client or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to a parent, legal guardian, other family member, or other unrelated individual of a client who is a minor, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client.
SMH	Specialty Mental Health: MHB's target population, the statewide definition of which includes certain mental health diagnoses, impairment and intervention-related criteria
SOC	Share of Cost System of Care
SPMP	Skilled Professional Medical Personnel
SS	Support Staff DHHS – Social Services

[1] W&I Code 5600.3

Stage of Recovery	Refers to practitioner's impression of where the client is; Client's stage of readiness to make changes to improve their quality of life; stage of change will inform treatment plan goals and interventions.
SV	Sempervirens-MH's Psychiatric Health Facility (PHF)

SV	Sempervirens – MH's acute psychiatric hospital, located on the 2nd floor of the Main Building at 720 Wood St.
SW	Social Worker
TAY	Transition Age Youth
TBA	Therapeutic Behavioral Aid (see TBS)
TBS	Therapeutic Behavioral Services: intensive 1:1 services for at-risk children who meet the criteria. This service is called BC (Behavioral Coaching) when the service is provided in a lockout situation (like on SV)
Title 9	Portion of California Code of Regulations Community Mental Health Services
TRTF	Transitional Residential Treatment Facility
UMDAP	Uniform Method of Determining Ability to Pay
UR	Utilization Review
USC	U.S. Government Code
WIC or W&I Code	Welfare and Institutions Code
WRAP	Wraparound – intensive services for children

Appendix B: Approved Abbreviations

abd.	abdomen
ac	before meals
acc.	Accompanied
ACTS	activities
A / D	antidepressant
ADHD	Attention Deficit Hyperactivity Disorder
ADL	activities of daily living
ad lib	as often as desired
adm	admission
A / H	auditory hallucinations
AIMS	abnormal involuntary movements
AKA	also known as
AMA	against medical advice
amb	ambulatory
AMB	ambulance
amp	ampule
amphet	amphetamines
amt	amount
ant.	anterior
A.P.	apical pulse
APAP	Tylenol or acetaminophen
approx, ≈	approximately
approp.	appropriate(ly)
appt.	appointment
apt.	apartment
ASAP, asap	as soon as possible
ASA	aspirin
assess.	Assessment
A.T.	Activities Therapist
a.t.t.	at this time
attn.	attention
ax	axillary
BAD	Bipolar Affective Disorder
b / f	boyfriend
BG	blood glucose
BIB	brought in by
BID	twice daily
bkf.	Breakfast
B.M.	bowel movement
B / P	blood pressure

BPD	Borderline Personality Disorder or Bipolar Disorder (must specify with DSM code)
br	bathroom
bro	brother
brp	bathroom privileges
BS	breath sounds or bowel sounds
BUN	blood urea nitrogen
bx	behavior
Ca	calcium
cann.	cannabis (marijuana)
cap	capsule
Cauc	Caucasian
CBC	complete blood count
CC	chief complaint
cc	cubic centimeter
cig	cigarette(s)
Coll.	Collateral
cm	centimeter
c / o	complains of
conc.	Concentrate
cont.	continued
coop	cooperative
coord.	coordinate or coordinator
COPD	Chronic Obstructive Pulmonary Disease
cor	heart
COS	change of shift
CP	Client Plan
CPT Schiz	Chronic Paranoid Type Schizophrenia
Cpz	Chlorpromazine, Thorazine
CS	Crisis Specialist
CSF	cerebro-spinal fluid
ct.	client
CUT Schiz	Chronic Undifferentiated Type Schizophrenia
CXR	chest x-ray
D / C or DC	discontinue or discharge
Da or Dau	daughter
Dec	Decanoate
disc	discussed
D / O or d / o	disorder
DOB	date of birth
DON	Director of Nurses
DP	Discharge Planner
dr	dram

d / r	dining room
DSM	Diagnostic and Statistical Manual
D / S	Discharge Summary
d / t	due to
DT	delirium tremens
DTO	danger to others
DTS	danger to self
Dx	diagnosis
DWF / DWM	divorced white female / male
ECG or EKG	electrocardiogram
ECT	electroconvulsive therapy
educ	educate, education
EEG	electroencephalogram
e.g.	for example
elix	elixir
EMA	early morning awakening
EMW	early morning wakening
enc	encourage(d)
ENT	ear, nose and throat
EOMI	extra ocular movements intact
EPR	extrapyramidal reaction
EPS	extrapyramidal symptoms
eq	equal
ER, ED	Emergency Room, Department
esp	especially
ETOH	alcohol
eval	evaluation
F	female
Fa	father
FAS	fetal alcohol syndrome
FBS	fasting blood sugar
FG	fasting glucose
fl	fluid
FOI	flight of ideas
freq	frequent(ly)
FTA	failed to appear
F / T	full time
FTD	formal thought disorder
f / u	follow up
FUO	fever of undetermined origin
fx	fracture
GD	gravely disabled
g / f	girlfriend

GI	gastrointestinal
GM	grand mal
Gm, gm	gram
gr	grains
grp(s)	group(s)
GSW	gun shot wound
gtts	drops
GU	genitourinary
G / W	glucose and water
h	hour
H	heroin
H / A	headache
Hct	hematocrit
Hgb	hemoglobin
H / H	hematocrit / hemoglobin
H / I	homicidal ideation
H / O or h / o	history of
HPI	history of present illness
HS or hs	bedtime (hour of sleep)
Hsb	husband
Ht., ht.	height
H / V	home visit
Hys	hysterical
Hx or hx	history
H_20	water
IDDM	Insulin Dependent Diabetes Mellitus
e.g.	that is, for example
IM	intramuscular
immed	immediate(ly)
inc.	incomplete
incl	include, including, inclusive
indep	independent(ly)
IP	inpatient
IQ	intelligence quotient, intellect
IU / L	international units per Liter
interv.	intervention(s)
I&O	intake and output
IOR	ideas of reference
IPPB	intermittent positive pressure breathing
IV	intravenous
IVP	intravenous pyelogram
K	potassium
Kg	kilogram

L	liter
LAF / LAM	Latin American female / male
lb., #	pound
LD	left deltoid
LiCo	Lithium Carbonate
liq	liquid
LLQ	left lower quadrant
LLT	left lateral thigh
LMP	last menstrual period
LOA	leave of absence
LOC	loss of consciousness
LT	long term
LUOQ	left upper outer quadrant (gluteus)

Marital status:

D	divorced
M	married
S	single
W	widowed

M	male
MAOI	mono-amine Oxidase Inhibitor
max	maximum
M / C	Medi-Cal
mcg	micrograms
MDD	Major Depressive Disorder
Med Nec	medical necessity
MS	medication support
med(s)	medication(s)
mEq	milliequivalents
meth	methamphetamine
mg	milligram
MH	Mental Health
min	minute(s)
MJ	marijuana
ml	milliliter
mm	millimeter
Mo	mother
mod	modify(ied)
mo(s)	month(s)
MR	may repeat
MSE	Mental Status Exam
ms, msg	message
mtg	meeting
MVA	motor vehicle accident

Na	sodium
narc	narcotic
neg	negative
NIDDM	Non-Insulin Dependent Diabetes Mellitus
NL	normal
NLT	no later than
NMP	no management problem
No., #	number
noc	night
NPO	nothing by mouth
N / V	nausea and / or vomiting
n / s	nurses' station
NTE	not to exceed
NMT	no more than
OBS	Organic Brain Syndrome
obs	observation(s)
OCD	Obsessive Compulsive Disorder
O / D or OD	overdose
O.D.	ocular dexter (right eye)
oint	ointment
oob	out of bed
ooc	out of county
ooh	out of hospital
oor	out of room
OPC, OPD	Outpatient Clinic, Department
O / R	own recognizance
os	mouth
O.S.	left eye (ocular sinister)
O.T.	Occupational Therapist
O.U.	both eyes (ocular units)
Ox4	oriented times 4
OV(s)	office visit(s)
oz.	ounce
P	pulse
PAP	papanicolaou test
PC	Probable Cause
P.C.	Penal Code
p.c.	after meals
p / c	phone calls
PD	Personality Disorder
P.E.	physical examination
PE	psychiatric examination
PERRL	pupils equal, round and reactive to light

pg	pregnant
PGO	Public Guardian's Office
pH	potential of hydrogen – degree of acidity or alkalinity
ph	phone
PD	Plan Development
pm	after noon
PMA	psychomotor activity
PO	by mouth, orally – per os
p.p.	after meals – post prandial
PPD	tuberculin skin test (for TB)
ppr	per patient request
pprwk	paperwork
PN	progress note
PR	Peer Review
PRN, prn	as needed
PRA	Patients' Rights Advocate
prob	problem(s)
prog	program
pro time	prothrombin time
PT	Psychiatric Tech
pt.	patient
P / T	part time
PTA	prior to admission
PTSD	Post Traumatic Stress Disorder
p / u	pick up
q	every
qd	every day
QHS	every bedtime
QID	four times a day
QOD	every other day
q.s.	sufficient quantity
qt	quart
R&B	risks and benefits
RBC	red blood count
R.D.	right deltoid
Re, RE	regarding
rec.	recreation
rec'd	received
ref.	refused
reg.	regular
Reg(s)	regulation(s)
rest.	restriction
rev.	review

RL	right / left
R.L.Q.	right lower quadrant
R.L.T.	right lateral thigh
R.N.	registered nurse
R / O or r / o	rule out
R.O.M.	range of motion
ROS	review of systems
R.R.	room restriction
RTC	return to clinic
R.U.O.Q.	right upper outer quadrant (gluteus)
Rx	prescription; take
Rxn	reaction
sub., subj	subject
S / A	suicide attempt
S.A.	substance abuse
Serv Nec	service necessity
S / I	suicidal ideation
sig.	label
Sis	sister
sl	slightly
S.L.	sublingual
S.O.B.	shortness of breath
Sol	solution
s / p	status post
spec.	specimen
$\overline{s}$ $\overline{s}$	one half
S / S	signs and symptoms
S.S.E.	Social Service Evaluation
SSI	Supplemental Security Income
S.T.	short term
STAT	at once, immediately
Sub q	subcutaneous(ly)
supp.	Suppository
Sx	symptoms
Sz	seizure(s)
tab	tablet
Tbsp	tablespoon
T.C.A.	tricyclic antidepressants
T-con	temporary conservatorship
TD	Tardive Dyskinesia
TDD	total daily dose
temp.	temperature
O	oral

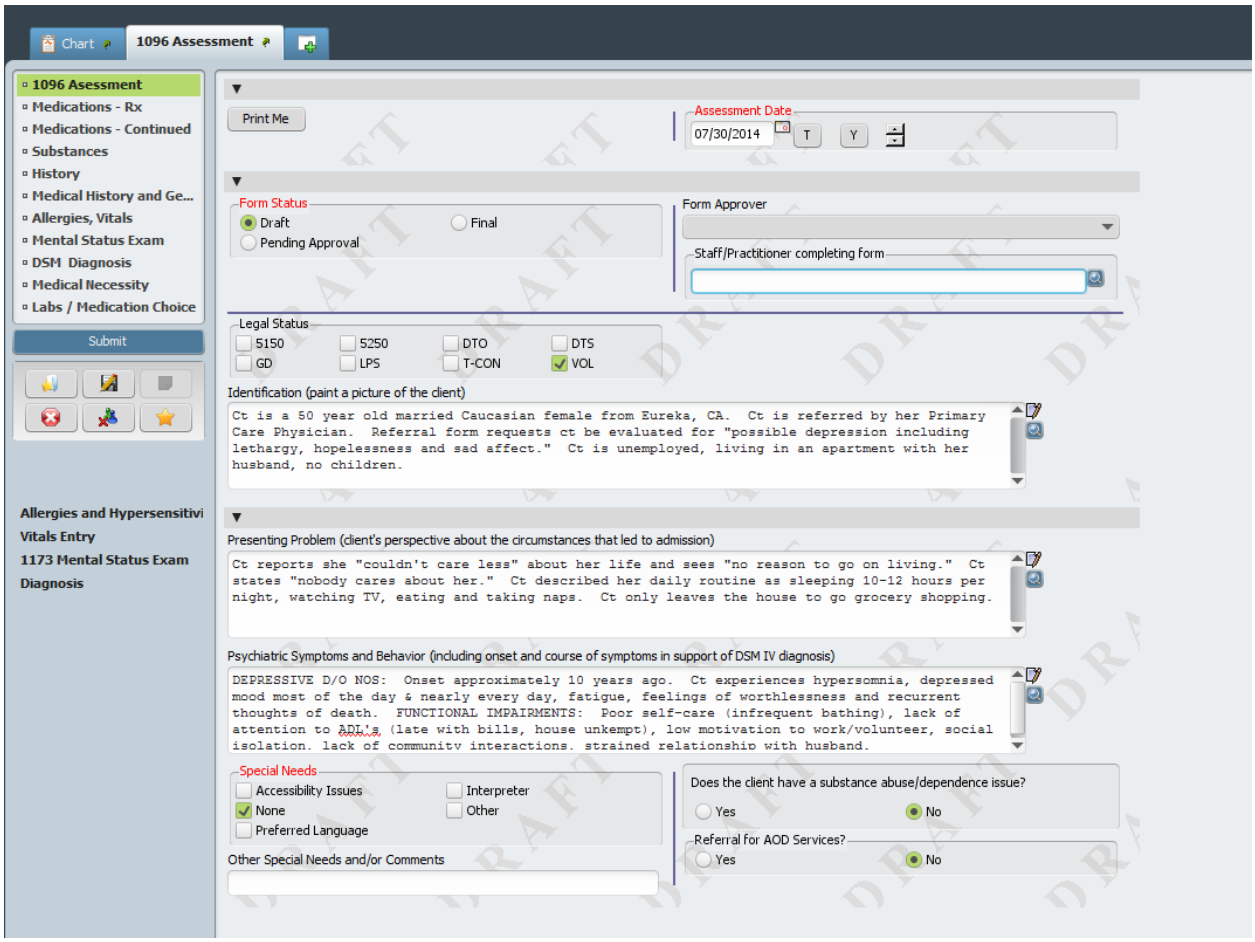
R	rectal
Ax	axillary
THC	tetrahydrocannabinol, the active ingredient in MJ
TID	three times a day
Tinct.	Tincture
TLC	tender loving care
T.O.	telephone order
TPR	temperature, pulse, respirations
tsp	teaspoon
Tx, tx	treatment or therapy
UA	urinalysis
U.G.I.	upper gastrointestinal series
unacc.	unaccompanied
ung	ointment
URI	upper respiratory infection
UTI	urinary tract infection
VD	venereal disease
VDRL	test for syphilis
VH, V / H	visual hallucination(s)
V / O	verbal order
vol	voluntary
V.S., V / S	vital signs
W / A	wide awake
WBC	white blood count
w / c	wheelchair
WD / WN	well-developed, well-nourished
W / E	weekend
wh	which
wk	week
wnl, WNL	within normal limits
Wt., wt	weight
x	times
y / o, y.o.	year(s) old
yr(s)	year(s)

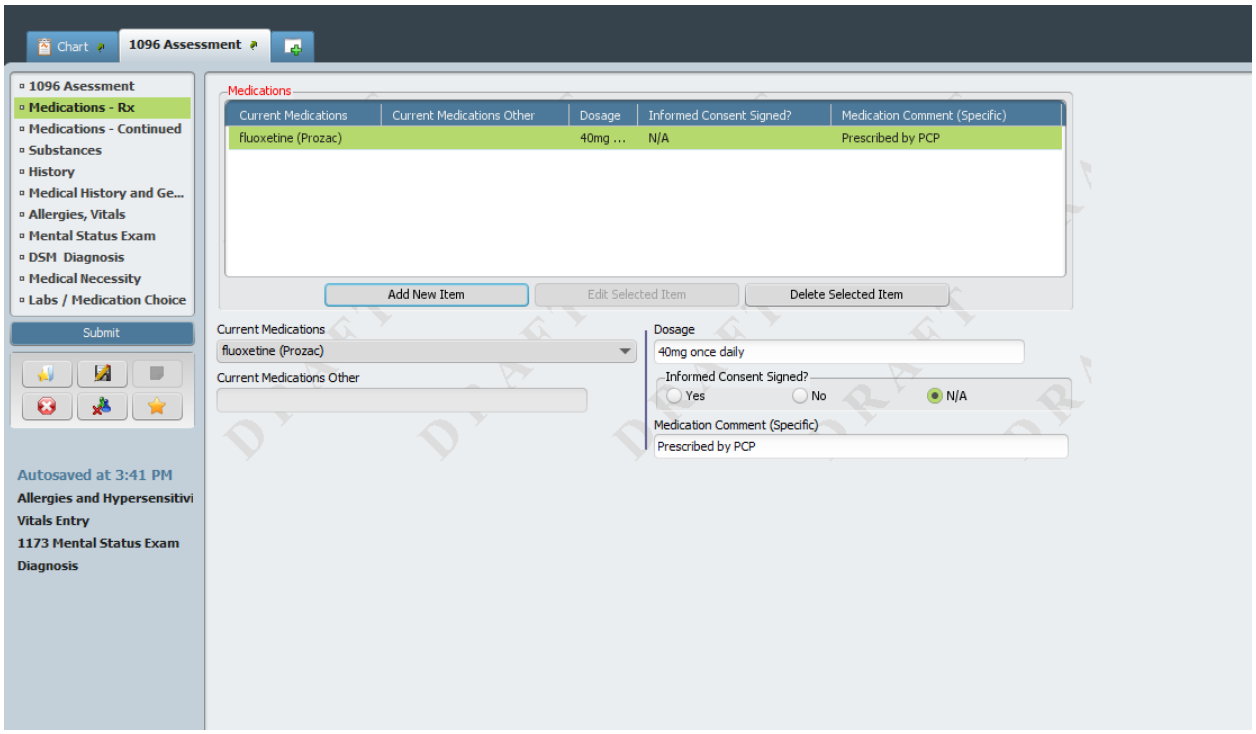
Appendix C: Approved Symbols

@	at
+	plus
#	number, pound
%	percent
=	equal
>	greater than
<	less than
Δ	change
♂	male
♀	female
$	money, dollar
N	degree
B	minus
≈, ~	approximately
±	plus or minus
↑	increase, up, elevated
↓	decrease, down, depressed
✓(ed,s,ing)	check(ed,s,ing)
≥	greater than or equal to
≤	lesser than or equal to
1:1	one-to-one
○	hours
'	minutes or feet
″	seconds or inches
5150	WIC 72 hour hold for mental health evaluation
5250 (or 14 day Cert)	Welfare & Institutions Code 14 day hold
0	no, none, not
a̅	before
c̅	with
s̅	without
Ⓛ	left
ⓜ	murmur
p̅	after
Ⓡ	right

Appendix D: Examples

Assessment

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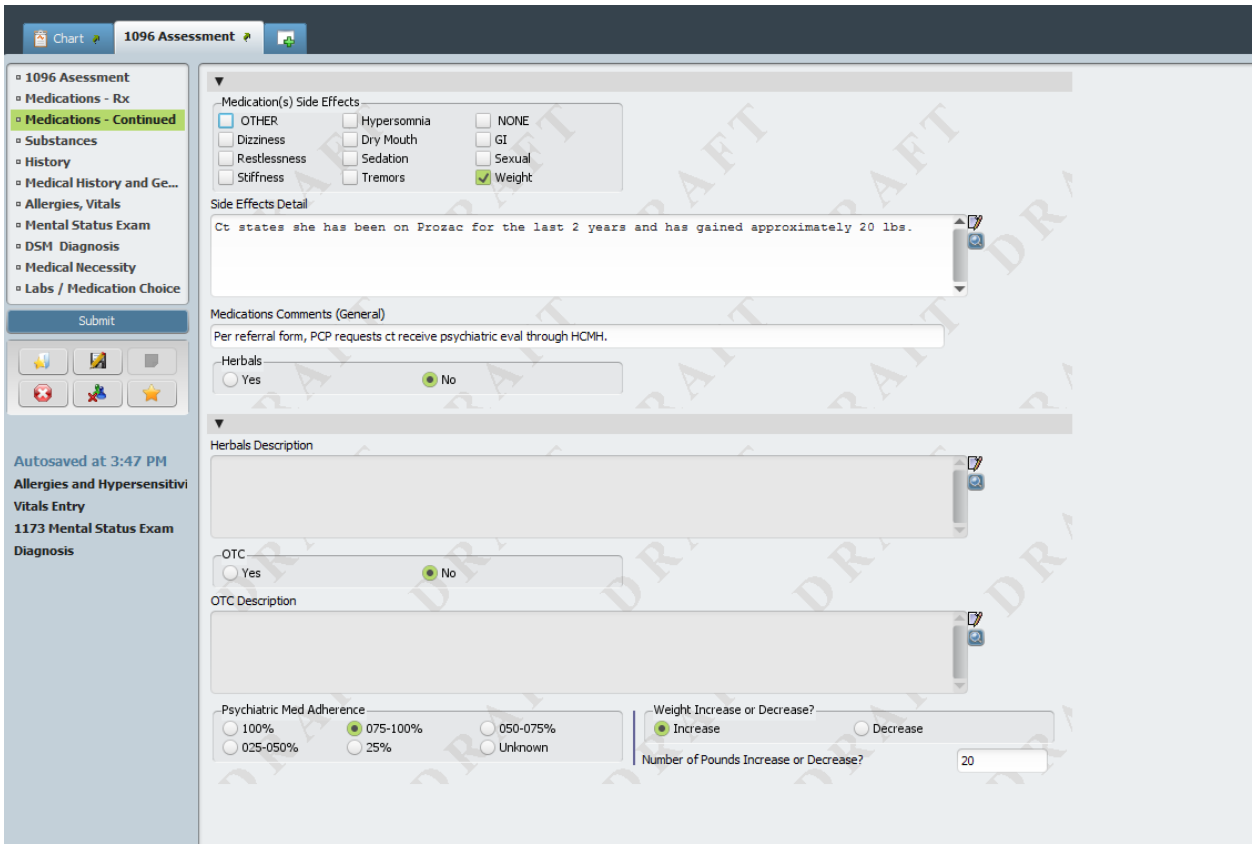
Medications - Rx
Medications - Continued
Substances
History
Medical History and Ge...
Allergies, Vitals
Mental Status Exam
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Submit
Autosaved at 3:41 PM
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Medications
Current Medications
Current Medications Other
Dosage
Informed Consent Signed?
Medication Comment (Specific)
fluoxetine (Prozac)
40mg ...
N/A
Prescribed by PCP
Add New Item
Edit Selected Item
Delete Selected Item
Current Medications
fluoxetine (Prozac)
Current Medications Other
Dosage
40mg once daily
Informed Consent Signed?
Yes
No
N/A
Medication Comment (Specific)
Prescribed by PCP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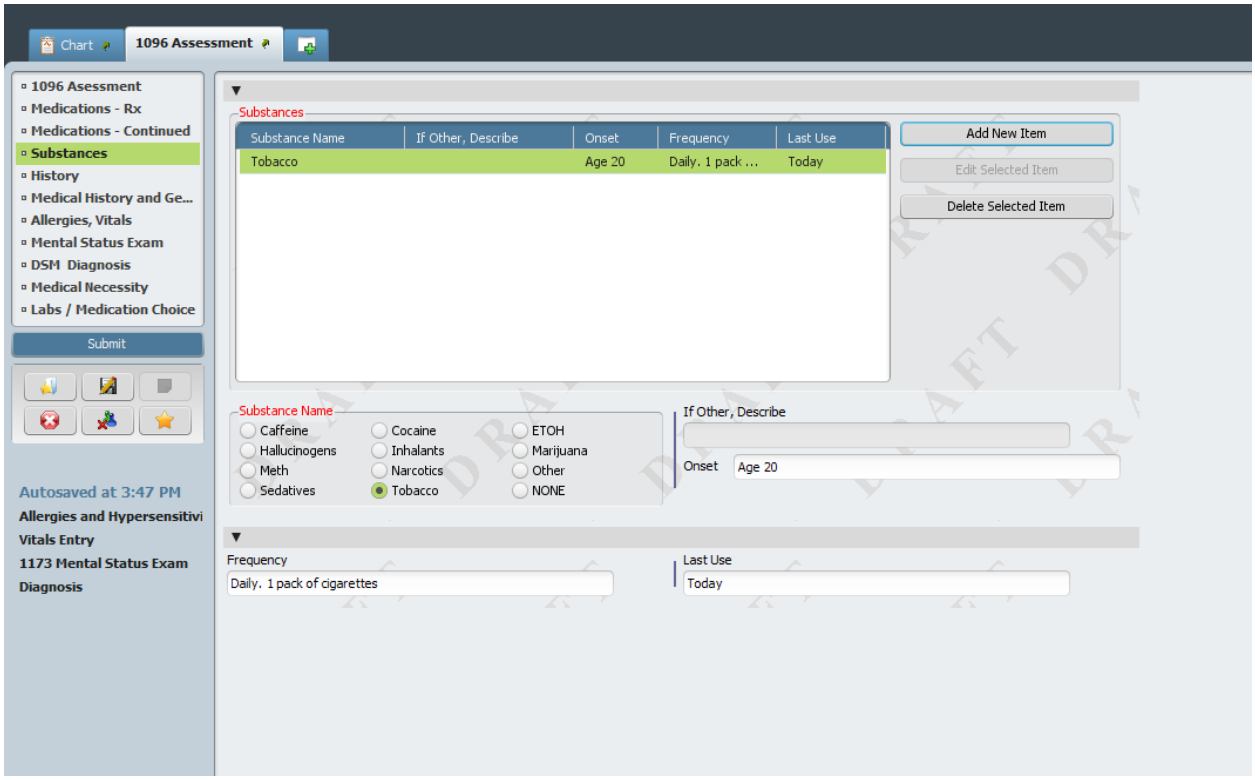
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Medication(s) Side Effects
OTHER
Hypersomnia
NONE
Dizziness
Dry Mouth
GI
Restlessness
Sedation
Sexual
Stiffness
Tremors
Weight
Side Effects Detail
Ct states she has been on Prozac for the last 2 years and has gained approximately 20 lbs.
Medications Comments (General)
Per referral form, PCP requests ct receive psychiatric eval through HCMH.
Herbals
Yes
No
Herbals Description
OTC
Yes
No
OTC Description
Psychiatric Med Adherence
100%
075-100%
050-075%
025-050%
25%
Unknown
Weight Increase or Decrease?
Increase
Decrease
Number of Pounds Increase or Decrease?
20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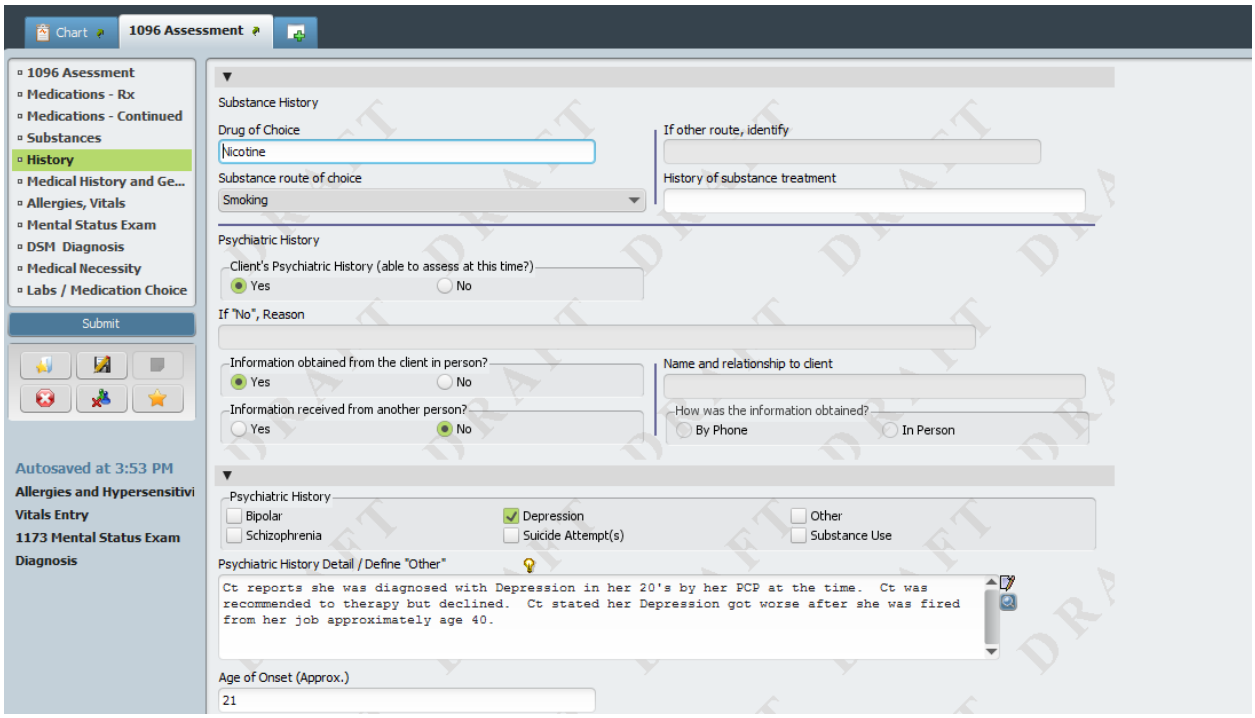
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Submit
Autosaved at 3:47 PM
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Substances
Substance Name
If Other, Describe
Onset
Frequency
Last Use
Tobacco
Age 20
Daily. 1 pack ...
Today
Add New Item
Edit Selected Item
Delete Selected Item
Substance Name
Caffeine
Cocaine
ETOH
Hallucinogens
Inhalants
Marijuana
Meth
Narcotics
Other
Sedatives
Tobacco
NONE
If Other, Describe
Onset
Age 20
Frequency
Daily. 1 pack of cigarettes
Last Use
Today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Allergies, Vitals
Mental Status Exam
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
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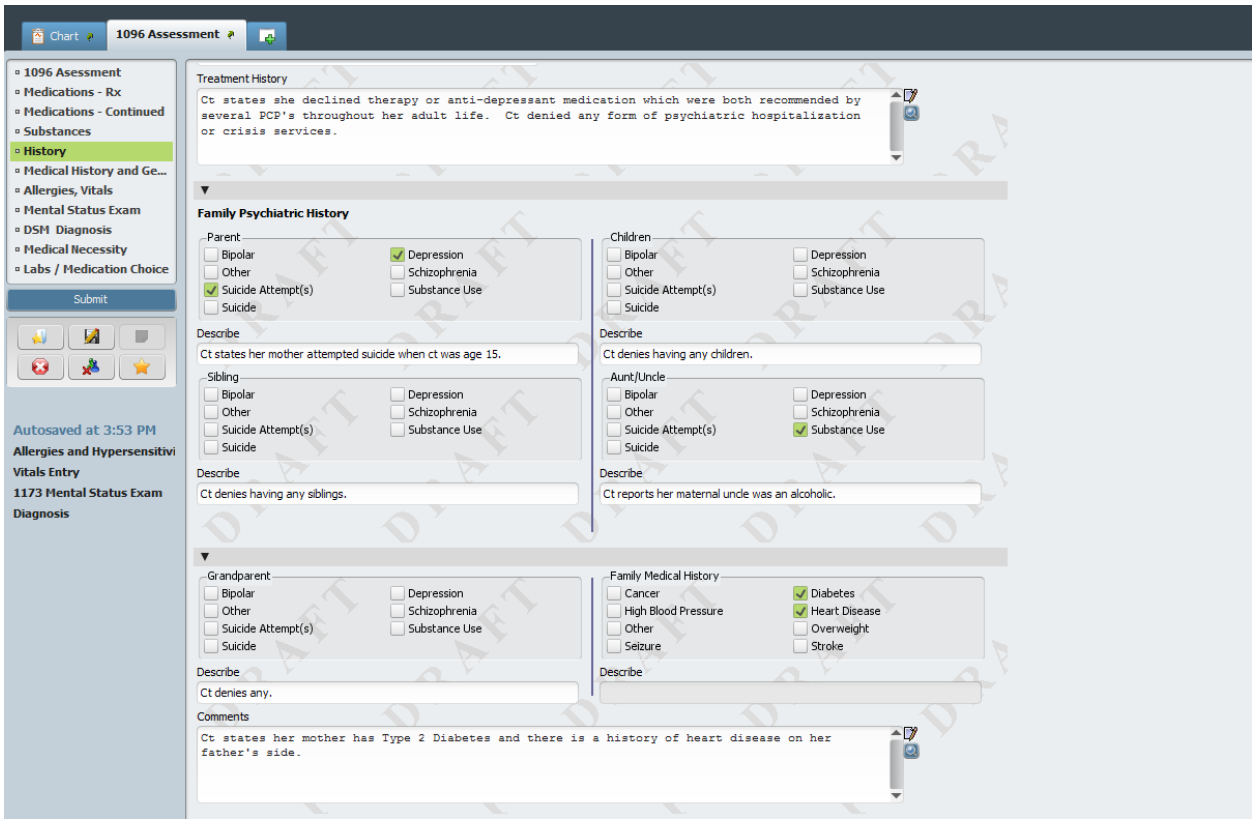
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Substance History
Drug of Choice
Nicotine
If other route, identify
Substance route of choice
Smoking
History of substance treatment
Psychiatric History
Client's Psychiatric History (able to assess at this time?)
Yes
No
If "No", Reason
Information obtained from the client in person?
Yes
No
Name and relationship to client
Information received from another person?
Yes
No
How was the information obtained?
By Phone
In Person
Psychiatric History
Bipolar
Depression
Other
Schizophrenia
Suicide Attempt(s)
Substance Use
Psychiatric History Detail / Define "Other"
Ct reports she was diagnosed with Depression in her 20's by her PCP at the time. Ct was recommended to therapy but declined. Ct stated her Depression got worse after she was fired from her job approximately age 40.
Age of Onset (Approx.)
21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Medications - Continued
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Medical History and Ge...
Allergies, Vitals
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DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Submit
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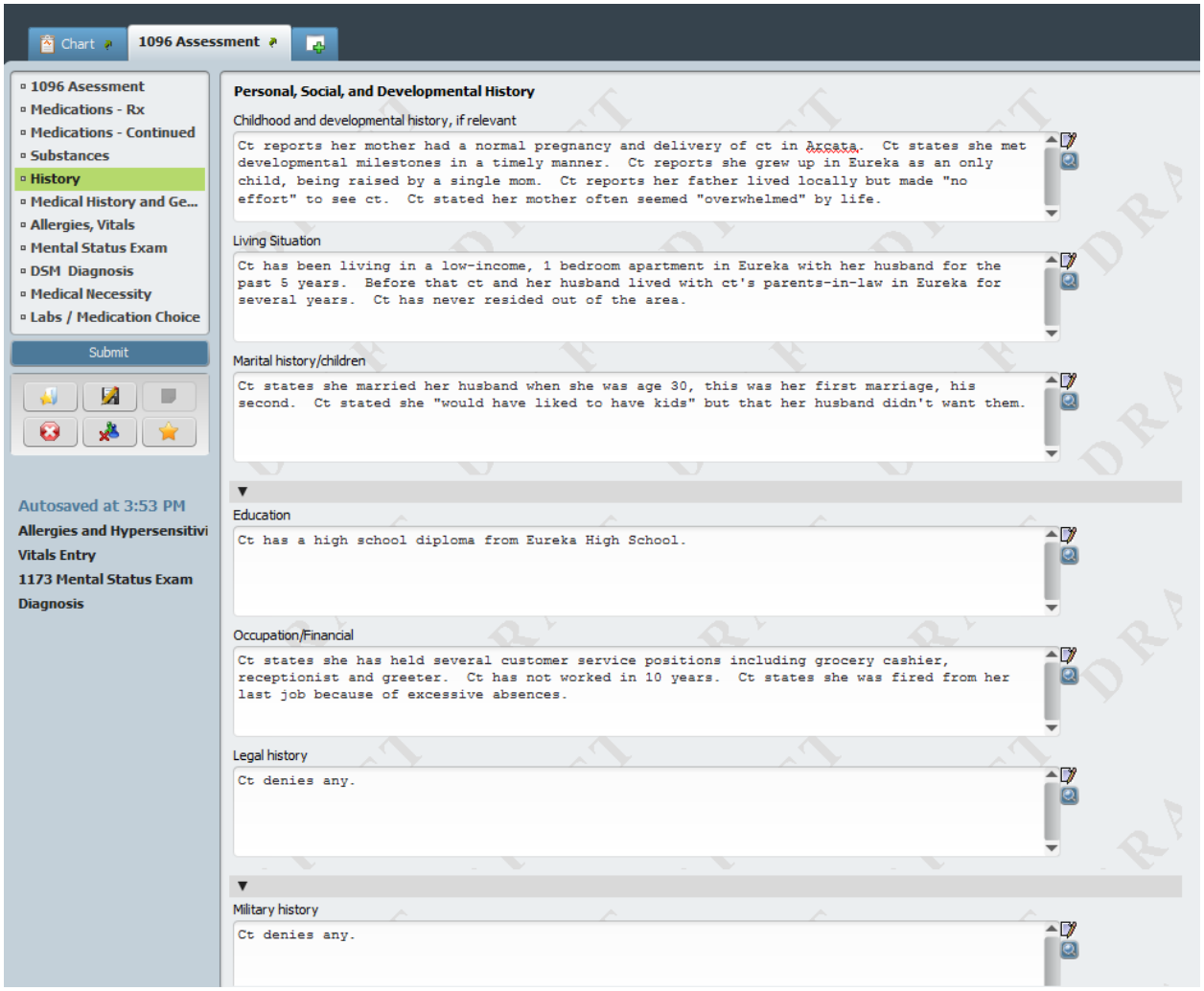
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Treatment History
Ct states she declined therapy or anti-depressant medication which were both recommended by several PCP's throughout her adult life. Ct denied any form of psychiatric hospitalization or crisis services.
Family Psychiatric History
Parent
Bipolar
Depression
Other
Schizophrenia
Suicide Attempt(s)
Substance Use
Suicide
Describe
Ct states her mother attempted suicide when ct was age 15.
Children
Bipolar
Depression
Other
Schizophrenia
Suicide Attempt(s)
Substance Use
Suicide
Describe
Ct denies having any children.
Sibling
Bipolar
Depression
Other
Schizophrenia
Suicide Attempt(s)
Substance Use
Suicide
Describe
Ct denies having any siblings.
Aunt/Uncle
Bipolar
Depression
Other
Schizophrenia
Suicide Attempt(s)
Substance Use
Suicide
Describe
Ct reports her maternal uncle was an alcoholic.
Grandparent
Bipolar
Depression
Other
Schizophrenia
Suicide Attempt(s)
Substance Use
Suicide
Describe
Ct denies any.
Family Medical History
Cancer
Diabetes
High Blood Pressure
Heart Disease
Other
Overweight
Seizure
Stroke
Describe
Comments
Ct states her mother has Type 2 Diabetes and there is a history of heart disease on her father's side.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Submit
Autosaved at 3:53 PM
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Personal, Social, and Developmental History
Childhood and developmental history, if relevant
Ct reports her mother had a normal pregnancy and delivery of ct in Arcata. Ct states she met developmental milestones in a timely manner. Ct reports she grew up in Eureka as an only child, being raised by a single mom. Ct reports her father lived locally but made "no effort" to see ct. Ct stated her mother often seemed "overwhelmed" by life.
Living Situation
Ct has been living in a low-income, 1 bedroom apartment in Eureka with her husband for the past 5 years. Before that ct and her husband lived with ct's parents-in-law in Eureka for several years. Ct has never resided out of the area.
Marital history/children
Ct states she married her husband when she was age 30, this was her first marriage, his second. Ct stated she "would have liked to have kids" but that her husband didn't want them.
Education
Ct has a high school diploma from Eureka High School.
Occupation/Financial
Ct states she has held several customer service positions including grocery cashier, receptionist and greeter. Ct has not worked in 10 years. Ct states she was fired from her last job because of excessive absences.
Legal history
Ct denies any.
Military history
Ct denies any.

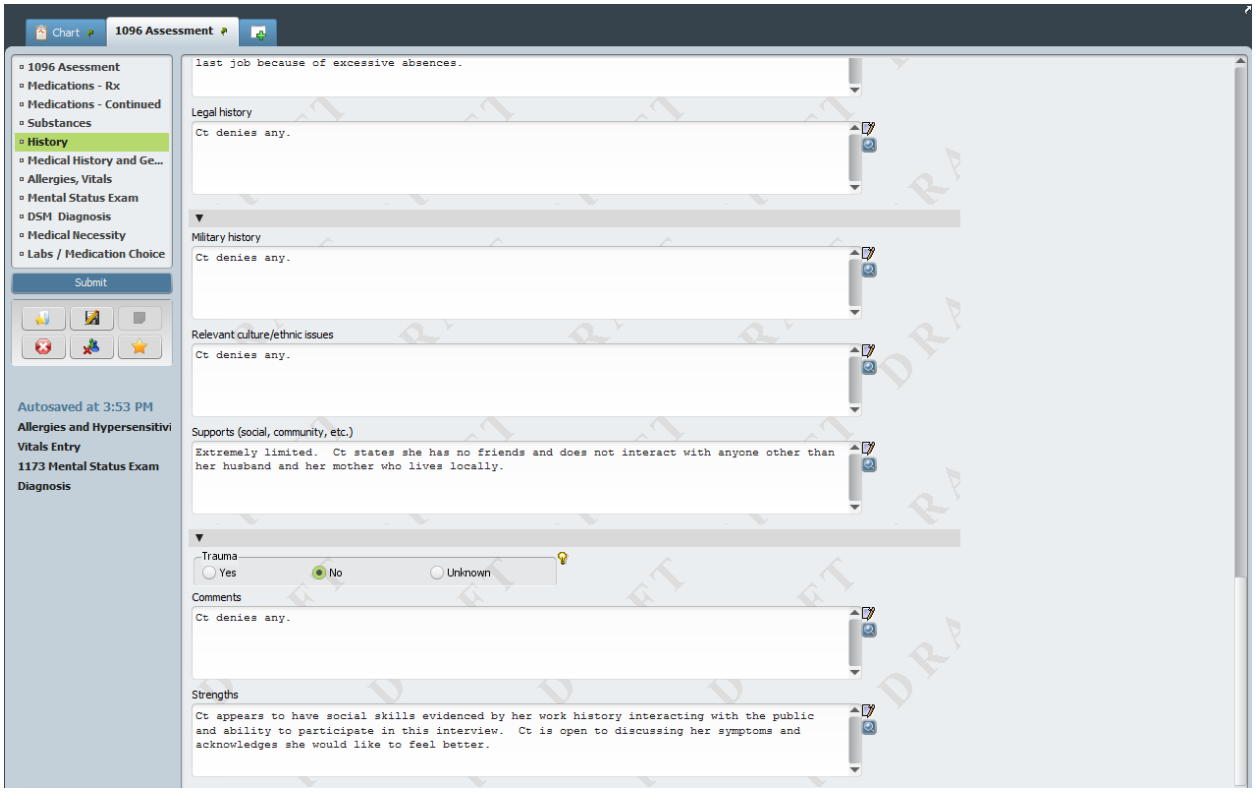
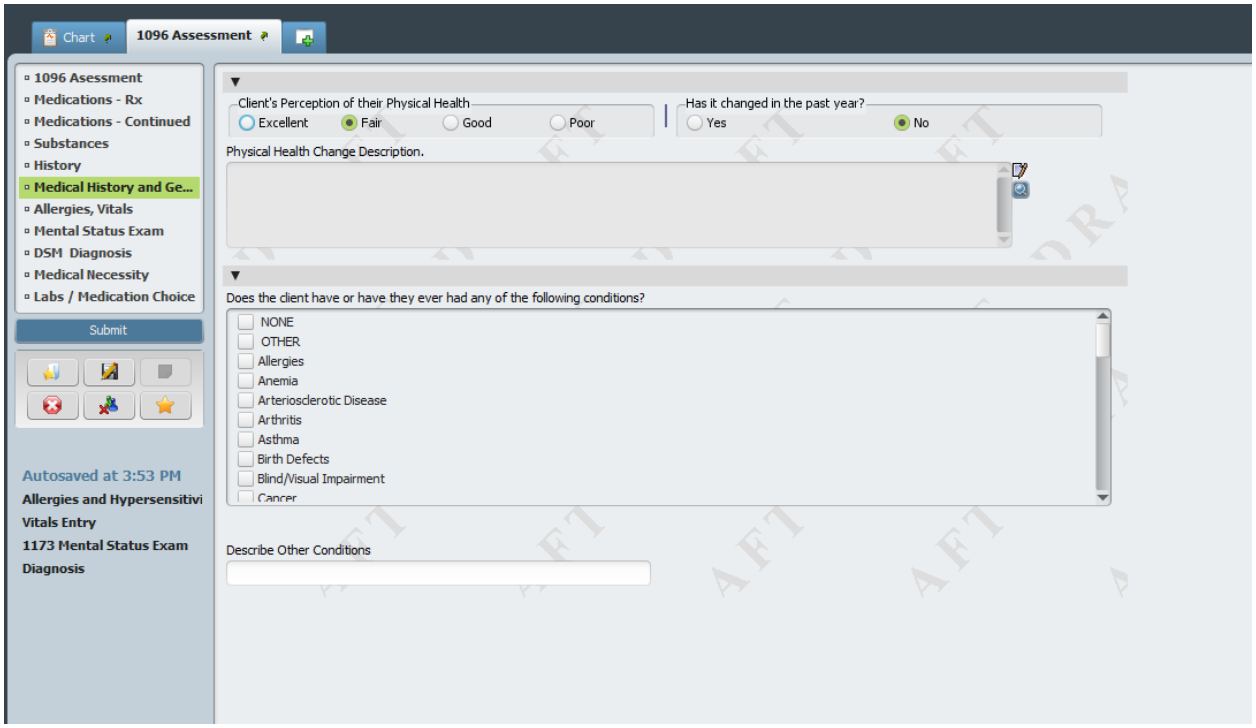


Chart
1096 Assessment
1096 Assessment
Medications - Rx
Medications - Continued
Substances
History
Medical History and Ge...
Allergies, Vitals
Mental Status Exam
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Submit
Autosaved at 3:53 PM
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
last job because of excessive absences.
Legal history
Ct denies any.
Military history
Ct denies any.
Relevant culture/ethnic issues
Ct denies any.
Supports (social, community, etc.)
Extremely limited. Ct states she has no friends and does not interact with anyone other than her husband and her mother who lives locally.
Trauma
Yes
No
Unknown
Comments
Ct denies any.
Strengths
Ct appears to have social skills evidenced by her work history interacting with the public and ability to participate in this interview. Ct is open to discussing her symptoms and acknowledges she would like to feel better.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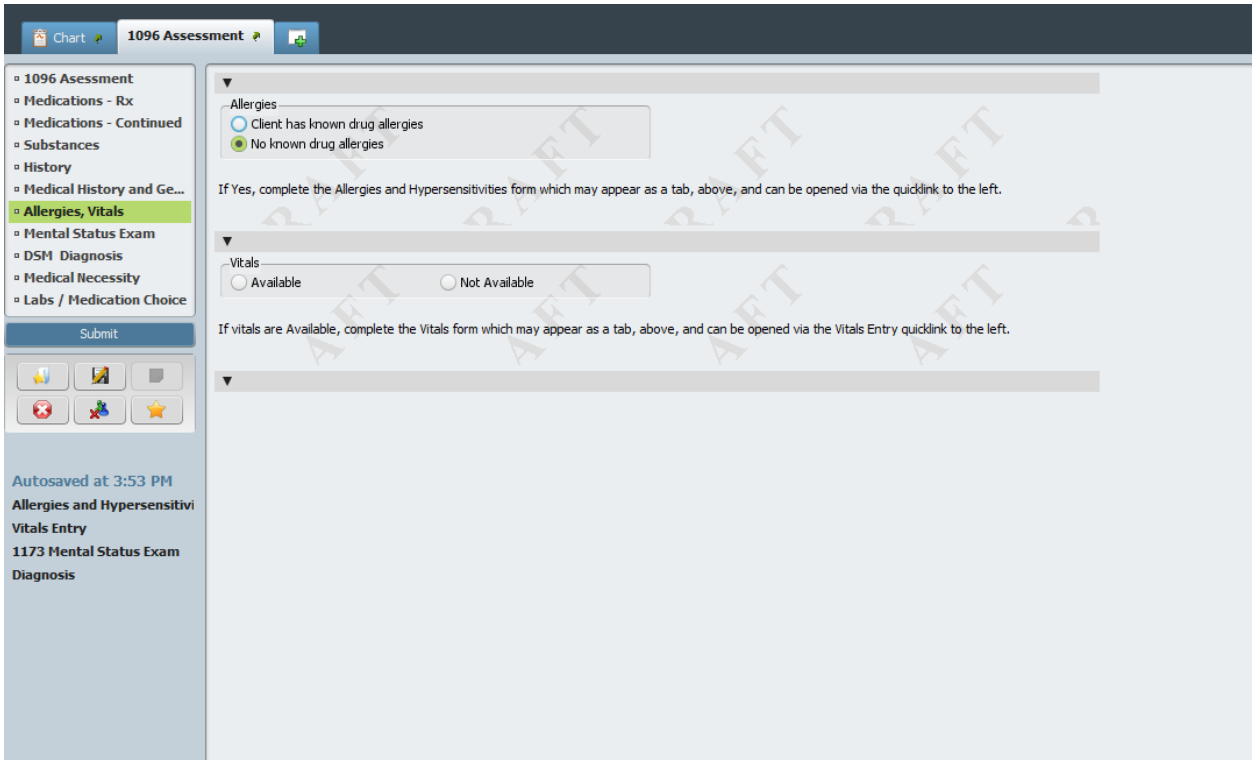
1096 Assesment
Medications - Rx
Medications - Continued
Substances
History
Medical History and Ge...
Allergies, Vitals
Mental Status Exam
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Submit
Autosaved at 3:53 PM
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Client's Perception of their Physical Health
Excellent
Fair
Good
Poor
Has it changed in the past year?
Yes
No
Physical Health Change Description.
Does the client have or have they ever had any of the following conditions?
NONE
OTHER
Allergies
Anemia
Arteriosclerotic Disease
Arthritis
Asthma
Birth Defects
Blind/Visual Impairment
Cancer
Describe Other Conditions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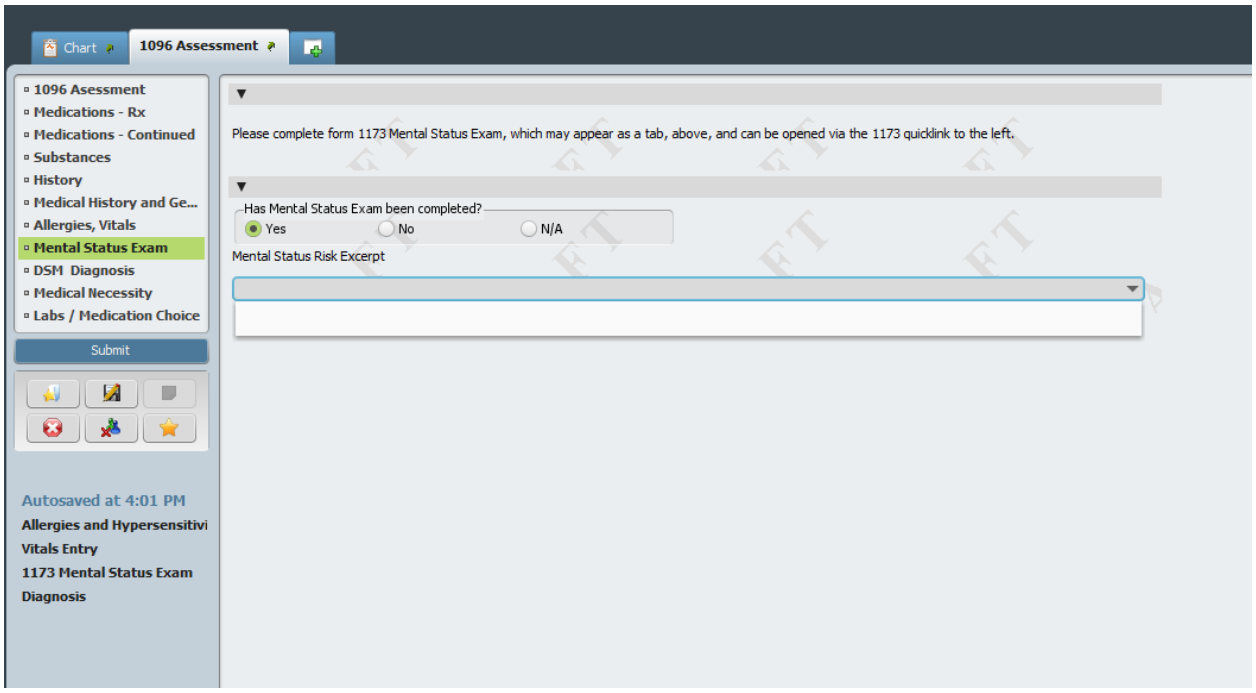
1096 Assessment
1096 Asessment
Medications - Rx
Medications - Continued
Substances
History
Medical History and Ge...
Allergies, Vitals
Mental Status Exam
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Submit
Autosaved at 3:53 PM
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Allergies
Client has known drug allergies
No known drug allergies
If Yes, complete the Allergies and Hypersensitivities form which may appear as a tab, above, and can be opened via the quicklink to the left.
Vitals
Available
Not Available
If vitals are Available, complete the Vitals form which may appear as a tab, above, and can be opened via the Vitals Entry quicklink to the left.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Medications - Rx
Medications - Continued
Substances
History
Medical History and Ge...
Allergies, Vitals
Mental Status Exam
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Submit
Autosaved at 4:01 PM
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Please complete form 1173 Mental Status Exam, which may appear as a tab, above, and can be opened via the 1173 quicklink to the left.
Has Mental Status Exam been completed?
Yes
No
N/A
Mental Status Risk Excerpt

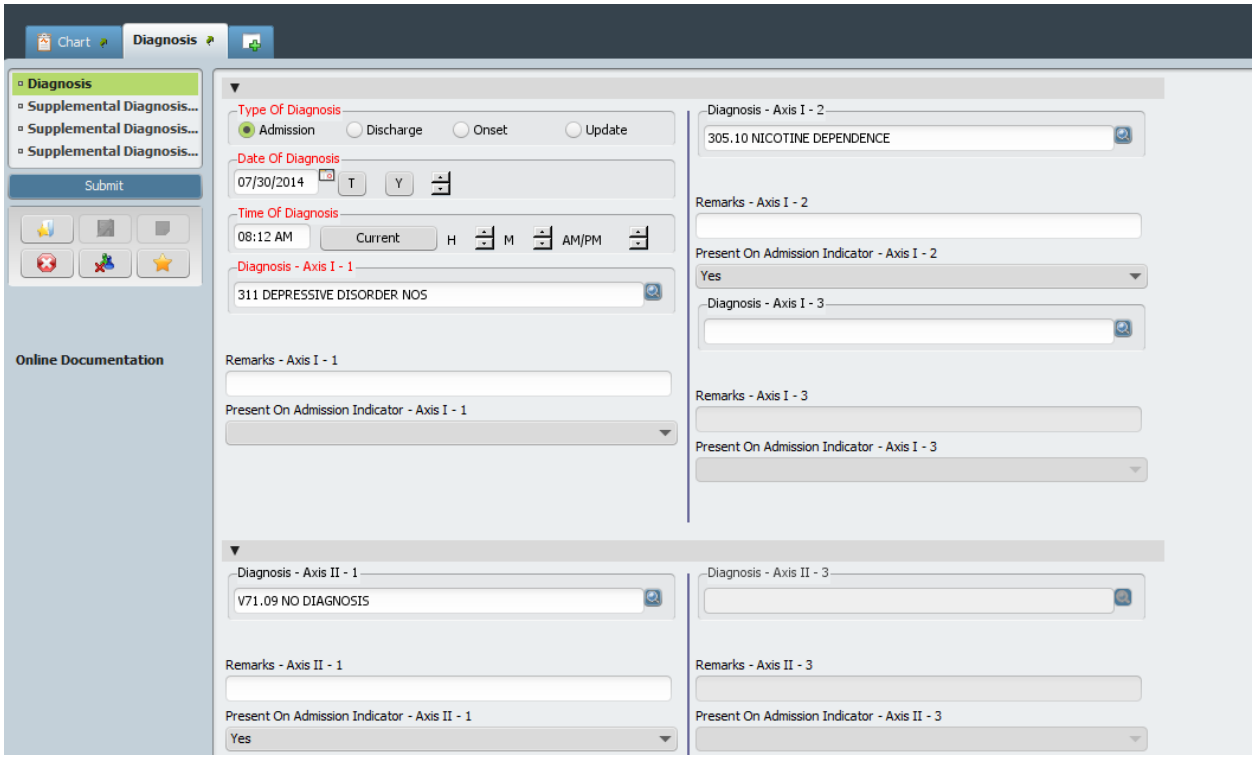


Chart
Diagnosis
Diagnosis
Supplemental Diagnosis...
Supplemental Diagnosis...
Supplemental Diagnosis...
Submit
Online Documentation
Type Of Diagnosis
Admission
Discharge
Onset
Update
Date Of Diagnosis
07/30/2014
T
Y
Time Of Diagnosis
08:12 AM
Current
H
M
AM/PM
Diagnosis - Axis I - 1
311 DEPRESSIVE DISORDER NOS
Remarks - Axis I - 1
Present On Admission Indicator - Axis I - 1
Diagnosis - Axis I - 2
305.10 NICOTINE DEPENDENCE
Remarks - Axis I - 2
Present On Admission Indicator - Axis I - 2
Yes
Diagnosis - Axis I - 3
Remarks - Axis I - 3
Present On Admission Indicator - Axis I - 3
Diagnosis - Axis II - 1
V71.09 NO DIAGNOSIS
Remarks - Axis II - 1
Present On Admission Indicator - Axis II - 1
Yes
Diagnosis - Axis II - 3
Remarks - Axis II - 3
Present On Admission Indicator - Axis II - 3

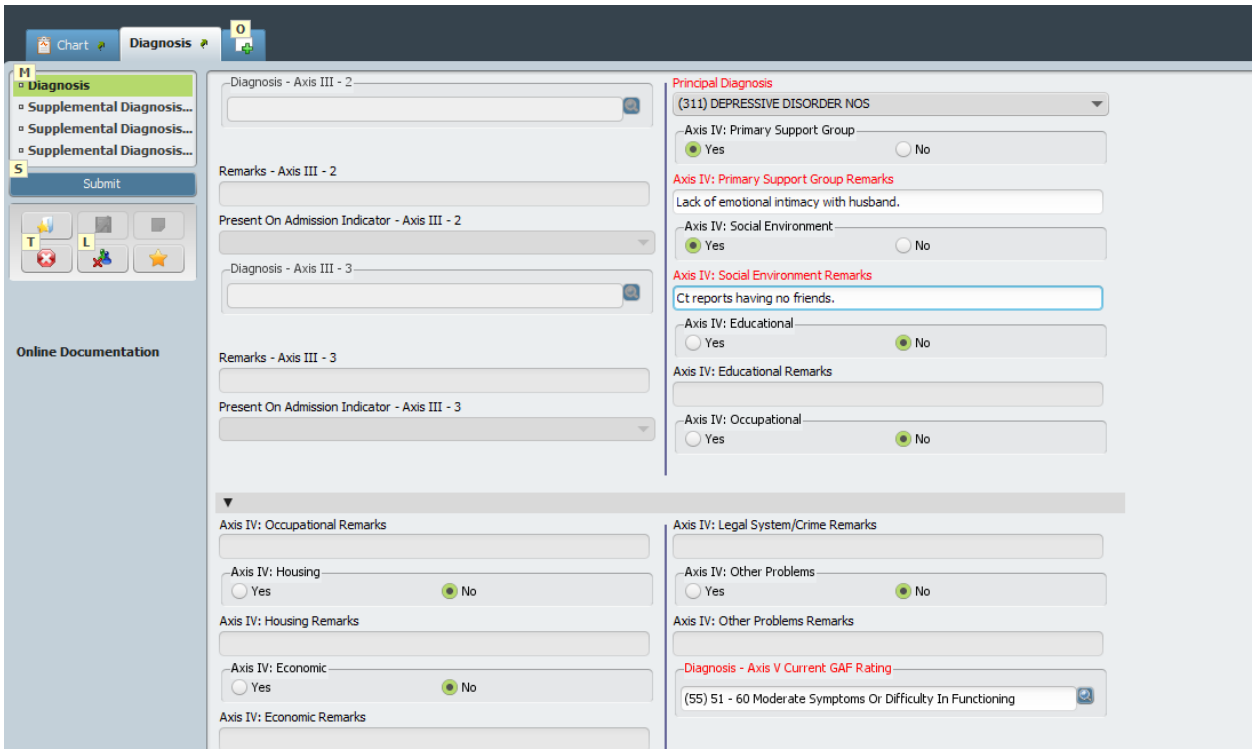
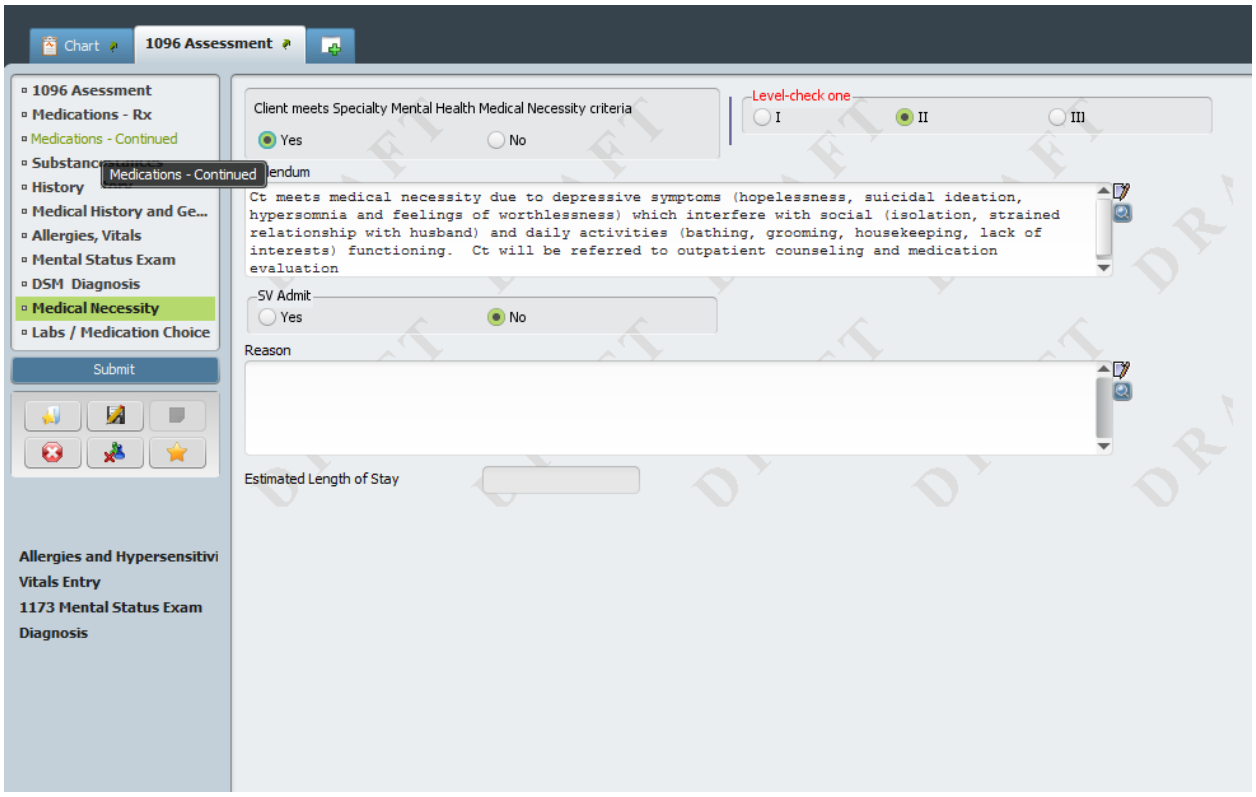


Chart
Diagnosis
Diagnosis
Supplemental Diagnosis...
Supplemental Diagnosis...
Supplemental Diagnosis...
Submit
Online Documentation
Diagnosis - Axis III - 2
Remarks - Axis III - 2
Present On Admission Indicator - Axis III - 2
Diagnosis - Axis III - 3
Remarks - Axis III - 3
Present On Admission Indicator - Axis III - 3
Principal Diagnosis
(311) DEPRESSIVE DISORDER NOS
Axis IV: Primary Support Group
Yes
No
Axis IV: Primary Support Group Remarks
Lack of emotional intimacy with husband.
Axis IV: Social Environment
Yes
No
Axis IV: Social Environment Remarks
Ct reports having no friends.
Axis IV: Educational
Yes
No
Axis IV: Educational Remarks
Axis IV: Occupational
Yes
No
Axis IV: Occupational Remarks
Axis IV: Housing
Yes
No
Axis IV: Housing Remarks
Axis IV: Economic
Yes
No
Axis IV: Economic Remarks
Axis IV: Legal System/Crime Remarks
Axis IV: Other Problems
Yes
No
Axis IV: Other Problems Remarks
Diagnosis - Axis V Current GAF Rating
(55) 51 - 60 Moderate Symptoms Or Difficulty In Functioning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Medications - Rx
Medications - Continued
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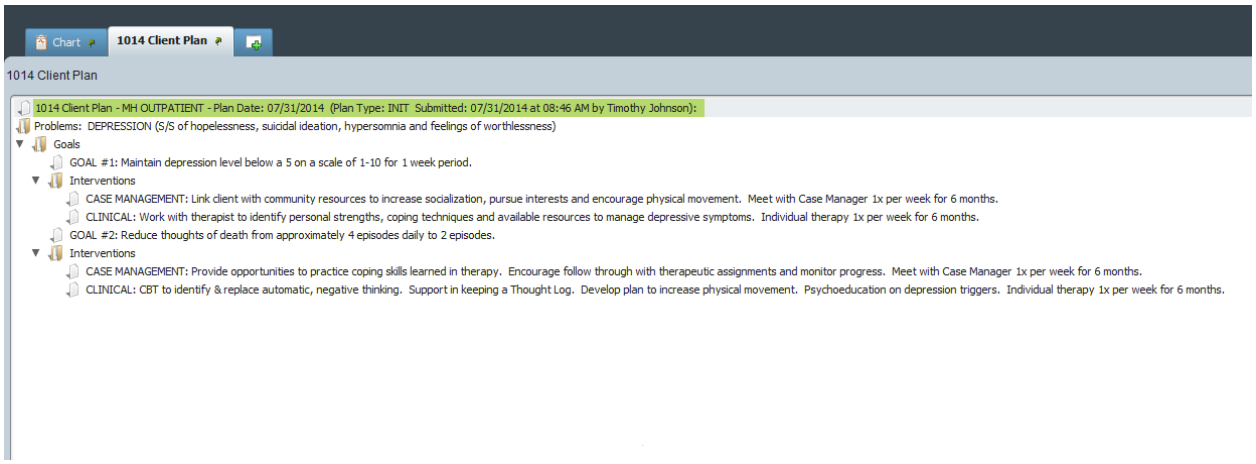
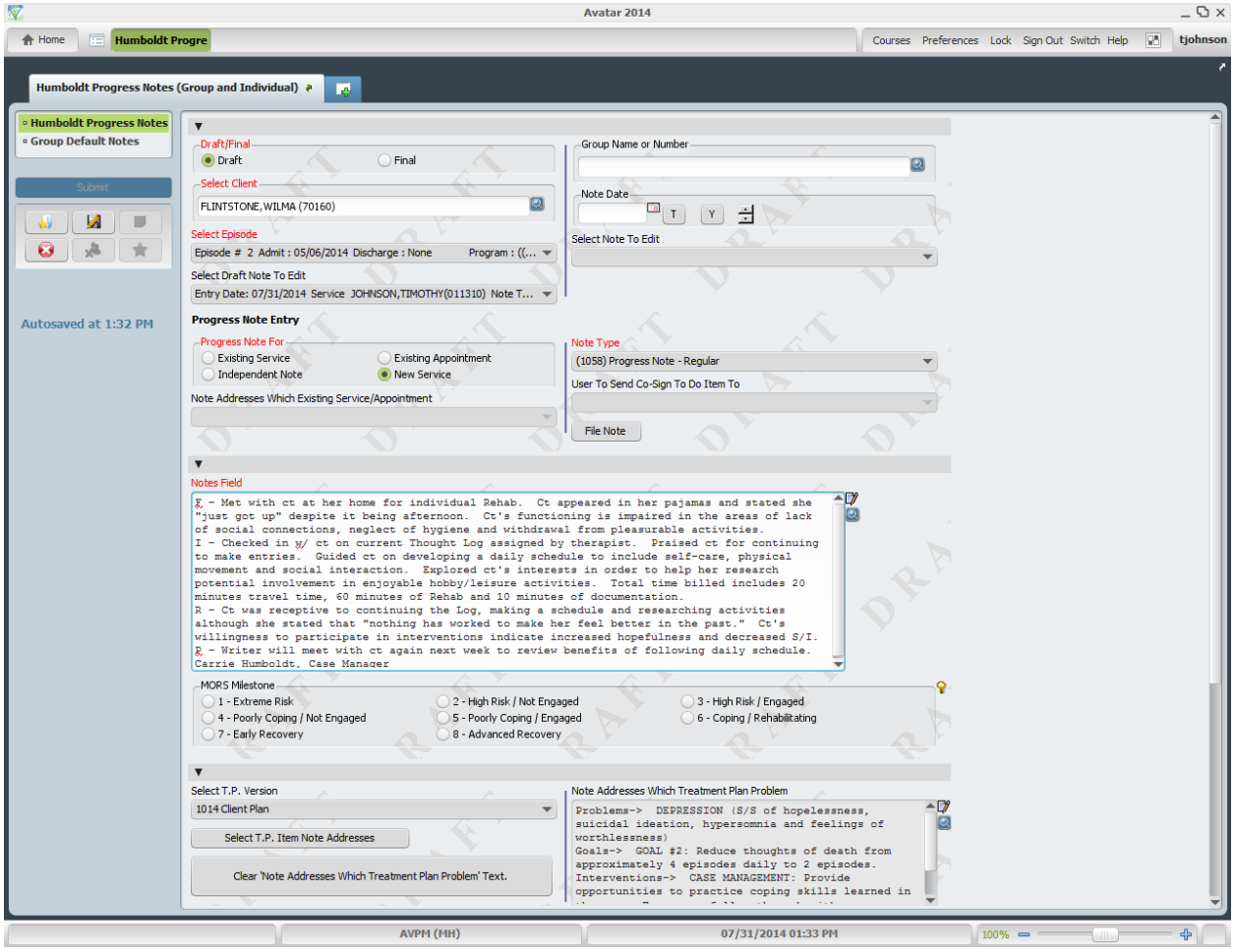
History
Medical History and Ge...
Allergies, Vitals
Mental Status Exam
DSM Diagnosis
Medical Necessity
Labs / Medication Choice
Medications - Continued
Submit
Allergies and Hypersensitivi
Vitals Entry
1173 Mental Status Exam
Diagnosis
Client meets Specialty Mental Health Medical Necessity criteria
Yes
No
Level-check one
I
II
III
endum
Ct meets medical necessity due to depressive symptoms (hopelessness, suicidal ideation, hypersomnia and feelings of worthlessness) which interfere with social (isolation, strained relationship with husband) and daily activities (bathing, grooming, housekeeping, lack of interests) functioning. Ct will be referred to outpatient counseling and medication evaluation
SV Admit
Yes
No
Reason
Estimated Length of Stay

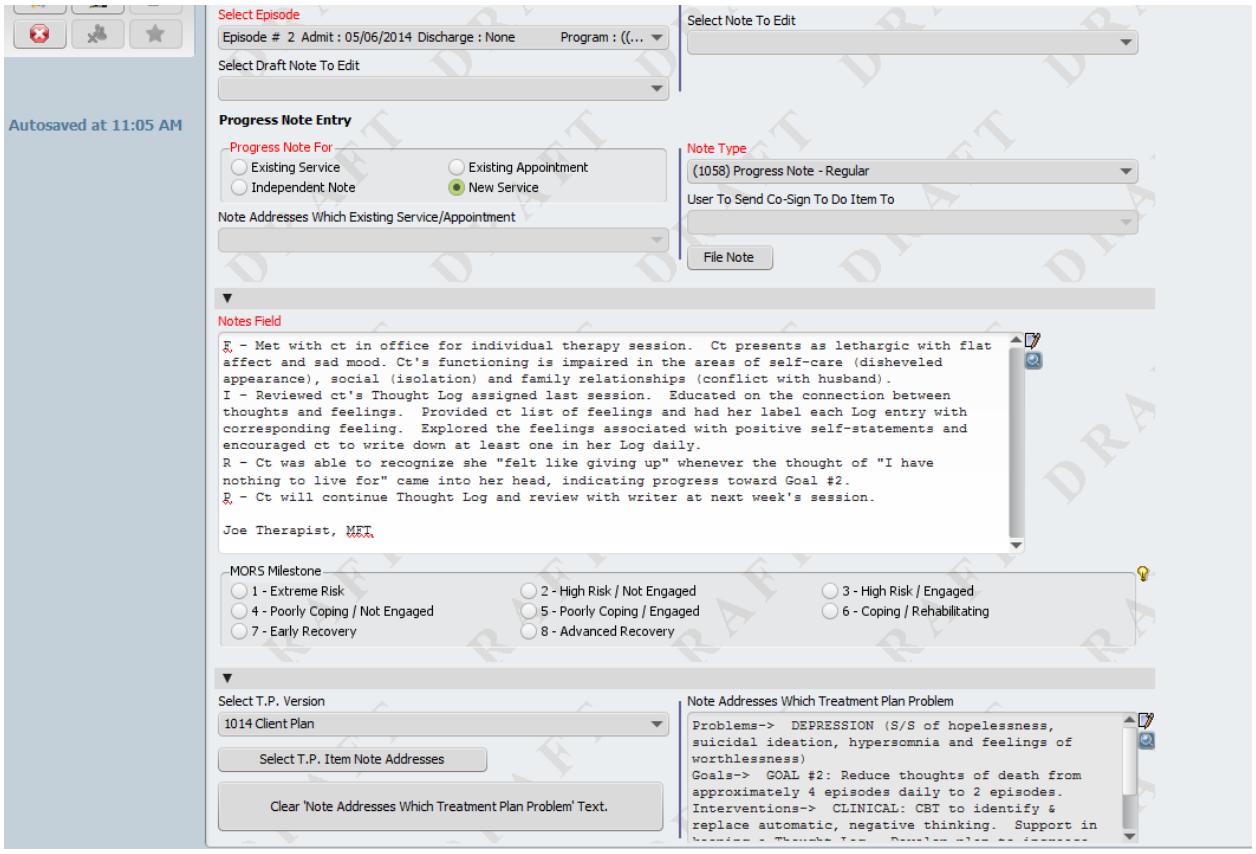
Client Treatment Plan



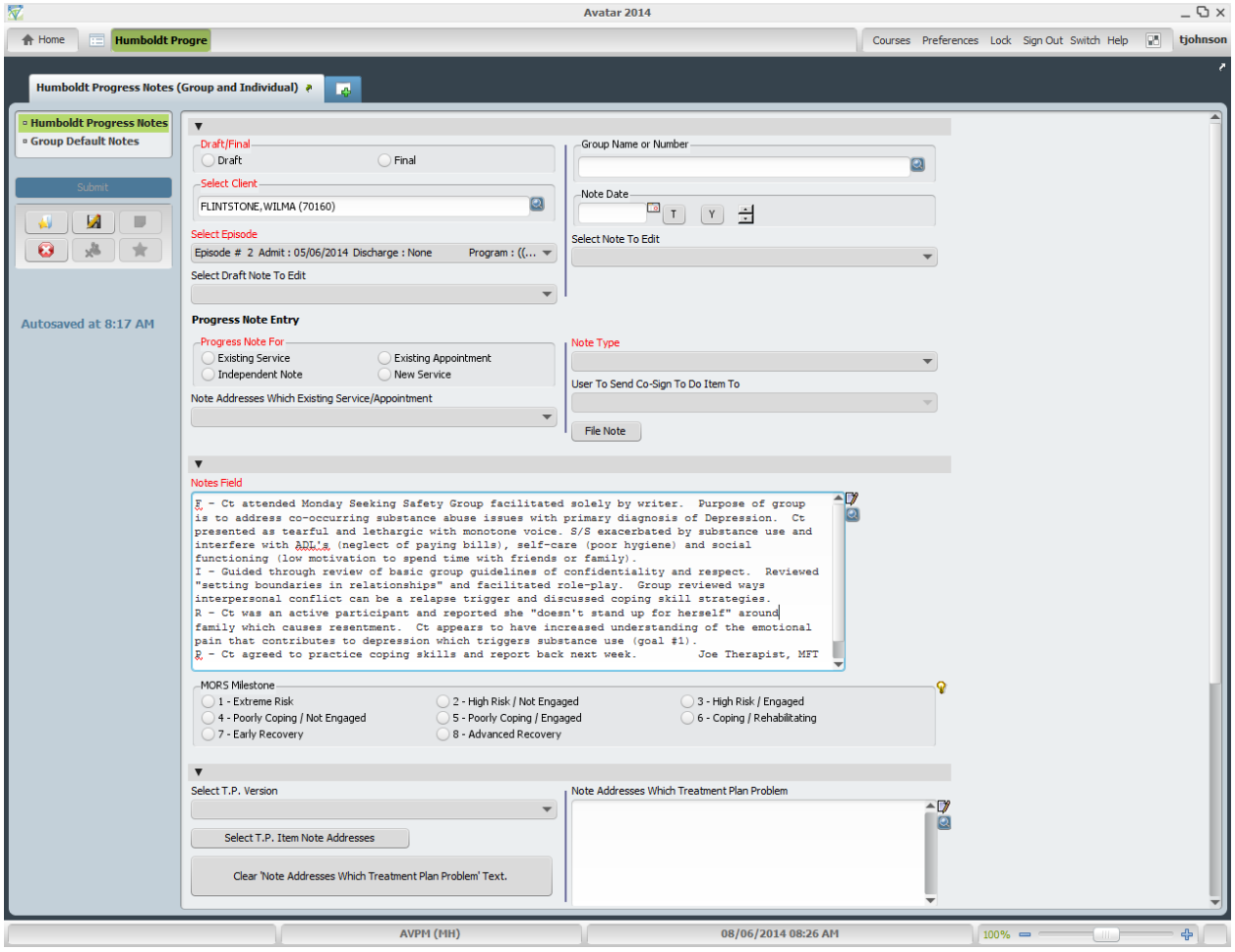
Rehabilitation



Therapy


Autosaved at 11:05 AM
Select Episode
Episode # 2 Admit : 05/06/2014 Discharge : None Program : ((...
Select Draft Note To Edit
Select Note To Edit
Progress Note Entry
Progress Note For
Existing Service
Existing Appointment
Independent Note
New Service
Note Addresses Which Existing Service/Appointment
Note Type
(1058) Progress Note - Regular
User To Send Co-Sign To Do Item To
File Note
Notes Field
S - Met with ct in office for individual therapy session. Ct presents as lethargic with flat affect and sad mood. Ct's functioning is impaired in the areas of self-care (disheveled appearance), social (isolation) and family relationships (conflict with husband).
I - Reviewed ct's Thought Log assigned last session. Educated on the connection between thoughts and feelings. Provided ct list of feelings and had her label each Log entry with corresponding feeling. Explored the feelings associated with positive self-statements and encouraged ct to write down at least one in her Log daily.
R - Ct was able to recognize she "felt like giving up" whenever the thought of "I have nothing to live for" came into her head, indicating progress toward Goal #2.
P - Ct will continue Thought Log and review with writer at next week's session.
Joe Therapist, MFT
MORS Milestone
1 - Extreme Risk
2 - High Risk / Not Engaged
3 - High Risk / Engaged
4 - Poorly Coping / Not Engaged
5 - Poorly Coping / Engaged
6 - Coping / Rehabilitating
7 - Early Recovery
8 - Advanced Recovery
Select T.P. Version
1014 Client Plan
Select T.P. Item Note Addresses
Clear 'Note Addresses Which Treatment Plan Problem' Text.
Note Addresses Which Treatment Plan Problem
Problems-> DEPRESSION (S/S of hopelessness, suicidal ideation, hypersomnia and feelings of worthlessness)
Goals-> GOAL #2: Reduce thoughts of death from approximately 4 episodes daily to 2 episodes.
Interventions-> CLINICAL: CBT to identify & replace automatic, negative thinking. Support in

Group Progress Note



Appendix E: Document List and Timelines for Completion – Outpatient Services

Name of Document	Initially Completed	Updated
Informing Materials Packet		
1. **Voter Preference Form (Adults Only)** 2. **Adult Directive (Adults Only)** 3. **Notice to Medi-Cal Beneficiaries – about Medi-cal Mental Health Services** 4. **Provider List** 5. **Problem Resolution Guide** 6. **Notice of Privacy Practices**	Documents reviewed with client at intake.	Provided as Requirement
1. **Access Brochure (Information about Humboldt County Mental Health)** 2. **Patients' Rights Advocacy Guide** 3. **Mental Health Services List** 4. **Community Resource List**	Documents reviewed with client at intake.	Provided as Courtesy

Name of Document	Initially Completed	Updated
Financial / Administrative Documents		
Client Information Form #1012	Obtained the day of the first face-to-face contact.	Annually (or if client moves)
Client Information Form #1027 – MCO (Org Provider)	Obtained the day of the first face-to-face contact.	Annually (or if client moves)
Demographic Information Update Form #1162	Obtained at each face-to-face contact	Ongoing
Copy of Medi-Cal or other insurance card (front and back)	Obtained the day of the first face-to-face contact.	Each time changes occur
Consent for Emergency Medical Treatment Form	Obtained the day of the first face-to-face contact, if needed.	Each time changes occur
Consent for Participation and Transportation of Child / Adolescent Form #1017	Obtained the day of the first face-to-face contact, if needed.	Prior to expiration date noted on form.

Name of Document	Initially Completed	Updated
Clinical Documents		
Informed Consent for Outpatient Services Form	Obtained the day of the first face-to-face contact.	Annually
Release of Information Form # 1006 and 1007 (Authorization for Use or Disclosure of Protected Health Information)	As needed to obtain, disclose, or exchange protected health information.	Annually (unless otherwise specified in release or updated as needed)
Initial Assessment Form #1096	At first assessment appointment	Annually – may be updated as needed
Client Plan Form #1014	No later than **60** days from opening date. Until a client plan is finalized with necessary signatures, the only services that can be provided are assessment, plan development, CMB and crisis intervention.	Annually – and updated at time of significant life change for client
Levels / Med Nec Authorization Adult Form #1038	Obtained at time of assessment	At least annually
Levels / Med Nec Authorization Minor Form #1039	Obtained at time of assessment	At least annually

Name of Document	Initially Completed	Updated
Clinical Documents (continued)		
Health History Form #1028	Obtained the day of the first face-to-face contact.	Annually
Progress Note Form #1058	At time of each client service.	N / A
Outpatient Medication Advisement Form # 1042	By prescriber when medication is prescribed.	As needed
Medical Necessity Criteria for Therapeutic Behavioral Services Form # 1172	At time of referral.	As needed
Family Intervention Team Case Summary and Referral Form # 1130	At time of referral.	As needed
Family Intervention Team Level X to XII Placement Indicator Checklist and Review	At time of referral. At FIT meeting.	As needed
FIT ROI Form # 1007	At time of referral.	As needed
Therapeutic Behavioral Services (TBS) Assessment Form #1068	At time of referral.	As needed

Name of Document	Initially Completed	Updated
Clinical Documents (continued)		
Katie A. Subclass Eligibility Verification / Assessment and Intensive Care Coordination (ICC) Authorization Form # 1189	By an Administrative Analyst within a month of identifying the subclass member.	By an Administrative Analyst every ninety days thereafter, until the client is no longer a subclass member.
Treatment Summary Form # 1077	Complete at time of last service with client to close or transfer case. Discharge diagnosis is entered as well as completing Avatar Discharge option.	N / A
Notice of Action (NOA) Form #1045A , #1045B, #1045C, #1045D, #1045E	Complete and provide consumer with NOA. Send copy to QI.	N / A
1004.25 – Child and Adolescent Needs and Strengths (CANS-SB)	Completed at Intake	Significant life event and every six months
MORS	At Assessment	During each client contact; at least once per month per policy

Name of Document	Initially Completed	Updated
Clinical Documents for Full Service Partnership (FSP)		
Provider Assessment Form (PAF)	Initially completed in Data Collection & Reporting (DCR)	N / A
3 M (Three Month)Forms	Completed in Data Collection & Reporting (DCR) three months after PAF	Quarterly updates
Key Event Tracking	Initially completed in DCR	As needed upon key event changes defined in DCR

Appendix F: Notice of Actions / Grievance Appeals

What is a Notice of Action?

A Notice of Action (NOA) is issued to a client or provider to advise them of an action that our agency is conducting as it relates to the provision of SMHS. The Notice of Action is important because it is used to advise the client of the "action" taken and to provide information to the client's on their right to appeal the decision. Before completing a NOA a practitioner should consult with their supervisor.[2]

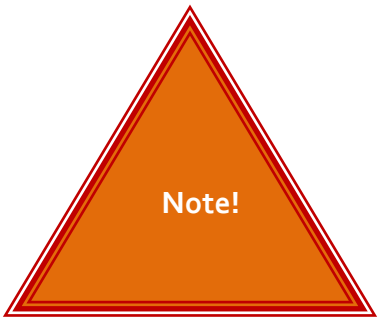
What are the five types of NOAs?

1) NOA-A Not meeting Medical Necessity (Form 1045 A)
2) NOA-B Denied, modified or deferred authorized payment request from a provider (Form 1045B)
3) NOA-C Post Service Denial of Payment (Form 1045 C)
4) NOA-D Delays in Grievance / Appeal Processing (Form 1045 D)
5) NOA-E Lack of Timely Service (Form 1045 E)

When do I give a NOA to the client?

With exceptions, the NOA must be hand delivered or put in the mail no later than the third working day after the action was taken. The completed NOA must be provided to the client via US Mail along with the second page of this report which explains the client's rights to appeal the decision made by the MHP. Client shall be informed of their right to file an appeal if they do not agree with the proposed action. Whenever possible, the staff shall make all appropriate efforts to assist client in preparing for the proposed action, including, but not limited to, pointing out alternate resources and / or support such as self-help groups and other community services. Also, the clients shall be advised, where appropriate, that they may become eligible for an increased level of services if their condition worsens. And, inform the client that she / he will not be subjected to any discrimination, penalty sanction, or restriction, for filing a complaint.

[2] Title 9, CCR, Section 1850.205.
Sections 5777, 5778, and 14684, Welfare and Institutions Code and Title 42, Code of Federal Regulations, Part 438, Subpart F



Remember to document your activities pertaining to the NOA on a Progress Note.

Who receives a copy of the NOA?

All NOAs are given to the client.

Is the NOA still addressed to the client when the client is a minor?

Unless it is a minor consent case, the original should be sent to the minor and a copy should be sent to the minor's parent or legal guardian. For minor consent cases, the NOA should be handled in one of the following ways:

1. Given to the minor in person
2. Given to the minor's eligibility worker to give to the minor next time s / he comes in
3. Held by the practitioner until the next time the minor comes into the office / clinic.

In minor consent cases, the NOA must not be mailed to the minor's address and the minor's parent / guardian must not receive a copy or be otherwise notified.

F.A.Q.

Q1. Must a NOA be issued when a network provider does an Assessment and determines the client does not meet Medical Necessity?

A1. Yes, the client must be provided with a NOA regardless of whether the Assessment is completed by the DHHS-MH or its provided.

Q2. Can we simply issue a NOA when the County does not provide a particular SMHS that the client needs?

A2. No, if we determine the client is in need of a particular SMHS, we are obligated to provide or arrange for that service. The issuing of an NOA does not excuse Mental Health from meeting its contractual obligation to provide medically necessary services to its clients.

Q3. Must a NOA be issued if the County offers a SMHS, but not necessarily the service requested by the client?

A3. No, however, the client must participate in the development of the client plan. The county should ensure that services, to the extent possible, are client directed. A

Notice of Action - 1

client who believes additional services are necessary has the right to challenge the County and provider decisions through the client appeal and state fair hearing processes.

Q4. Must a NOA be issued when the client is not approved for a service he / she has requested?

A4. No, unless the county determines that no specialty mental health services will be provided.

Q5. Must a NOA be issued if a treatment team determines a lack of Medical Necessity?

A5. Yes, a NOA is required for decisions by the county or its providers. The treatment team, acting as a provider, is deciding that the client will not receive services from the county.

Q6. Must a NOA be issued when a client, who originally asked for services, changes his / her mind during the Assessment proces and, as a result, no services were offered?

A6. No, assuming the decision that services are not necessary was made by the

client. The trigger for a NOA is the decision by the county or its providers that no services are needed. When the county or its providers explain to the client why no services are needed and the client then agrees, a NOA is required.

Q7. Can we simply issue a NOA when the County does not provide a particular SMHS that the client needs?

A7. No, if we determine the client is in need of a particular SMHS, we are obligated to provide or arrange for that service. The issuing of an NOA does not excuse Mental Health from meeting its contractual obligation to provide medically necessary SMHSs to its clients.

Q8. Is an Assessment to determine Medical Necessity considered a SMHS?
In particular, if a client is found to not meet Medical Necessity criteria after a few Assessment sessions or by the end of the Assessment period, do we need to issue a NOA?

A8. Yes, the County needs to issue a NOA, if a client is found not to meet Medical

F.A.Q.

Notice of Action - 4

Necessity after a few Assessment sessions or by the end of the Assessment period. An Assessment to determine Medical Necessity is a SMHS covered by the County. A client does not need to meet Medical Necessity to receive such an Assessment. [3] The NOA applies to a determination that future services will not be provided because the client being assessed does not meet medical necessity.

[3] See Title 9, CCR, Section 1810.345

Appendix G: Outcome Measures

What are Outcome Measures?	DHHS-MH is committed to providing integrated services that are outcome driven—with proven or promising results. DHHS offers child, youth and adult focused Evidence-Based Practices (EBP), providing prevention, early intervention and focused treatment interventions.
Is there a list of EBPs that DHHS uses?	There is a list located at EBP Outcome Measures by Treatment Focus.
Is there an EBP Summary Sheet?	There is a list located at EBP Summary Info Sheet.

Child Assessment of Needs and Strengths (CANS)

What are CANS?	The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 25 states in child welfare, mental health, juvenile justice, and early intervention applications. A comprehensive, multi-system version exists as well.
How was CANS developed?	The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is easy to learn and is well liked by parents, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to an individual child and family.
How is CANS used?	CANS is used to monitor outcomes. This can be accomplished in two ways. First, items that are initially rated a '2' or '3' are monitored over time to determine the percent of youth who move to a rating of '0' or '1' (resolved need, built strength). Or, dimension scores can be generated by summing items within each of the dimensions (Problems, Risk Behaviors, Functioning, etc). These scores can be compared over the course of treatment. CANS has demonstrated reliability and validity. The average reliability of the CANS is 0.75 with vignettes, 0.84 with case records, and can be above 0.90 with live cases. The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level. Validity is demonstrated with the CANS relationship to level of care decisions and other similar measures of symptoms, risk behaviors, and functioning.
Who can use CANS?	The CANS is an open domain tool that is free for anyone to use. There is a community of people who use the various versions of the CANS and share experiences and additional items and supplementary tools.

Milestones of Recovery Scale (MORS)

What is MORS?	MORS is an effective evaluation tool for tracking the process of recovery for individuals with mental illness. It provides easy to use data that allows staff, supervisors and administrators to see how individual programs and agencies are performing.
How is MORS used?	MORS is a one page, single score assessment that takes just a few minutes to complete. It focuses on the here and now, providing a snapshot of an individual's progress toward recovery. It can help staff tailor services to fit each individual's needs, assign individuals to the right level of care and create "flow" through a mental health system by quantifying the stages of an individual's recovery using milestones that range from extreme risk to advanced recovery and everywhere in between. MORS has in-depth descriptions of what individuals at each stage might typically look like in terms of their levels of risk, engagement and support from others.
What is the foundation of MORS?	MORS is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and service utilization. It operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.
How can MORS be applied?	MORS can help systems and programs demonstrate to funding sources, politicians and the public that mental health systems can be cost-effective and achieve positive outcomes. It has been extensively tested and researched for validity and reliability.
What will it take to be able to use MORS?	MORS concepts and use can be learned by attending three hours of training with a licensed MORS trainer.

How was MORS created?

The MORS Scale was created in 2002, by Dave Pilon, Ph.D. and Mark Ragins, M.D., both from Mental Health America of Los Angeles (MHA). The idea for MORS grew out of a 1997 workgroup assembled by the California Association of Social Rehabilitation Agencies (CASRA) that was made up of 50 individuals who identified themselves as consumers, family members, mental health program staff and program directors. The group's task was to try to identify important indicators of recovery. After many meetings filled with lively discussions, the group participants came to a conclusion: individuals in the recovery process could be assigned to clusters based on their level of risk, their level of coping skills and their level of engagement with the mental health system. They also concluded that an individual's movement from cluster to cluster could be seen as a description of "the process of recovery." Five years later, Dr. Pilon and Dr. Ragins, both participants in the CASRA group, expanded on the group's conclusions by developing the Milestones of Recovery Scale.

How was MORS tested?

MORS was tested for reliability at the MHA Village in Long Beach, California and Vinfen Corp in Cambridge, Massachusetts. Its validity was substantiated by the Center for Behavioral Research and Services (CBRS) at California State University Long Beach in 2005. An article entitled "Psychometric Properties of an Assessment for Mental Health Recovery Programs," about the creation of the scale and related research, was published in the Community Mental Health Journal in July 2009.

Appendix H: Release of Information

What is a Release of Information?	A Release of Information (ROI) is a statement signed by the client authorizing a contact person to give information about the client's situation.
Who must sign an ROI?	Due to the fact that all information and records obtained in the course of providing services are confidential, a client or authorized representative who consents to release of any and / or specific information about their health record must read and sign the "Authorization for Use or Disclosure of Confidential / PHI Information."
When does the ROI become invalid?	The Authorization, once signed, may be valid for a designated period of time or an event (1 year expiration maximum
What additional information must be noted in relation to the ROI?	In addition to listing the client's demographic information, staff will indicate the types of information to be released, the purpose of the disclosure and the unit or agency within DHHS-Mental Health that is being authorized.

Appendix I: Websites

The following websites are available for all to access and to find additional relevant information and resources:

- **California Code of Regulations -** https://govt.westlaw.com/calregs/Index?transitionType=Default&contextData=(sc.Default)
- **California Substance Use Disorder (SUD) Services - Alcohol and Other Drugs Programs -** http://www.dhcs.ca.gov/services/Pages/DMCD-TreatmentProgram-Svcs.aspx
- **California Department of Health Care Services (DHCS) -** http://www.dhcs.ca.gov/Pages/default.aspx
- **California Institute of Mental Health (CiMH) -** http://www.cimh.org/
- **California Penal Code -** http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=pen
- **Humboldt County Homepage -** http://www.humboldtgov.org/
- **Humboldt County Department of Health and Human Services (DHHS) Bulletinboard-** http://dhhsbulletinboard/SitePages/Home.aspx
- **Humboldt County Network of Care -** http://humboldt.networkofcare.org/mh/
- **Mental Health Services Act -** http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx
- **Title 9. Rehabilitative and Developmental Services (CCR) -** https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I948674A0D45211DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1
- **W & I Codes -** http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic

HUMBOLDT COUNTY
MEDI-CAL MANAGED MENTAL HEALTH CARE

ORGANIZATIONAL PROVIDER MANUAL

FOR

OUTPATIENT MENTAL HEALTH SERVICES

DAY TREATMENT

AND

THERAPEUTIC BEHAVIORAL SERVICES

720 WOOD STREET
EUREKA, CA 95501
1-888-849-5728 (Toll Free)
(707) 268-2955
Fax (707) 476-4049

June 2006

I have reviewed and approved the contents of this HCMMMHC Organizational Provider Manual (Revised June 2006) for OutPatient Mental Health Services, Day Treatment and Therapeutic Behavioral Services.

Deputy Mental Health Director	**Mental Health Branch Director**
Date	**Date**

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I. WELCOME

We want to welcome you personally to a new level of partnership with Humboldt County Mental Health and the Department of Health and Human Services. As a provider partner, you will assist us in continuing our core mission of providing services to severely mentally ill adults and severely emotionally disturbed adults and children who are diagnosed with mental illness.

The mission of the Humboldt County Managed Medi-Cal Mental Health Care (HCMMMHC) is to provide eligible persons of Humboldt County with access to a high quality, effective, cost-efficient system of mental health care which is community based, culturally competent and consumer- guided.

With this mission in mind, HCMMMHC must effectively manage scarce inpatient, residential, and other costly resources, while providing a higher level of access to a larger covered population. We hope to "break" the mold and provide a managed care program that is provider friendly, accessible, and committed to core values of putting consumer needs and quality of care first.

Given the limited resources within our system, this will be a difficult task demanding innovative, creative and thoughtful solutions to maximizing the value of mental health care dollars.

We look forward to our work together, and once again welcome you to the community of providers dedicated to providing public mental health services.

1. INTRODUCTION

In Humboldt County, mental health services have been consolidated into a unified and comprehensive system to meet the mental health care needs of all County Medi-Cal beneficiaries.

Beneficiaries previously seen in the Short-Doyle/Medi-Cal system and those previously seen in the Fee-For-Service system will now receive needed services through the Humboldt County Medi-Cal Managed Mental Health Care Plan (HCMMMHC). The reasons for a “carved-out” integrated mental health system are many:

- Efficiency in administration of a consolidated mental health care system, though the majority of Medi-Cal funds and clients have historically been in the County system of care;
- Existence of long-standing effective partnerships with other public and private agencies that will impact and be impacted by the effective care of the Medi-Cal population; and
- Elimination of duplicated and uncoordinated services.

In this context, it is critical that psychiatric outpatient services be viewed, along with inpatient and other system of care services, as components in a total continuum of care for mentally ill adults and emotionally disturbed children and youth. This manual describes the paired responsibilities of contracted outpatient providers and of County employed service providers. It

mandates a collaborative partnership in which family/client and all service providers, County and contractors, work together to achieve desired outcomes in a cost-effective, efficient manner.

2. PRINCIPLES

HCMMMHC is guided by clearly stated principles which direct implementation activities for all levels of beneficiary service. For outpatient services, the following are especially relevant:

- Emphasis is on serving adults with serious and persistent mental illness and children and youth with serious emotional disturbances through a comprehensive, community-based, coordinated system of care.

- For less serious, non-acute conditions, the emphasis is on outcome-focused treatment at all levels of service.

- Services will be evidence-based, flexible, client and family-centered, and culturally competent. Within the spectrum of outpatient services, there will be sufficient levels of language and cultural skills to serve the beneficiaries.

- Services will provide opportunities for beneficiary/family preferences and choice to the greatest extent that is appropriate. In order for services to be truly beneficiary-driven, family-focused, there must be beneficiary/family involvement in the planning and delivery of services.

- The system will be "user-friendly" with easy access for eligible beneficiaries, a single point of responsibility for service delivery, and sufficient coordination so that the system appears "seamless" from the beneficiaries' points of view.

- The system will be accountable for defined outcomes as a way of measuring system effectiveness and efficiency.

- The system will be responsive to the beneficiary through measurement of beneficiary satisfaction and a process for dealing with consumer complaints and grievances.

3. Forms

Throughout this manual we refer to documents and forms. HCMMMHC requires all Providers to use these forms referred to. **Copies of all forms used are available on disc from HCMMMHC.**

II. CONTACT INFORMATION

Therapeutic Behavioral Services (TBS) and Day Treatment Providers requesting Service Authorizations and Re-Authorizations should call/contact:

During office hours -

Adult Clients:	Children Clients:
HCMMMHC	Children, Youth & Family Services
Service Authorization	Service Authorization
720 Wood Street	1711 3rd Street
Eureka, CA 95501	Eureka, CA 95501
Voice (707) 268-2900 Option 1	Voice: (707) 268-2800
Fax (707) 476-4070	Fax (707) 445-7270

Providers may also fax/mail clinical documentation to the above addresses/numbers.

For **clients** with **urgent situations**, providers may call:

1-888-849-5728 or
(707) 445-7715

For questions about **claims processing**, call:

(707) 441-5449

Mail claims to:

HCMMMHC
Claims Processing
720 Wood Street
Eureka, CA 95501

For questions about Quality Improvement activities, call:

(707) 268-2955, Option #2

For information about available services or list of providers, Beneficiaries should call:

1-888-849-5728

To request forms on disc or brochures or for general questions please call the Provider Relations Coordinator at (707) 268-2955 Option #1 then Option #2.

III. HCMMMHC PROVIDER NETWORK REQUIREMENTS

HCMMMHC has assumed the responsibility for ensuring the provision of medically necessary specialty mental health services to beneficiaries through the establishment of a provider network. All outpatient services must be provided in a manner that is cost-effective, while maintaining and improving clinical quality, geographic access, and cultural competency. Network outpatient services must be provided in coordination with any acute services, other County mental health services, and physical health care services the beneficiary may require.

Organizational Providers must have as their Head of Service either a Medi-Cal-approved licensed physicians, licensed clinical psychologist, licensed clinical social workers, licensed marriage family therapist, and registered nurse with a Masters Degree within their scope of practice. Providers geographically located in Humboldt County may apply to enroll in the network by:

- Completing an application and furnishing required professional references;
- Providing a copy of the current professional license, Drug Enforcement Administration (DEA) certificate, and any Board Certifications;
- Submitting a copy of the Declaration Page of their Professional Liability Insurance and other insurance requirements outlined in the Service Agreement, and
- Signing and submitting a Service Agreement.

Organizational providers located out of Humboldt County may be authorized to provide services upon the submission of current copies of their state license, Drug Enforcement Administration certification, the Declaration Page of their Professional Liability Insurance certificate, furnishing documentation that they have been credentialed and privileged by their local County Mental Health Plan or facility where services are/were rendered and signing and submitting a Service Agreement.

IV. BENEFICIARY SERVICES

1. Description of Beneficiaries

A beneficiary of HCMMMHC is defined as "a person certified as eligible for Medi-Cal through Humboldt County". **Only beneficiaries with no other health coverage except Medi-Cal with mental health service benefits are included.**

Beneficiaries of Medicare and Medi-Cal will be covered as "Medi-Care Supplemental to Medicare Primary," which means Medicare will forward claim information to fee-for-service Medi-Cal system for supplemental reimbursement. *HCMMMMHC will not be administering this claiming process. Therefore, authorization by HCMMHC is not required.*

2. Beneficiary Rights

Clients of Humboldt County Mental Health are entitled:

- To be treated with respect and with due consideration for their dignity and privacy;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand;
- To have access to information about services or grievances procedures 24 hours a day
- To confidential care and record keeping
- To participate in decisions regarding their healthcare, including the right to refuse treatment;
- To participate in planning their treatment
- To give informed consent to treatment and medication(s), including potential side effects;
- To be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- To register a grievance or appeal;
- To request a second opinion or a change of provider;
- To authorize another person to act on their behalf during the problem resolution process;
- With the beneficiaries permission, to involve significant others with the service provider's about the beneficiary's treatment
- To receive services which are culturally competent and sensitive to language and cultural differences;
- To involve family and/or significant others in their care if they wish;
- To request and receive a copy of their medical records, and request that they be amended or corrected;
- To receive services in a safe environment;
- To receive information in accordance with Title 42, CFR, Section 438.10, which describes information requirements;
- To be furnished health care services in accordance with Title 42, CFR, Sections 438.206 through 438.210, which cover requirements for availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

These rights will be communicated to clients through inclusion in the Humboldt County Informing Materials, which will be given to all clients at the initial visit, and will also be available at all entry points into HCMMMHC services.

All Mental Health/AOD Branch staff and HCMMMHC Providers will receive information about these client rights when first beginning employment or contracting with MH/AOD Branch.

3. Client Problem Resolution Process

To assure that individuals receive thoughtful and timely response to requests for problem resolution, the following policy and procedure has been developed.

Clients will not be subject to any penalty or discrimination for initiating a request for problem resolution. During the process of responding to and resolving clients' concerns, their rights to confidentiality shall be respected by all persons involved.

The HCMMMHC Quality Improvement Coordinator (QIC) will be responsible to coordinate, facilitate, log and track all client requests for problem resolution.

4. Cultural Competency

Cultural competence is a fundamental value of the Mental Health Branch. We are committed to developing and maintaining a system of care that is culturally competent and age appropriate, as well as consumer guided. HCMMMHC will further its cultural competency goals and objectives by integrating aspects of cultural competency in all operational areas of the Branch and through the development of standards by which outcomes can be measured.

One of the methods that HCMMMHC utilizes to further cultural competency is by providing training through the Cultural Diversity Committee, which has as its mission statement a commitment to inclusive, responsive, and effective mental health services within a system of care that honors diversity in the delivery of services and increases staff awareness of a wide variety of cultural influences. CDC trainings are available to all providers.

V. SERVICES COVERED BY HCMMMHC

1. Overview

When medical necessity for some level of Specialty Mental Health service is found, benefits for beneficiaries are limited to appropriate services within the provider's scope of practice. Provider can refer to the Scope of Services in their Agreement with HCMMMHC. Please see Attachments for **Medical Necessity Criteria for Outpatient Specialty Mental Health Services**

Nothing expressed or implied herein shall require the psychiatrist or provider to provide to the beneficiary, or order on behalf of the beneficiary, covered services which, in the professional opinion of the psychiatrist or provider, are not required.

The following describes the array of services that may be available to Providers, but the specific services you may receive payment authorization for are listed in your individual contracts.

2. Assessment

All beneficiaries are eligible for an assessment to determine the medical necessity for Specialty Mental Health (SMH) services without authorization by Humboldt County Mental Health Plan.

This service activity is a face-to-face meeting with the client to assess the client's mental, emotional, or behavioral disorder. It will include an analysis of the client's need for services, a determination if the client meets the medical necessity criteria, and either opening the client to services or referring to other providers or agencies. It also can include time spent gathering data from other sources, including the client's chart and significant others in the client's life.

3. What to do if Specialty Mental Health Criteria are not Met

If the Provider feels that the client does not meet medical necessity criteria for Specialty Mental Health services, the Provider must notify the Humboldt County HCMMMHC Quality Improvement Coordinator at (707) 268-2955 Option 2 immediately (within one working day of the decision) of the finding. Humboldt County HCMMMHC may decide to review the assessment, and will be responsible for issuing the State required Notice of Action. (A Notice of Action is a letter to a Medi-Cal beneficiary explaining the reason for a denial of services and informing the beneficiary of the right to make an Appeal to the HCMMMHC and subsequently to the State Department of Health Services if the HCMMMHC Appeal process is not resolved in their favor.)

In summary, an assessment may find:

- medical necessity for some level of Specialty Mental Health service, or
- no medical necessity for Specialty Mental Health services, in which case the beneficiary may be discharged after:

- notification to HCMMMHC within one working day of decision, and
- referral to other County or community social welfare, protective or health agencies, and
- education about the immediate non-mental health or non-specialty mental health situation.

4. Individual Therapy

This service activity consists of psychotherapeutic interventions consistent with the client's goals, focusing primarily on symptom reduction and improvement in the client's functional impairments. This can also be counseling or therapy for the significant other people in the client's life in order to benefit the client, for example, in a family therapy session.

5. Group Therapy

This activity is defined as counseling or therapy provided to individuals while in a group setting. Each client's claim reflects the total amount of time of the group divided by the number of clients (for example, if the group lasted 1 hour and had 4 participants, the time claimed for each client is 15 minutes).

6. Mental Health Plan Development

Plan development consists of development of client plans, approval of client plans, and/or monitoring of progress. The service may be direct (working on the client Plan with the client and/or family) or indirect (planning with another person about the client).

Plan development may ***include***:

- development of a written Client Plan
- approval of Plan
- consultation with other service providers relating to the client's plan goals
- consultation specific to the client or family needs in relation to the client's impairment as identified in the assessment or to the client's plan goals

Plan development ***does not include***:

- assisting client to access services
- discussion of resources with client
- development of resources for client or family
- activity access and support.

7. Collateral Therapy

Collateral services are provided by Clinicians. This service is defined as therapy for the

significant other people in the client's life in order to benefit the client. For example, this could be a family therapy session, with or without the client's presence.

8. Case Management/Brokerage

Case Management brokerage services are provided to assist clients and their families to access and maintain access to medical (including mental health), educational, social, pre-vocational, vocational, rehabilitative or other needed community services.

Brokerage: The identification and pursuit of resources including but not limited to:

- Inter- and intra- agency consultation, coordination and referral
- Monitoring service delivery to ensure an individual's access to services and activities
- Monitoring of clients progress.

Linkage: The direct connection of the client to an agency, activity and/or resource either through:

- Phone contact
- Assisting client in accessing a service, activity or appointment
- Direct or indirect referral of client to identified resource.

Placement: Supportive assistance to the client and/or their family in relation to the living situation including but not limited to:

- Assisting clients or their families in their search for adequate housing when needed
- Supporting or assisting clients or their families in accessing services necessary to maintain their living situation.

9. Mental Health Rehabilitation

This is a service activity that can be provided by non-licensed as well as licensed staff. The focus of rehabilitation is to assist clients and their families in taking charge of their own lives through acquired skill, resources and informed decision making. Services are focused on achieving specified and agreed upon measurable goals to support the client and family in accomplishing the desired outcomes.

Activities may include:

- Assistance in acquiring functional skills including daily living skills, educational, recreational skills, and pre-vocational skills
- Supporting, modeling and/or guiding the client in activities that may have been neglected due to their functional impairment by implementing a plan to learn, practice and maintain needed skills or behaviors
- Providing support and guidance in the undertaking of new ventures or activities that the client or family has been unable to successfully complete on their own due to emotional or behavioral disorders.

10. Therapeutic Behavioral Service

This service activity is one-to-one therapeutic contact between a mental heath provider (Therapeutic Behavioral Aid) and a child/ youth for a specified short term time period of time which is designed to maintain the client's residential placement at the lowest appropriate level of care by resolving problem behaviors and achieving short term treatment goals.

11. Day Treatment Rehabilitation

This is a structured program of rehabilitation and therapy to improve, maintain, or restore personal independence and functioning, which provides services to a distinct group of beneficiaries.

12. Day Treatment Intensive

This is a structured multi-disciplinary program of therapy which may be am alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting.

13. Pharmacy, Laboratory and Radiology Services

Pharmacy, laboratory and radiology benefits are excluded from the Humboldt County Mental Health Plan. Humboldt County HCMMMHC does not assume responsibility for providing medications for our beneficiaries. That benefit continues to be managed by Fee-For-Service Medi-Cal and EDS with no change to current billing procedures for these services.

When submitting claims for services, please refer to service and rate schedule issued at the time of service agreement execution for appropriate service codes.

VI. SERVICE AUTHORIZATION

1. OVERVIEW OF AUTHORIZATION

Authorization by HCMMMHC is not required for contract services (other than Therapeutic Behavioral Services and Day Treatment specified below) provided to beneficiaries who meet medical necessity criteria.

Providers will complete the **Client Information Form** (see Attachments) and
fax one copy each to both Access staff and HCMMMHC Claims Processing:

Adult	Children	Claims Processing
(707) 476-4070	(707) 445-7270	(707) 441-5586

Pre-authorization by HCMMMHC is required for Therapeutic Behavioral Services (TBS) and Day Treatment Services only. For these services, HCMMMHC reserves the final right of assignment of the beneficiary to a specific provider. Client choice, past history of treatment, and ability to meet special needs will be important factors in this decision.

Services will be authorized for a specified time period and number of visits based on State Department of Mental Health regulations.

When referral is made to a contract provider, HCMMMHC will consider whether:

- The client requests a specific provider;
- The client is referred by a specific provider;
- The client is unknown to the contract provider network and should be referred to a provider from the contract list; and/or
- Special linguistic, cultural access, other service needs are present.

The authorization for services ends when the authorized number of visits limit has been reached, or the authorization period expires, whichever comes first. No allowed visits will carry over into another transaction period. Services which continue past the expiration of the conditions of authorization will not be reimbursed.

HCMMMHC Service Requests that are approved for TBS and Day Treatment are issued an Authorization Number by the HCMMMHC Claims Processing.

When the provider feels that additional services are necessary, the request must be made to HCMMMHC. Re-authorization requests must be submitted to HCMMMHC at least fourteen days prior to expiration of the current authorization. Should any further documentation be necessary to determine service need, the Provider will be requested to submit this documentation to HCMMMHC staff.

Requests for authorization or re-authorization of services may be requested, mailed or faxed to:

Adult Clients	**Child Clients**
HCMMMHC	Children, Youth & Family Services
Service Authorization	Service Authorization
720 Wood Street	1711 3rd Street
Eureka, CA 95501	Eureka, CA 95501
Voice (707) 268-2900 Option 0	Voice (707) 268-2800
Fax (707) 476-4070	Fax (707) 445-7270

2. Eligibility Verification

Individual Medi-Cal eligibility is established monthly by the State Department of Social Services. Beneficiaries are classified into different eligibility aid codes. Some aid codes exclude specialty mental health service reimbursement.

Medi-Cal recipients/beneficiaries with identification numbers beginning with any number other than "12" (Humboldt County) are excluded from service coverage by the HCMMMHC.

The HCMMMHC service authorization, hereinafter referred to as Service Authorization, is not a guarantee of payment; service providers are responsible for verifying beneficiaries' Medi-Cal eligibility. ***Currently only beneficiaries with no other health coverage except Medi-Cal with mental health service benefits are included.***

Please contact HCMMMHC if a beneficiary for whom services are authorized:
1) is no longer eligible for Medi-Cal and/or;
2) the aid code indicates reimbursement of specialty mental health services is not allowed; and/or,
3) the County of responsibility changes.

You may verify Medi-Cal eligibility by:

- The EDS Point of Service (POS) Device
- Medi-Cal Website Network / Internet
- Automated Eligibility Verification System (AEVS) by phone

Instructions on how to access these resources are outlined in the **Attachments.** See **Eligibility Verification (EDS/POS/AVES).**

The Provider is required to maintain proof of eligibility for every month of service, and attach a copy to the claims upon submission to HCMMMHC. We recommend verification via Medi-Cal Website, as you can print out a paper copy of the verification. ***Please do not contact HCMMMHC to verify eligibility.***

Beneficiaries' Medi-Cal identification number, names, and dates of birth on claims must match Medi-Cal eligibility records. Inconsistent entries will be returned to the provider for correction.

3. Share of Cost

Medi-Cal may determine that a beneficiary must meet a share of cost (SOC) prior to services becoming reimbursable. SOC detail is obtained through the eligibility verification process. HCMMMHC will not reimburse service providers for beneficiaries' SOC. The provider is responsible for meeting the SOC and then claiming the balance to HCMMMHC.

4. Medicare / Medi-Cal Crossovers and Other Primary Insurance Coverage

Primary insurance plans, including Medicare, must be billed first. HCMMMHC may make exceptions to authorize and reimburse for services in the case claims are denied by all other funding sources. The provider is required to supply a copy of denial obtained from other funding sources in such cases in order to obtain authorizations and reimbursement. Current methods for claims processing will apply for all beneficiaries until primary, non-Medi-Cal coverage is exhausted.

5. Initial Authorization for TBS and Day Treatment

Provider will request for Service Authorization by calling the appropriate access office indicated below.

6. Service Re-Authorization for TBS and Day Treatment

When the provider feels that additional services (beyond the initial authorization) are necessary, the request must be made to HCMMMHC:

- The reauthorization request must be received by HCMMMMHC at least 14 days prior to the end of the authorization period.
- The reauthorization request must include appropriate documentation required by HCMMMHC (refer to **Forms Checklist for Organizational Providers** and **Justification for Reauthorization Form** (see Attachments)
- Most services will be authorized for a maximum period, depending on the beneficiary's needs.

7. Subsequent Authorizations

Beneficiaries identified as "high need" and/or "high risk" will be carefully reviewed by HCMMMHC to assure referral to needed support services and prevent long term decompensation and costs. In consultation with the provider, HCMMMHC may obtain a second opinion with regard to the beneficiary's ongoing care.

Requests for authorization or re-authorization of services may be requested, mailed or faxed to:

Adult Clients	Child Clients
HCMMMHC Service Authorization 720 Wood Street Eureka, CA 95501 Voice (707) 268-2900 Option 0 Fax (707) 476-4070	Children, Youth & Family Services Service Authorization 1711 3rd Street Eureka, CA 95501 Voice (707) 268-2800 Phone (707) 445-7270

VII. MENTAL HEALTH BRANCH and PRIMARY CARE PROVIDERS COORDINATION

1. Referral to Children, Youth & Family Services (CYFS) For Medication Services

Should a child client require medication consultation or evaluation, the following procedure must be followed:

- Make sure the client/family is aware of and in agreement with this referral.
- Have the parent/legal guardian sign Releases of Information (ROIs) for the CYFS psychiatrist to be able to consult with the Provider as the referring clinician, the school and the primary care physician (PCP). It is always advisable to have the parent/guardian discuss this referral with their PCP prior to meeting with a psychiatrist.
- Complete the **Referral Form** (see Attachments) and attach that to the Medi-Cal eligibility sheet, Physicians Referral Form, Request to Access Service with Stage 1 completed and the ROIs and submit to the CYFS Access Clinician.
- In addition, submit a completed **Assessment (Comprehensive)** and **Client Information Form** (see Attachments).

CYFS will then get the client open to services and scheduled with the doctor. The parent/guardian will be contacted by CYFS front desk staff and an appointment will be scheduled for the client to see the CYFS psychiatrist.

Emergency services may require 9-1-1 intervention or emergency admission. The HCMMMHC has a 24-hour Crisis line (1-707-445-7715) to provide guidance in these instances.

2. Referral to Adult System of Care for Medication Services

Should an adult client require medication consultation or evaluation, Provider should contact:

Adult Clients:

HCMMMHC
Service Authorization
720 Wood Street
Eureka, CA 95501
Voice (707) 268-2900 Option 0
Fax (707) 476-4070

3. Primary Care Physician Requests

A Primary Care Physician (PCP) may request a consultation with a HCMMMHC Provider in order to provide optimum care to a beneficiary. The PCP must contact HCMMMHC and together a decision will be made about the most appropriate consultative resource.

VIII. LEGAL REQUIREMENTS

1. Confidentiality

With respect to any identifiable information concerning a Beneficiary under this Agreement that is obtained by the Provider, the Provider:

(1) Shall not use any such information for any purpose other than carrying out the express terms of the Agreement,

(2) Shall transmit to HCMMMHC all requests for disclosure of records that the Provider obtained from HCMMMHC and did not create, and shall not release such records,

(3) Shall not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than HCMMMHC, the U.S. Department of Health and Human Services, the State Department of Health Services, the State Department of Mental Health without HCMMMHC's prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. seq., Section 14100.2, Welfare & Institutions Code, and regulations adopted thereunder,

(4) Shall, at the expiration or termination of the Agreement, return all such information to HCMMMHC or maintain such information according to written procedures sent HCMMMHC by the State Department of Health Services for this purpose.

Privacy is a fundamental right, recognized in the State and Federal Constitutions. At the Federal level, privacy protection is provided by the Health Insurance Portability and Accountability Act of 1996 (HIPA), effective April 14, 2003 [45 C.F.R. parts 160 and 164].

2. Reporting Abuse- See **Reporting Child Abuse Policy and Procedure** – see Attachments

3. Duty to Warn- See **Duty to Warn/Tarasoff Warning Policy and Procedure** – see Attachments

4. Scope of Practice Matrix- See Attachments

IX. HCMMMHC RESPONSIBILITIES

1. To provide a 24-hour toll-free telephone line for information and referrals. (1-888-849-5728).

2. To respond to beneficiaries with urgent situations within one hour.

3. To assess all beneficiaries for ongoing need and eligibility who request or are referred for mental health services. Assessments may be via telephone, face-to-face, or review of written documentation.

4. To respond to a request for services within five (5) working days of requests for non-urgent services.

5. To maintain written communication with beneficiaries, contract providers, and referring sources so that an unbroken feedback loop concerning service need and beneficiaries' rights is established.

6. To assure that all beneficiaries are aware of their rights to Client Problem Resolution procedures including State Fair Hearing.

7. To monitor satisfaction of beneficiaries and providers, utilization and clinical outcomes by providers, and system effectiveness.

8. To schedule annual and special meetings with Providers for procedural updates and other related issues.

9. To provide a "Notice of Privacy Practices" compliant with HIPAA Title 14 CFR Part 164§164.520 (a).

10. To forward all complaints of HIPAA violations filed by individuals within twenty-four (24) hours of the complaint to DHHS Privacy Officer, 507 F Street, Eureka, CA 95501.

X. PROVIDER RESPONSIBILITIES

1. COMPLIANCE WITH STATE REQUIREMENTS

Provider recognizes that County operates its mental health system under an agreement with the State of California Department of Mental Health, and that under said agreement the State imposes certain requirements on County and its subcontractor. Provider shall adhere to the State requirements including but not limited to those listed below. It is understood that this section also grants County certain rights that are also reserved to the State; such rights are fully described herein. A complete copy of HCMMMHC's current contract with the State may be viewed upon request.

Medi-Cal Organizational Provider Standards

1.1 The organizational provider possesses the necessary license to operate, if applicable, and any required certification.
1.2 The space owned, leased or operated by the provider and used for services or staff meets local fire codes
1.3 The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary and in good repair.
1.4 The organizational provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well being of beneficiaries and staff.
1.5 The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, access and service delivery policies, and procedures for reporting unusual occurrences relating to health and safety issues.
1.6 The organizational provider maintains client records in a manner that meets the requirements of HCMMHHC pursuant to applicable state and federal standards and as defined in HCMMMHC's contract with the State Department of Mental Health, and Attachments of this Provider Manual.
1.7 The organizational provider has staffing adequate to allow the HCMMMHC to claim federal financial participation for the services the Provider delivers to beneficiaries, as described in Division 1, Chapter 11, Subchapter 4 of Title 9, CCR, when applicable.
1.8 The organizational provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.
1.9 The organizational provider has as head of service a licensed mental health professional or other appropriate individual as described in Title 9, CCR, Sections 622 through 630.
1.10 For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:
    1.10.1 All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so;

1.10.2 Drugs intended for external use only or food stuff are stored separately from drugs for internal use;
1.10.3 All drugs are stores at proper temperatures, room temperature drugs at 59-86 degrees F and refrigerated drugs at 36-43 degrees F;
1.10.4 Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication;
1.10.5 Drugs are not retained after the expiration date. IM multi-dose vials are dated and initialed when opened;
1.10.6 A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws;
1.10.7 Policies and procedures are in place for dispensing, administering and storing medications.

2. Day Treatment Service Providers. Provider shall submit to HCMMMHC, to the execution of the contract, written description of the day treatment intensive and/or day rehabilitation program that complies with Exhibit A, Attachment 1, Section X, paragraph 1 of the HCMMMHC contract with the State Department of Mental Health.

3. Provider shall adhere to the additional **State Day Treatment Regulations** as outlined in the Attachments.

4. **Group Home Providers**. Provider shall ensure that the Therapeutic Behavioral Services (TBS) notice and general Early & Periodic Screening, Diagnosis and Treatment (EPSDT) informational notice are given to Medi-Cal beneficiaries under age 21 and their representatives at the time of service provision or placement.

5. **TBS Providers**. Provider shall adhere to the additional **State TBS Regulations** outlined in the Attachments.

6. Ensure that covered services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose of which the services are furnished. The Provider may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation as provided in Title, 9, CCR, Sections 1820.205, 1830.205, and 1830.210. Provider shall make covered services available in accordance with Title 9, CCR, §1810.345 and §1810.405 with respect to timelines of routine services as established by HCMMMHC as sufficient to meet beneficiary needs.

7. Offer hours of operation that are no less than hours of operation offered to commercial enrollees, if the Provider also serves enrollees of a commercial health plan, or that are comparable to the hours the Provider makes available for Medi-Cal services that are not covered by HCMMMHC or another Mental Health Plan, if the Provider serves only Medi-Cal clients.

8. Post notices and make available forms explaining the **Client Problem Resolution Processes** and **Form**, methods of obtaining a **Second Opinion**, and **Request for Change of Service Provider** and others as required by HCMMMHC. (See Attachments)

9. Encourage all beneficiaries to complete and mail a HCMMMHC **Satisfaction Survey** (See Attachments)

10. The Provider shall, within fifteen (15) calendar days of receipt/issuance of the termination of contract to/from HCMMMHC, give written notice to each beneficiary who received his/her mental health services from, or was seen on a regular basis by the terminated Provider.

11. Comply with applicable requirements of the **Health Insurance Portability and Accountability Act** (HIPAA), Title 45 CFR, Parts 160, 162, and 164. Provider further agrees to require any agent or subcontractor to comply with all applicable parts.

12. **Provide a "Notice of Privacy Practices"** compliant with HIPAA Title 14 CFR Part 164§164.520 (a).

13. **Forward all complaints** of HIPAA violations filed by individuals within twenty-four (24) hours of the complaint to the DHHS Privacy Officer, 507 F Street, Eureka, CA 95501.

14. **Confidentiality of Beneficiary Information**. With respect to any identifiable information concerning a Beneficiary under this Agreement that is obtained by the Provider, the Provider, (1) shall not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) shall transmit to HCMMMHC all requests for disclosure of records that the Provider obtained from HCMMMHC and did not create, and shall not release such records, (3) shall not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than HCMMMHC, the U.S. Department of Health and Human Services, the State Department of Health Services, the State Department of Mental Health without HCMMMHC's prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. seq., Section 14100.2, Welfare & Institutions Code, and regulations adopted thereunder, (4) shall, at the expiration or termination of the Agreement, return all such information to HCMMMHC or maintain such information according to written procedures sent HCMMMHC by the State Department of Health Services for this purpose.

15. Make all books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination, fiscal audits, program compliance and beneficiary complaints review, or copying:

15.1. By HCMMMHC, the State Department of Mental Health, the State Department of Health Services, the United States Department of Health and Human Services, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives.
15.2. At all reasonable times at the Provider's normal place of business or at such other mutually-agreeable location in California.
15.3. In a form maintained in accordance with the general standards and HCMMMHC standards applicable to such book or record keeping.
15. For a term of at least seven (7) years from the close of the State Department of Health Services fiscal year in which the services were provided.

2. STAFF QUALIFICATIONS AND SUPERVISION

Mental Health Services Organizational Providers shall ensure that Interns and/or Associates (I/A), Case Managers and Therapeutic Behavioral Aids meet the criteria specified in the Service Agreement.

3. OTHER REQUIREMENTS

In addition Providers must:

1. Verify Medi-Cal eligibility of Beneficiaries who present themselves at the time of service. Prior authorization from HCMMMHC is not a guarantee of eligibility throughout the authorized period.

2. Facilitate communication between the beneficiaries and HCMMMHC including obtaining necessary Releases of Information (ROI) between the provider and HCMMMHC, and the beneficiary's family/significant support, the provider and HCMMMHC.

3. Inform HCMMMHC's Provider Relations Coordinator within two (2) working days if the is unable to offer services to beneficiaries for any reason.

4. Notify HCMMMHC's Quality Improvement Coordinator within one (1) working day when it is determined that beneficiary does not meet medical necessity and Provider intends to deny services.

5. Notify HCMMMHC of a potential planned admission of a beneficiary into an inpatient psychiatric hospital. (Call Quality Improvement Coordinator (707) 268-2955 Option 2.)

6. Provide beneficiaries with a list of HCMMMHC's providers as stipulated in the current Standard Agreement between HCMMMHC and the State Department of Mental Health and any amendments. HCMMMHC shall furnish the Provider with copies of this list within five (5) working days after the receipt of a request from the Provider.

7. Provide all new beneficiaries with the **"Guide to Medi-Cal Mental Health Services"**, also known as "**Informing Materials"**.

8. Orient and train all staff in procedures for submission, use and deadlines for submission of clerical and claim forms and reports to HCMMMHC as outlined in this manual.

9. Participate in Performance Outcome Surveys semi-annually, as required by the State Department of Mental Health.

10. The Provider may be required by HCMMMHC to appear in fair hearings (as defined in Title 9, CCR, Section 1810.216.1) dealing with beneficiaries' appeals of denials, modifications, deferrals, or terminations of covered services.

11. Provider recognizes that in the interest of program integrity or the welfare of Beneficiaries, HCMMMHC may introduce additional utilization controls as may be necessary at any time and without advance notice to Provider. In the event of such change, the change may take effect immediately upon receipt by Provider of notice from the HCMMMHC Director, but Provider shall be entitled to appeal such action to the Provider Grievance Process.

12. Provider shall submit to HCMMMHC in a timely manner, copies of their State License, Insurance Certificates and other documents required in the provider Manual, the Service/Professional Agreement between HCMMMHC and the Provider, and Section 1810.435, Title IX, Chapter 11 of the California Code of Regulations. Provider is aware that HCMMMHC shall suspend service authorization and claims processing if provider license or insurance on file has expired

13. Providers shall provide services to beneficiaries in accordance with legal and ethical standards as prescribed by all relevant professional, Federal, State, and/or local regulatory and statutory requirements.

14. Providers must recognize that HCMMMHC operates its mental health system under an agreement with the State of California Department of Mental Health, and that under this agreement the State imposes certain requirements on County *and its subcontractors.* A complete copy of HCMMMHC's current contract with the State may be viewed upon request. HCMMMHC providers shall adhere to all Short-Doyle medical regulations, including clinic certifications, audits and documentation standards directed by HCMMMHC

4.AUDIT REQUIREMENTS

Refer to the provisions for Organizational Providers in the Service Agreement.

XI. QUALITY MANAGEMENT STANDARDS

The purpose of the Humboldt County Mental Health Plan's Quality Management (QM) is to provide for the development of quality assurance and improvement standards that address individual, program, and system levels of service in order to continually improve care provided to the consumer. The processes developed are designed to obtain input from all participants in the systems of care, including consumers, family members, providers, community agencies, and the HCMMMHC. The QM Program is directly accountable to the Director of the Mental Health Branch.

The following briefly describes the Quality Management Program and lists the functions which the Provider must perform as a requirement for participation the Humboldt County Mental Health Plan's Provider Network.

1. Structure

The structure and processes of the Quality Management Program are described in detail in the Humboldt County Mental Health Plan's Quality Management Program Description, copies of which may be obtained by calling the Quality Management Unit at (707) 268- 2955 option 2.

There is a Continuous Quality Improvement Committee (CQIC), whose members consist of the Quality Improvement Coordinator, the MHB Director and Deputy Director, Program Administrative staff, Patient's Rights Advocate, consumers, family members and providers, and which meets at least quarterly to review reports, data and outcomes collected through the CQI processes, and to make recommendations as necessary for policy or system changes to improve the quality of care provided to the consumers. Some of the QI information that is reviewed is generated from the following functions.

2. Organizational Providers Standards

Organizational Providers shall participate in the HCMMMHC Quality Improvement program by:

- Establishing mechanisms to monitor the accessibility of service **(**See Attachments for Access Standards for Specialty Mental Health Services)
- Reporting beneficiary grievances and appeals to the Quality Improvement Coordinator.
- Participating in specific quality improvement evaluations and performance improvement projects, as required by HCMMMHC
- Establishing a written description of their Utilization Management program that includes the following elements
    - Licensed staff will have substantial involvement in UM program

implementation.

- A description of the authorization process:
  - Authorization decisions will be made by licensed or "waivered/registered" staff consistent with state regulations
  - There will be a written description of the information that is collected to support authorization decision making
  - The Provider will use the statewide medical necessity criteria to make authorization decisions.
  - The Provider will clearly document and communicate the reasons for each denial.
- The Provider will provide the statewide medical necessity criteria to consumers and family members upon request
- The Provider will monitor the UM program to ensure it meets the established standards for authorization decision making, and take action to improve performance if it does not meet the established standards.

3. Client Safety and Quality of Care Reporting

All providers of mental health services for the MHP are required to report certain quality of care concerns using the Humboldt County **DHHC-MHB Contract Provider Patient/Visitor Incident Report Form - (**See Attachments**)**. Specifically, providers must report the following types of occurrences within one working day of incident: violent behavior/assaults, client death, physical or sexual assault/misconduct, suicide attempts, occurrences that require reports to licensing agencies, physical damage to facility caused by a client, accidents on-site resulting in serious injury to a client and other incidents which in your judgment threaten the welfare, safety, or health of a resident, visitor, volunteer, student or employee, and violation of professional codes of ethics. These reports will be faxed to the Quality Improvement Unit at (707) 476-4096. Questions about the reporting requirements can be sent to the Quality Improvement Coordinator at (707) 268-2955 Option 2.

4. Documentation Review and Documentation Standards

Humboldt County HCMMMHC shall have access to Providers' relevant clinical records to the extent permitted by state and federal laws. Documentation reviews are one method that the Humboldt County HCMMMHC has to review routine care at individual and system wide levels. QI reviews may be conducted on a sample of consumer cases using a standardized protocol to evaluate compliance with standards of care and State-mandated documentation requirements. Documentation is also reviewed by HCMMMHC Authorization staff to evaluate standard of care and to determine the need for continued services and the level of services required.

The Humboldt County Department of Health and Human Services Mental Health Branch SAL and Documentation Manual is a resource for documentation and claiming standards and copies can be obtained by calling the Quality Improvement Unit at (707) 268-2955 option 2.

The State and County mandated documentation requirements are as follows:

1. **ALL DOCUMENTATION *MUST* BE LEGIBLE**

2. All clients will receive a comprehensive initial assessment that includes at a minimum the following areas:
   - Presenting problems and relevant conditions affecting the client's physical and mental status
   - Health Relevant physical health conditions reported by the client
   - Mental health history including previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of lab tests and consultation reports
   - For children and adolescents, pre-natal and perinatal events and complete developmental history
   - Psychosocial assessment
   - Past and present use of tobacco, alcohol and caffeine, as well as illicit, prescribed, and over-the-counter drugs
   - Mental status examination
   - Medications: names, dosages, and dates of initial prescriptions and refills
   - Allergies and adverse reactions to medications
   - Client strengths in achieving client plan goals
   - Special status situations that present a risk to the client or others
   - Five axis diagnosis from the most current DSM that is consistent with the presenting problems, history, mental status evaluation, and other assessment data.

The initial Assessment will be completed in order to open the client to service. Assessments are to be updated as changes occur or new information becomes known, and at a minimum annually. If after Assessment the client is found not to meet the State-Mandated **Medical Necessity Criteria** (see Attachments), Providers must notify the Quality improvement Unit at (707) 268-2955 option 2 within one working day of the determination of lack of medical necessity for Specialty Mental Health Services.
A copy of the **Assessment (Comprehensive) – Form 1096** (see attachments) is available on disc.

3. All clients who continue to receive services beyond the assessment will have a Client Plan, which will include all of the services provided.

The Plan shall identify:

- At least two specific observable and/or quantifiable goals consistent with the client's diagnosis and impairments
- Intervention(s) that are consistent with the Client Plan goals
- Proposed duration of intervention(s)
- In addition the Client Plan will be signed by:
- The person providing the services with co-signature by LPHA-level staff if the person providing services is not licensed or wavered
- The client, and in the case of a minor, by the parent, legal guardian or caregiver of the child.

If the client refuses to sign or is unavailable for signature, the chart shall include a written explanation.

Client Service Plans are to be completed as soon after the Assessment as possible, but no later than sixty (60) days for added service within thirty (30) days after the first planned visit, and updated at a minimum annually.

If a new service is added (for example Case Management is added to therapy), the client plan must be updated or a new plan written ***within thirty (30) days*** of the addition. The anniversary date remains the original annual date.

A copy of a **Client Service Plan – Form 1014** (see Attachments) is available on disc**.**

4. There shall be progress notes documenting relevant aspects of client care. Each claim submitted to the HCMMMHC shall have a corresponding progress note which matches the claim and which documents:

- Date, location, duration and type of service
- Medical or service necessity documentation (the client's symptoms or behaviors that impair an area of life functioning)
- Clinical observations, decisions and interventions
- Client/family response
- Referrals to community resources and other agencies as necessary
- Plan for follow up care
- Signature and title, licensure, or professional degree of Provider

5. The Provider shall establish a chart for each client which shall be consistent with appropriate medical and professional practice which permits effective internal professional review and external audit. **Provider shall maintain such records for at least seven (7) years from the close of the State's fiscal year during which services were provided, or in the case of minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no such case less than seven years.** California Code of Regulations Title 22 Chapter 3, Section 72543**.**

Each chart shall:

- Be organized in a manner that permits rapid retrieval of information
- Contain the consumer's name, date of birth, address, phone, marital status, (legal guardian's name, address, and phone in the case of a minor), and the name, address, and phone of someone to contact in case of an emergency
- Contain the consumer's name and/or ID number on each page
- Be legible (each entry)
- Contain a signed consent for treatment
- Contain a written consent for release of information (ROI) that is signed prior to any release of written or verbal consumer health information.

5. Consumer Rights

In order to protect clients' rights and allow them full participation in their mental health care, Providers are required to do the following:

- Post notices explaining the **Client Problem Resolution Guide** at all sites, and have **Client Problem Resolution Request Form** **(**see Attachments**)** with self-addressed envelopes available for clients to be able to access without having to ask for the forms.
- Encourage clients to complete the Humboldt County HCMMMHC's Satisfaction Survey entitled "How Are We Doing?" (see Attachments)
- Have the "Guide to Humboldt County Mental Health Services" and current Provider List available at all sites, offer them to clients upon the initial visit, and provide them to clients upon request.
- Whenever feasible allow an initial choice of the person who will provide services to the beneficiaries, and to change their provider.
- Notify clients of their right to obtain a copy of their Client Plan.
- Have other HCMMMHC brochures and forms available at each site as required such as the **Request for Change of Service Provider** and **Request for Second Opinion** Forms, (see Attachments).
- Encourage clients to participate in other satisfaction surveys as required by the HCMMMHC.
- Provide a Notice of Privacy Practices to each client on intake.

6. Treatment Approach

Humboldt County Department of Health and Human Services is committed to providing mental health services which are evidence based and founded on the Recovery, Wellness and Discovery philosophy in order to promote the best possible mental health care, consumer empowerment and open communication. To this end, Providers will utilize Evidence Based Practices whenever possible, set realistic treatment goals in collaboration with the client, provide services of sufficient intensity and type to meet the clients' needs, and coordinate with other health care and social service providers as necessary.

7. Professional Office Standards

Humboldt County HCMMMHC Providers shall deliver services in a professional office setting with the following minimum requirements:

- The site is clean, sanitary and in good repair.
- There is signage identifying the space as a professional office.
- Client records are maintained in a manner that protects client privacy and the overall office environment guarantees confidentiality.

(Please see Medi-Cal organizational Provider standards part 2 of this section.)

XII. CLAIMS PROCESSING AND PAYMENT

1. Payment Policies and Procedures

HCMMMHC will reimburse Provider for Covered Services rendered to Beneficiaries if the following conditions are met:

- The Beneficiary is eligible for Medi-Cal Program benefits at the time the Covered Service is rendered by Provider;
- The service is a Covered Service under Humboldt County Medi-Cal Managed Health Care according to regulations in effect at that time; and
- Adherence to the HCMMMHC **Claims Deadlines & Processing Instructions** (see **Attachments**).

2. Claims

Psychiatrists and Mental Health Services Providers shall use the claim forms currently in use in the Mental Health Branch. Claim forms must be complete, and submitted to HCMMMHC within thirty (30) days from the end of the month that Covered Services were rendered. Upon submission of a complete and uncontested clean claim within the timelines defined in this Manual, payment shall be made to provider within thirty (30) days; except that should Medi-Cal funds payable by the State to HCMMMHC be delayed or unavailable, HCMMMHC may delay payment until receipt of such funds. An uncontested clean claim shall include all information needed to process the claim.

3. Beneficiary Liability

Unless Beneficiary has other health insurance coverage, Provider shall look only to HCMMMHC for compensation for Covered Services and, with the exception of authorized Share of Cost payments, and/or non-covered services, shall at no time seek compensation from Beneficiaries.

Mail claims to: Claims Processing
720 Wood Street
Eureka, CA 95501

4. Claim Periods

Each HCFA 1500 shall not claim for more than one calendar month, nor for more than one service authorization number.

5. Claims Submission and Deadline

Submit the signed claim in its original form. ***Faxed or copied claims will NOT be accepted***.
Claims must be submitted no later than the end of the month following the month of service.

For Example:

	Date of Service	Claims Submitted to HCMMHC by:
Example 1:	May 7, 2006	June 30, 2006
Example 2:	May 31, 2006	June 30, 2006

If you indicate a reason *with good cause* (i.e. obtaining denial from other funding sources, finding client's retroactive Medi-Cal eligibility), HCMMMHC may accept claims beyond this deadline up to 90 days from the month of service. We will strictly enforce this rule and late claims will not be honored.

Upon submission of a complete and uncontested clean claim, payment shall be made to Provider within thirty (30) days; except that should Medi-Cal funds payable by the State to HCMMMHC be delayed or unavailable, HCMMMHC may delay payment until receipt of such funds. An uncontested clean claim shall include all information needed to process the claim.

For questions or resolution of claims issues, contact:

Claims Processing
720 Wood Street
Eureka, CA 95501
Voice: (707) 441-5449
Fax: (707) 441-5586

6. Claims Processing Instructions

All claims must be submitted utilizing the HCFA 1500 claim form or by diskette in HCMMMHC format. Please contact Claims Processing for instructions.

HCFA 1500 Completion by Section:

Claims are to be submitted for Medicaid (Medi-Cal) only;

1a. Indicate the Medi-Cal ID# from Medi-Cal eligibility record. Medi-Cal ID#s beginning with any number other than 12 (Humboldt County) will be returned;

2. Indicate patient's name from Medi-Cal eligibility records;
3. Indicate date of birth from Medi-Cal eligibility records;
4. Completion not required;
5. Indicate the member's current address. The address does not need to match eligibility records;
6-20. Completion not required.
21. Indicate primary diagnosis code.
23. Indicate HCMMMHC service authorization number covering dates of service;

By Column:

Column A service date ranges are not allowable; utilize the "from" date in Column A to indicate the date of service. Leave the "to" section blank;
Column B-C Completion not required;
Column D Indicate the HCMMMHC applicable procedure code or the non-contract HCMMMHC authorized CPT/HCPCS code in the CPT/HCPCS section. Do not utilize the modifier section of Column D.
Column E Reference only the primary diagnosis;
Column F Charges are a calculation of the applicable procedure cost rate multiplied by the number of units in Column G. Reimbursement rates for contractors by specific procedure code are detailed in Appendix H, Schedule of Contract Procedure Codes and Rates;
Column G For all services except group therapy, indicate the number of minutes spent performing the procedure.
Units for Group Therapy are calculated as follows:
Number of total minutes × number of staff ÷ by number of recipients. We cannot reimburse for seconds, units will need to be rounded to minutes for submission.

Column H-K Completion not required;
25. Indicate either the service provider Social Security Number (SSN) or the Federal Employer Identification Number (EIN).
26. Indicate the five-digit HCMMMHC assigned client# from the service authorization.
27. Completion not required;
28. Total column F;
29-30. Completion not required;
31. Affix signature;
32. Indicate service address;
33. Indicate Provider Identification Number (PIN) from HCMMMHC contract and/or service authorization.

If you need any information or assistance regarding your billing concerns, please feel free to contact Claims Processing at (707) 441-5449.

7. Notice of Inquiries (see Attachments)

Claims that cannot be processed due to insufficient or invalid information will be returned to service providers accompanied by a Notice of Inquiry that specifies what documents or information need to be provided in order for HCMMMHC to further process the claims. The provider is required to re-submit claims that are corrected, and/or accompanied with all requested documents or information within 30 calendar days from the issue date, otherwise claimed services will be automatically denied. A separate denial notice will *not* be issued.

8. Letter of Denial

Claims that cannot be processed due to beneficiary's Medi-Cal ineligibility, non-covered services, or not claimed timely to meet Short-Doyle/Medi-Cal claiming deadline will be denied and returned to the provider of services accompanied by a Letter of Denial specifying the reason for denial. The claim deadline may be extended for good cause such as retrospective Medi-Cal eligibility of beneficiary, or obtaining primary insurance denials. However, the provider must contact HCMMMHC Claims Processing to request an extension prior to the claim submission deadline.

9. Correction of Previously Paid Claims

Claiming errors detected by the provider following the approval of claims must be immediately reported in writing to HCMMMHC Claims Processing. This notice must include explanation of corrections to be made and accompanied with a copy of the original claim the reimbursement was based on.

10. Diagnosis

The Statewide mental health managed care carve-out involves only the primary diagnosis; as a result, secondary and following diagnoses are not applicable. *Do not bill for diagnoses beyond the primary diagnosis.*

XIII. PROVIDER PROBLEM RESOLUTION PROCESS

Good relations between Humboldt County Mental Health Plan and the Providers are essential to the effective delivery of mental health services. The following outlines the mechanism by which Providers may address their concerns to HCMMMHC on any issue including payment for services, service authorization and processing delays.

Grievances and Appeals must be in writing and submitted to:

Quality Improvement Coordinator
Humboldt County Mental Health
720 Wood Street
Eureka, CA 95501
(707) 268-2955
Fax (707) 476-4096

Providers may use the **Provider Problem Resolution Request Form** which is in the Attachments.

The Humboldt County Mental Health Plan Provider Problem Resolution Process provides for two types of problem resolution:

Grievance - an expression of dissatisfaction with HCMMMHC regarding contract interpretation, policies, authorization process, timeliness of payment, or any situation believed to be unjust or inequitable in the relations between the provider and the HCMMMHC.

Appeal – an appeal of denial or modification of an authorization request, or denial of payment for services by HCMMMHC.

1. GRIEVANCE PROCEDURE

There shall be a sixty (60) working day resolution period during which time the responsible HCMMMHC staff shall review the grievance issue(s) and make a decision regarding resolution. The decision will be communicated in writing to the Provider within the sixty day timeframe.

If no satisfactory resolution is proposed, the Provider may request review of the Grievance by the Mental Health Director, whose decision shall be final.

2. APPEAL PROCEDURE

A provider may appeal a denied or modified request for treatment authorization or a denial of payment of a claim within 90 calendar days of the provider's receipt of the decision. The appeal must be in writing and include supporting documentation. Supporting documentation shall include, but is not limited to:

- A copy of the original decision received from HCMMMHC
- Any documentation supporting allegations related to timeliness, if at issue, including copies of fax records, phone records or memos.
- Clinical records supporting the existence of medical necessity, if at issue.
- A summary of reasons why the HCMMMHC should have approved treatment authorization or a more intensive level of treatment.
- A contact person(s) name, address and phone number.

There shall be a sixty (60) working day resolution period during which time HCMMMHC staff shall review the appeal and make a decision regarding resolution. The decision will be communicated in writing within the sixty day timeframe, and will address each issue raised by the provider, and any action required by the provider to implement the decision.

If the appeal concerns the denial or modification of a payment authorization request due to lack of medical necessity, HCMMMHC shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

If the Appeal is granted, the Provider has thirty (30) calendar days from the date of receipt of Humboldt County's decision to submit a revised request for payment authorization.

If HCMMMHC does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied.

XIV. PROVIDER BULLETINS

Provider Bulletins will be emailed in a timely manner to contract providers to inform them of policy, administrative or financial changes. All changes to the HCMMMHC Manuals that are noticed in Provider Bulletins have the authority of policy and are binding, as indicated, to the County and Providers.

ACCESS STANDARDS

The Provider shall be responsible for assuring that the beneficiary has access to specialty mental health services. Referrals may be received through beneficiary self-referral or through referral by another person or organization.

The Provider shall maintain a written log of the initial requests for specialty mental health services from beneficiaries. The requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain the name of the beneficiary, the date of the request, the date of the response, and the initial disposition of the request.

The Provider shall ensure that a licensed or waivered professional will respond to beneficiary request for services within five (5) working days of the request.

At the request of the beneficiary, a second opinion by a licensed mental health professional shall be provided when it is determined that medical necessity criteria have not been met, and that the beneficiary is not entitled to specialty mental health services. The Provider must notify HCMMMHC within one (1) working day whenever a beneficiary is determined not to need medical necessity criteria. At that time the Provider must notify HCMMMHC if the beneficiary has requested a second opinion. The beneficiary will utilize the HCMMMHC "Request for Second Opinion" form, which will be forwarded to the HCMMMHC Quality Improvement Coordinator.

Reference: Title 9, Chapter 11

ADDITIONAL DOCUMENTATION REQUIREMENTS
FOR
CONTRACT PROVIDERS

1. Claims may be submitted monthly as services are delivered.
   1.1_ Submit claims on HCFA 1500

2. Documentation on the HCMMMHC forms must be legible, complete and cosigned, if required. A copy of each form is contained in this manual.

   2.1 Opening a case:

      2.1.1 Documentation must be completed and submitted to HCMMMHC as follows:

         2.1.1.1 **Client Information** form (see *Attachments*) 1 copy sent to each of the following
         - HCMMMHC Claims Processing
         - Appropriate Access Team

      2.1.2 Documentation must be completed by the Provider on these forms and maintained in client files:

         2.1.2.1 **Consent to Treat** (see ***Attachments***) signed by adult client, parent or legal guardian for minor clients
         2.1.2.2 **Release of Information** (see ***Attachments***) required any time either written or verbal information is to be exchanged between a Provider and another individual regarding a client.
         2.1.2.3 **Health History** (see ***Attachments***)
         2.1.2.4 Mental Health Assessment (**Assessment (Comprehensive)** see ***Attachments***)
         2.1.2.5 **Progress Note** *(see* ***Attachments***) completed following each contact with or on behalf of client plan.
         2.1.2.6 **Client Plan** (see ***Attachments***) started at first planned service and completed within sixty(60) days.

   2.2 Closing a case

      2.2.1 Documentation must be completed and submitted to HCMMMHC at the time that services are complete or the case is closed.
         2.2.1.1 **Client Information** form (see *Attachments*) One (1) copy to each of the following:
         - HCMMMHC Claims Processing
         - Appropriate Access Team

      2.2.2. A Treatment Summary (see Attachments) and a closing progress note must be completed and maintained in client files.

2.3 Pre-authorization/Re-authorization:

2.3.1 Pre-authorization for the following services are required:

2.3.1.1 **Therapeutic Behavioral Services** (TBS) (see *Attachments*)
2.3.1.2 **Day Treatment** (see *Attachments*)

2.3.2 A TBS or Day Treatment service can be requested by contacting the HCMMMHC and the service request will be processed within fourteen (14) calendars days of receipt of the request.

As stated in the *Attachment* **State Regulations for TBS** the State Department of Mental Health (DMH) has issued a directive which affects the authorization timeline of TBS services. See *Attachments* for the **Expedited Review Request** form.

2.3.3 Re-authorization requests must be submitted to HCMMMHC at least ten (10) working days prior to expiration of the current authorization. Should any further documentation be necessary to determine service need, the Provider will be requested to submit this documentation to HCMMMHC staff.

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH
720 Wood Street Eureka, CA 95501

First
Last

Client ID

Date of Assessment M M - D D - Y Y

1096 Assessment (Comprehensive)

Agency or Provider Name:

Duration: :__ **Location:** **Service Code:**
Language Preferred: (Client): English/_____ **(Guardian):** English/_____
Source(s) of Information:

Please provide information on the individual assessed and family as applicable

1. Identifying Information Include ethni

2a. Psychiatric Symptoms & Behaviors List symptoms reported by the individual/family as well as those observed. Include onset & course of symptoms, appetite & sleep disturbance, risk-taking behaviors, & symptoms in support of DSM IV diagnosis.

2b. Presenting Problem(s) Include client's perspective about the circumstances that led to admission or that caused the client to seek services at this time.

2c. Individual's Expectations What does the individual served want/expect in seeking help? Include individual and family expectations.

3a. Developmental/Family History Include any type of abuse. For children, must include prenatal/perinatal history and developmental history in the areas of physical, motor development, psychological, social, intellectual and academic.

CONFIDENTIAL PATIENT INFORMATION (SEE CA W&I CODE 5328)
This is privileged information, for professional use only, and shall not be placed at the disposal of any other person. Assessment

3b. Relevant Ethnic/Cultural Issues:	Ask if there are any cultural preferences that we need to know about to meet the individual's needs. Include how the individual and/or family identify themselves, levels of acculturation within the family, and cultural values that may influence treatment. May also comment on Religious/Spiritual beliefs that may be of clinical significance.

4. Educational History	Include highest grade completed, educational highlights, learning difficulties (e.g., special education) and conduct difficulties in school.

5a. Work/Military History	Include any relevant employment or military history.

5b. Relevant Financial Issues	Source of income and benefits; Client requesting assistance for some financial benefits applied for and not received yet?

6a. Social Functioning/Primary Relationships	Primary Relationships & current or past domestic violence (victim or perpetrator) that may be a focus of treatment, as well as current social support system.

6b. Marital History	

7a. Medical History/Physical Condition/Psychiatric History	Please note below any areas of concern that the client has identified during this assessment. Health History Form contains detailed history

7b. Substance Abuse History/Prior Treatment	Note first onset and history of use of abused drugs (including prescribed meds; over-the-counter drugs, tobacco & caffeine) detailing their frequency and quantity of usage. List outpatient or inpatient Chemical Dependency treatment obtained. For children list prenatal exposure.

Drug of choice **Last use** **Age Range of Onset:** ☐0-10 ☐11-18 ☐19-29 ☐over 30

☐Current use ☐Past use ***Frequency*** when using was: ☐Daily ☐Weekly ☐Monthly ☐Occasional

Check ALL that applies: ☐Tolerance ☐ Withdrawal ☐ Longer/larger use than intended ☐Attempts to cut down/control ☐Time spent to obtain/use ☐Recovering from effects ☐Use despite neg. consequences ☐Negative and/or psychological consequences:

Secondary Drug **Last use:** **Age Range of Onset:** ☐0-10 ☐11-18 ☐19-29 ☐over 30

☐Current use ☐Past use ***Frequency*** when using was: ☐Daily ☐Weekly ☐Monthly ☐Occasional

Check ALL that applies: ☐Tolerance ☐ Withdrawal ☐ Longer/larger use than intended ☐Attempts to cut down/control ☐Time spent to obtain/use ☐Recovering from effects ☐Use despite neg. consequences ☐Negative and/or psychological consequences:

Tertiary drug **Last use** **Age Range of Onset:** ☐0-10 ☐11-18 ☐19-29 ☐over 30

☐Current use ☐Past use ***Frequency*** when using was: ☐Daily ☐Weekly ☐Monthly ☐Occasional

Check ALL that applies: ☐Tolerance ☐ Withdrawal ☐ Longer/larger use than intended ☐Attempts to cut down/control ☐Time spent to obtain/use ☐Recovering from effects ☐Use despite neg. consequences ☐Negative and/or psychological consequences:

Additional Narrative Comments and Recommendations: _____

7c. Legal History/Incarcerations:	

7d. Mental Status Exam

Use comments for clarifying/specifying any and all relevant data.

Orientation:
- ☐ Person
- ☐ Place
- ☐ Time
- ☐ Situation

Rapport:
- ☐ Appropriate
- ☐ Hostile
- ☐ Evasive
- ☐ Distant
- ☐ Inattentive
- ☐ Poor Eye Contact

Appearance:
- ☐ Appropriately Dressed
- ☐ Appropriately Groomed
- ☐ Poorly Dressed
- ☐ Poorly Groomed
- ☐ Disheveled
- ☐ Body Odor

Mood:
- ☐ Euthymic
- ☐ Depressed
- ☐ Anxious
- ☐ Angry
- ☐ Irritable
- ☐ Elated

Affect:
- ☐ Appropriate
- ☐ Depressed
- ☐ Expansive
- ☐ Blunted
- ☐ Flat
- ☐ Labile

Speech:
- ☐ Coherent
- ☐ Appropriate
- ☐ Incoherent
- ☐ Loose Assoc
- ☐ Circumstantial
- ☐ Tangential
- ☐ Poverty
- ☐ Pressured
- ☐ Loud
- ☐ Soft
- ☐ Perseveration
- ☐ Clanging
- ☐ Word Salad
- ☐ Mute

Thought Content & Process:
- ☐ Appropriate
- ☐ Goal Directed
- ☐ Delusional
- ☐ Persecution
- ☐ Reference
- ☐ Hyperreligiosity
- ☐ Thought Insertion
- ☐ Broadcasting
- ☐ Grandiose
- ☐ Obsessions
- ☐ Thought blocking
- ☐ Phobias
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Loneliness
- ☐ Guilt

Describe Hallucinations:
☐ Auditory ☐ Visual ☐ Command ☐ Derogatory ☐ Tactile ☐ Persecutory

Insight:
- ☐ Good
- ☐ Fair
- ☐ Poor

Judgement:
- ☐ Good
- ☐ Fair
- ☐ Poor

Cognitive:
- ☐ No Gross Cog Deficits
- ☐ Concrete
- ☐ Easily Distracted
- ☐ Concentration Problem

Psychomotor Activity:
- ☐ Normal ☐ Restless
- ☐ Retardation ☐ Agitated
- ☐ Compulsions

Memory:

	Good	Fair	Impaired
Immediate	☐	☐	☐
Recent	☐	☐	☐
Long Term	☐	☐	☐

Comments: _____

7e. SUICIDE RISK ASSESSMENT (*Circle appropriate # in each column, total at end, and enter comment as appropriate*)

Criteria	None or Some	Much of the Time	Most or All of the time
A. Current Plan	No thoughts, thought of but no plans, some plan 2	Vague planning, some preparation 4	Specific plan, lethal means prepared, distinct time 6
B. Prior Suicidal	None 0	Gesture, self-harm behavior 4	Previous serious attempts family history 6
C. Resources	Family, friends, able & willing to access 2	Few, but available; hesitant to reach out 4	Few/none, isolated, feels alone, not able/willing to access resources 6
D. Symptoms	Sad, anxious but able to cope with symptoms 1	Depressed, anxious intermittent inability to cope 2	Depressed, anxious, feels hopeless, helpless no longer able to cope 3
E. Stressors	None identified 1	Chronic grief, sadness 2	Recent loss or abuse, multiple losses, failures, significant rejections 3
F. Contract	Willing/able to engage in firm commitment to follow-up plan 1	Contracts Vaguely 2	Unwilling/unable to engage in contract 3

Comment: (Clinical interpretation of numerical value, specify high-risk categories) **Score**: _____ / 27

7f. ASSAULT RISK ASSESSMENT

1. Current thoughts/plan to harm others: ☐No ☐Yes, explain:_____
Tarasoff criteria met? ☐No ☐**Yes, if so was**: Law enforcement notified? ☐No ☐Yes Victim notified? ☐No ☐Yes

2. Assault History? ☐No ☐Yes, explain: _____

7g. Diagnostic Impression: **Indicate DSMIV-TR diagnosis, designating which diagnosis is the Primary and which is the Secondary diagnosis (only one [1] each category)**

Axis I: _____
_____

Axis II: _____
_____

Axis III:

Axis IV: Stressors: *(circle & explain below)* A / B / C / D / E / F / G / H / I / J-none known

Axis V: **Current GAF: _____** **Highest GAF: _____**

7h. Clinical Summary/Impressions **Summarize** and **integrate** assessment information. Highlight **central themes and interrelationships** among data. Include **the individual's view** of his/her needs, preferences, strengths, limitations and problems and **positive and negative factors** that may influence treatment and outcome.

8a. Individual's Strengths and Disabilities Include strengths/aptitudes/skills/abilities that promote positive functioning, include leisure/recreational interests. Include problem areas to be the focus of attention.

8b. Current Areas of Functional Impairment **Indicate** areas of functional impairment.
Briefly **describe** areas of significant impairment.

AREA	None	Mild	Mod	Severe	Extreme
1. Community Living	☐	☐	☐	☐	☐
2. Community Participation	☐	☐	☐	☐	☐
3. Community Contribution	☐	☐	☐	☐	☐
4. Financial	☐	☐	☐	☐	☐
5. Relationships with Others	☐	☐	☐	☐	☐
6. Education and Learning	☐	☐	☐	☐	☐
7. Physical and Emotional Health	☐	☐	☐	☐	☐
8. Legal	☐	☐	☐	☐	☐

9. Other Relevant Data:

10a. Treatment Recommendations & Discharge Plans	**Identify treatment areas** that may potentially be used in the individual's plan of care.

10b. Referrals provided:

10c. Final Plan: What services client agrees to.

11. SV/PTP (SV only) Short-Term/Long-Term goals; Discussion of PATP with client?

Physician approved treatment plan signed by client? ☐Yes ☐No

12. ROI's Obtained Please review the authorizations on file at this time to determine if additional entities exist which might provide information necessary to provide adequate services and referrals to this client. Obtain any authorizations needed at this time. **INCLUDE RELATIONSHIP AND PHONE NUMBER IN SPACE INDICATED**

Authorizations for Release of Information have been obtained for the following individuals/agencies:

☐ Private Treatment Providers: _____
Phone #: _____
☐ Primary Care Physician: _____
☐ Family/Other Support System: _____
Relationship: _____ Phone #: _____
☐ School: _____
Phone #: _____
☐ Other: _____
Relationship: _____Phone #:_ _____

Completed by:_____ Signature:_____ Date:_____

Co Signature (if applicable):_____ Date: _____

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH

720 Wood Street Eureka CA 95501

First

Last

Client ID

Date: M M - D D - Y Y

11101

1006 AUTHORIZATION FOR USE/DISCLOSURE CONF/PHI INFO

(This release complies with CA WIC, §5328 for LPS Protected Records, 42 U.S.C. §290dd-3 & CFR, Part 2, Substance Abuse Regulations &Confidentiality of Medical Info Act, CC § 56 et seq, & H&S code § 199.21-199.40, and HIPAA Privacy Stds see 45 CFR §164.508)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

DOB:_____Address:_____Ph#:_____

I hereby authorize the use or disclosure of health information for the above listed client as follows: (Check box[es]) □*verbal exchange only* □Mental/Physical Health Info □Alcohol/Drug Abuse Services* □STD/HIV/AIDS Info*

Authorization is hereby given to DHHS–Mental Health Branch , (_____) to disclose *or* request the information specified below.

DISCLOSURE IS REQUIRED FOR:

☐ my personal records ☐appl for financial assistance/benefits

☐ sharing w/other health care providers ☐ legal representation

☐coordination of treatment &/or placement ☐ other (specify): _____

INFORMATION TO BE RELEASED includes: (*Name of auth party*:_____)

☐ Diagnosis or problem(s) ☐ Medications/Prescriptions ☐ Allergies & Immunizations

☐ Progress Notes/History ☐ Discharge Summary ☐ Assessments

☐ Treatment Plans ☐ Treatment/Placement Issues ☐ School Records

☐ Lab results ☐ x-ray & imaging results (dates/types of labs): _____

☐ Consultation reports from (supply doctors' names): _____

☐ Court/Police Records

☐ Entire record (except for: _____)

☐Other (please describe): _____

Page 1 of 2 **(See Reverse for additional Information & Signatures)**

DHHS-MHB-1006 (Rev 02/09/05)

Patient Name:_____Case# _____ DOB: _____

The information identified above may **be <u>DISCLOSED TO – OR - RELEASED FROM</u>** the following individuals or organization(s):

Name: _____ Address: _____Ph#:_____
(Relationship:_____) _____

Name: _____ Address: _____Ph#:_____
(Relationship:_____) _____

Name: _____ Address: _____Ph#:_____
(Relationship:_____) _____

<u>EXPRIRATION OF AUTHORIZATION</u>: Authorization shall not exceed one (1) year, and, will terminate on _____, if not revoked sooner.

<u>NOTICE OF RIGHTS AND OTHER INFORMATION:</u>

This Authorization is effective immediately. I may revoke this authorization at any time, *however my revocation must in writing, signed by me or on my behalf, and delivered to the records department of this facility.* **Revocation will <u>NOT</u> apply to information that has already been released in response to this authorization.**

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of your health information from making further disclosure of it unless you (or your legal guardian) provide them with written authorization, or as specifically required or permitted by law. **<u>(Calif CC 56.10(c)</u>.** Authorization for sharing information shall be consistent with all state & federal regulations concerning protection of juvenile records (See W&I Code §827, §828, §830, & §16010).

I UNDERSTAND THAT AUTHORIZING THE USE OR DISCLOSURE OF THE INFORMATION IDENTIFIED ABOVE IS VOLUNTARY. I NEED NOT SIGN THIS FORM TO ENSURE HEALTHCARE TREATMENT.

<u>A photocopy or a facsimile of this Authorization may be used in place of the original.</u>

I may request to inspect or obtain a copy of the health information that I am being asked to authorize or disclose. **I may ask for a copy of this authorization (requested □ provided □)**

<u>SIGNATURES:</u>

Authorizing Signature: _____Date: _____
(Circle One: Patient/Rep/Legal Rep/Legal Guardian/Spouse/Financially Responsible Party, Other: _____)

Witness: _____ Date: _____

<u>Distribution of copies</u> ☐ Agency Providing Information ☐ Program File ☐ Client/Personal Copy

***<u>HIV confidentiality requirements</u>** allow signature by a person other than the patient only under the following circumstances: the patient is under 12 years of age, or as a result of his/her physical condition is incompetent to consent to HIV antibody blood test or the release of the test results; **<u>and</u>** the person authorizing the release of test results is lawfully authorized to make health care decisions for the patient (e.g., an attorney-in-fact appointed under the Durable Power of Attorney for Health Care); the parent or guardian of a minor; an appropriately authorized conservator; or, under appropriate circumstances, the patient's closest available relative. H&S Code §199.27. ***<u>Substance Abuse records requirements</u>** prohibit the information obtained in response to this authorization to be used to prosecute the individual. Disclosure for such purpose must meet requirements of 42CFR §2.63 and be ordered by the court.

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH

720 Wood Street Eureka CA 95501

11101

First

Last

Client ID

Date M M - D D - Y Y

1007 AUTHORIZATION FOR USE/DISCLOSURE CONF/PHI INFO (INTER-AGENCY)

(This release complies with CA WIC, §5328 for LPS Protected Records, 42 U.S.C. §290dd-3 & CFR, Part 2, Substance Abuse Regulations &Confidentiality of Medical Info Act, CC § 56 et seq, & H&S code § 199.21-199.40, and HIPAA Privacy Stds see 45 CFR §164.508)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

DOB:_____ Address:_____ Ph#:_____

I hereby authorize the use or disclosure of health information for the above listed client as follows: **(Check box[es])** □***verbal exchange only*** □Mental/Physical Health Info □Alcohol/Drug Abuse Services* □STD/HIV/AIDS Info*

Authorization is hereby given to DHHS–Mental Health Branch , (_____) to disclose *or* request the information specified below.

DISCLOSURE REQUIRED FOR: Coordination of Services for my: ☐child ☐self ☐client

INFORMATION TO BE RELEASED includes: (*Name of auth party*:_____)

☐ Assessment(s) ☐ Medications/Prescriptions ☐ Allergies & Immunizations
☐ Treatment Plans ☐ Psychological Evaluations ☐ Psychiatric Evaluations
☐ Court/Police Records ☐ School Records ☐ Other (specify): _____
☐ Treatment/Placement Issues & Progress Update _____

The information identified above may **be USED BY, OR DISCLOSED TO,** the following individuals or organization(s):

☐ Humboldt County Office of Education □Minor's Attorney:_____
☐ Eureka City Schools □Center for Applied Social Analysis & Education
☐ Department of Health & Human Services: ☐ Remi Vista
□Social Services □Public Health □Humboldt Child Care Council
☐ Humboldt County Probation Department ☐ United Indian Health Services
☐ California Forensic Medical Grp (CFMG) ☐ California Children's Services
☐ Humboldt County Juvenile Court ☐ Redwood Coast Regional Center
☐ CASA:_____ ☐ Other:_____

Page 1 of 2 **(See Reverse for additional Information & Signatures)**

DHHS-MHB-1007 (Rev 02/09/05)

DHHS – MHB Authorization for Release of Confidential/Protected Information Inter-Agency
Page 2 of 2
Patient Name:_____Case# _____ DOB: _____

EXPRIRATION OF AUTHORIZATION: Authorization shall not exceed one (1) year, and, will terminate on _____, if not revoked sooner.

NOTICE OF RIGHTS AND OTHER INFORMATION:

This Authorization is effective immediately. I may revoke this authorization at any time, *however my revocation must in writing, signed by me or on my behalf, and delivered to the records department of this facility.* **Revocation will NOT apply to information that has already been released in response to this authorization.**

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of your health information from making further disclosure of it unless you (or your legal guardian) provide them with written authorization, or as specifically required or permitted by law. **(Calif CC 56.10(c).** Authorization for sharing information shall be consistent with all state & federal regulations concerning protection of juvenile records (See W&I Code §827, §828, §830, & §16010).

I UNDERSTAND THAT AUTHORIZING THE USE OR DISCLOSURE OF THE INFORMATION IDENTIFIED ABOVE IS VOLUNTARY. I NEED NOT SIGN THIS FORM TO ENSURE HEALTHCARE TREATMENT.

A photocopy or a facsimile of this Authorization may be used in place of the original.

I may request to inspect or obtain a copy of the health information that I am being asked to authorize or disclose. **I may ask for a copy of this authorization (requested □ provided □)**

SIGNATURES:

Authorizing Signature: _____Date: _____
(Circle One: Patient/Rep/Legal Rep/Legal Guardian/Spouse/Financially Responsible Party, Other: _____)

Witness: _____ Date: _____

Distribution of copies ☐ Agency Providing Information ☐ Program File ☐ Client/Personal Copy

***HIV confidentiality requirements** allow signature by a person other than the patient only under the following circumstances: the patient is under 12 years of age, or as a result of his/her physical condition is incompetent to consent to HIV antibody blood test or the release of the test results; **and** the person authorizing the release of test results is lawfully authorized to make health care decisions for the patient (e.g., an attorney-in-fact appointed under the Durable Power of Attorney for Health Care); the parent or guardian of a minor; an appropriately authorized conservator; or, under appropriate circumstances, the patient's closest available relative. H&S Code §199.27. ***Substance Abuse records requirements** prohibit the information obtained in response to this authorization to be used to prosecute the individual. Disclosure for such purpose must meet requirements of 42CFR §2.63 and be ordered by the court.

COUNTY OF HUMBOLDT

Department of Health and Human Services

Mental Health /Alcohol & Other Drug Branch

POLICIES AND PROCEDURES

Policy Title Child Abuse Reporting	Approved by Mental Health Branch Director on _____day of_____, 200____
Effective Date ?	Printed Name of Director
Revisions 10/2005, 06/1994	Signature of Director

POLICY:

It is the policy of Humboldt County Dept. of Health and Human Services Mental Health Branch employees and volunteers to comply with mandated reporting requirements. The purpose of this policy is to delineate the requirements of the Child Abuse and Neglect Reporting Act, California Penal Code Section 11164-11174.3. All behavioral health practitioners are held responsible for knowing and complying with such act.

I. DEFINITION OF CHILD ABUSE AND NEGLECT:

“Child” means any person under age 18.

The term "child abuse or neglect" includes physical injury inflicted by, other than accidental means, upon a child by another person, sexual abuse as defined in Section 11165.1, neglect as defined in Section 11165.2, willful cruelty or unjustifiable punishment as defined in Section 11165.3, and unlawful corporal punishment or injury as defined in Section 11165.4.

“Mandated reporter” means any behavioral health practitioner, student, intern or trainee whether employed directly as a civil service provider, as a staff member of a contract provider or as a contracted network provider.

“Reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. For the purpose of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse. A child not

receiving treatment for religious reasons shall not be considered neglected for that reason alone.

Child abuse and neglect includes all of the following:

A. “Sexual abuse” which includes sexual assault or sexual exploitation

B. “Severe neglect” means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed non-organic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as prescribed by Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care. (11165.2).

C. “General neglect” means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred. (11165.2).

D. “Willful cruelty or unjustifiable punishment of a child” means a situation where any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered.(11165.3) (Please note that in the 1/1/2001 revision to the Child Abuse and Neglect Report Act, “unjustifiable mental suffering” requires a mandatory report.)

E. "Unlawful corporal punishment or injury" means a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition. (11165.3)

II. REPORTING REQUIRMENTS AND TIME FRAME

Child abuse reporting is one of the few exceptions to client confidentiality. The Child Abuse and Neglect Reporting Act specifically exempts reporters from any liability if they make a good faith report of child abuse or neglect.

Behavioral health practitioners, students, interns or trainees whether employed directly as a civil service provider, as a staff member of a contract provider or as a contracted network provider shall make a report whenever, in his or her professional capacity or within the scope of his or her employment, he/she has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect.

The mandated reporter shall make a report to Child Welfare Services (CWS) immediately or as soon as is practicably possible by telephone, and the mandated reporter shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. The mandated reporter may include with the report any non-privileged documentary evidence the mandated reporter possesses relating to the incident.

PROCEDURE:

PROCEDURES FOR MANDATED REPORTS

1. Notify Child Welfare Services at the Department of Health Services immediately at (707) 445-6180. If you are unsure whether or not to report, you are strongly encouraged to call this number for consultation.

2. The telephone report shall include:

a. The name of the person making the report

b. The name of the child

c. The present location of the child and name of school child attends

d. The nature and extent of the injury

e. Any other information requested by Child Welfare Services that is relevant to the child abuse investigation.

3. You must file a written report to Child Protective Services within 36 hours using the Suspected Child Abuse Report Form. (See attached sample form, Suspected Child Abuse Report.) A copy of the written report is to be filed _____.

The written report shall include, if known:

a. The child's name, present location of the child and the nature and extent of the injury

b. The name, business address, and telephone number of the mandated reporter

c. The capacity and/or condition that makes the person a mandated reporter

d. Location of incident, and where applicable, school, grade, and classroom

e. Names, addresses, and telephone numbers of the child's parents or guardians

f. Information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information

g. Name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child

h. If the child is not able to safely return to place where abuse likely occurred and/or if the child is in immediate danger, please report this information as well.

- The report is to be made even when information provided is incomplete or uncertain to the mandated reporter.

Please note that if an individual under 18 years of age reports abuse that transpired when he or she was a young child, such abuse must also be reported.

- Parental consent is not required prior to filling a Child Abuse Report. However, in the interests of maintaining a treatment alliance, parents/guardians should be notified when a report of child abuse is being made, but only if this communication poses no risk for the minor (i.e. if the parent/guardian is not suspected abuser).

IV. OTHER CONSIDERATIONS

When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any staff member who has knowledge that the member designated to report has failed to do so shall thereafter make the report. (11166)

- The reporting duties under this section are individual, and no supervisor or administrator may impede or inhibit the reporting duties, and no person making a report shall be subject to any sanction for making the report.

The identity of all persons who report shall be confidential and disclosed only between Child Welfare Services or to counsel representing a child protective agency or to district attorney.

- The legislature finds that even though it has provided immunity from liability to persons required to report child abuse, that immunity does not eliminate the possibility that actions may be brought against those persons based upon required reports of child abuse. If such actions occur the State Board of Control will pay up to fifty thousand dollars ($50,000) for reasonable attorney's fee incurred in any action against that person on the basis of making a report of child abuse.

- Any mental health practitioner failing to report a suspected, known, or observed child abuse is guilty of a misdemeanor and is punishable by confinement in the county jail for a term not to exceed six (6) months or by a fine of not more than one thousand dollars ($1,000) or both.

- Any violation of the confidentiality of the reports shall be a misdemeanor punishable by up to six (6) months in jail or by a fine of five hundred dollars ($500) or by both.

REFERENCE:

Child Abuse and Neglect Reporting Act, California Penal Code Section 11164-11174.3

Policy author printed name/ title **Mary Johnson, LCSW**	**Date** **10/31/2005**
Contact person printed name **?**	**Contact telephone number** **?**
Distribution to Administrative Manual	**Distribution to All Programs**

HCMMMHC/HUMBOLDT COUNTY MENTAL HEALTH SERVICES
CLIENT INFORMATION FORM

(PLEASE PRINT CLEARLY) Case#: _____

Legal Name: Last Name: _____ First Name: _____ M.I.:___

Other Names Used (Maiden/Nick Names /AKA=s): _____

Name on Birth Cert: Last: _____ First: _____ Middle:_____ Suffix:_

Place of Birth: County: _____ State: _____ Country: _____ Mother=s First Name: _____

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Ph: _____ Work Ph: _____ County of Permanent Residence: _____

If you do not have a phone, please list a message phone where we can contact you: _____

Other Client Information/Demographic:

Gender/Sex: [ ] Male [ ] Female [ ] _____ DOB:_____ SSN:_____ Marital Status: _____

Primary Ethnicity: _____ Race Most Closely Associated With: _____ Of Hispanic Origin? [ ] Yes [ ] No

Are you currently participating in any type of self-help group? [ ] no [ ] yes: [ ] CalWorks [ ] _____

Who Referred You Here?[ ] Primary MD [ ] _____

Your Employment Status: [ ] Full Time [ ] P/T (20 hrs/wk) [ ] Student [ ] Other: _____

Source of Income:[ ]None [ ]Employment [ ]Disability [ ]GR/Public Assistance [ ]Other (VA/Alimony/etc) [ ] Retired [ ] _____

Living Arrangement: [ ]Self [ ]Family/Parents [ ]Non-related Persons [ ]_____

# of Dependents: _____ Occupation: _____ Primary Language:[ ]English [ ] _____

Education/Highest Grade Completed:_____ Known Disabilities/Impairments:[ ]None [ ] _____

Client=s religious preference, if known: _____

Primary Care Physician Info: Doctor=s Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone:_____

Significant Other/Emergency Contact:

1) Name:_____ Type of Contact: _____Relationship:_____

Address/City/State/Zip: _____ Phone: _____

Financial/UMDAP Information: (Attach copies of cards front & back)

Responsible Party Name: _____ Relationship: _____

Address/City/State/Zip: _____ Home Phone: _____

Work Phone: _____ Employer (Name): _____ Employer=s Phone#: _____

Spouse=s Employer: _____ Is this visit employment related? [ ] Yes [ ] No

If yes, how is it to be paid for?_____

Medi-Cal #: _____ (Issue date: _____) Source of Income: _____

Medicare #: _____ Part A Effective Date: ___

_____ Part B Effective Date:

Is Medicare: [ ] Primary [ ] Secondary If applicable, complete & sign Medicare Screening form.

(PLEASE TURN PAGE OVER TO COMPLETE & SIGN BACK SIDE OF THIS FORM) Page 1 of 2

CLIENT INFORMATION FORM (cont'd from front side)

Client Name: _____ SSN: _____ DOB: _____ Case#: _____

UMDAP (Sliding Fee) Info: # in household: _____	UMDAP Exp Date: __ Liability Amt:$____	
Monthy Income:	Monthly Assets:	Monthly Expenses (not rent/utilities):
1. Self: _____	1. Savings: _____	1. Court Ordered: _____
2. Parent/Spouse: _____	2. Other (Interest/Dividends):___	2. Child Care: _____
3. Other: _____		3. Dependent Support: _____
		4. Medical: _____ (Ins. prem/prescriptions/doctors)
		5. Retirement _____ (retirement contributions)
Total Montly Income: $_____	Total Monthly Assets:$	Total Monthly Expenses $_____

Primary Insurance/Contract Information:

Effective Date: _____ Policyholder ID#: _____ Group/Plan #: _____

Plan Name: _____ Policyholder's Name: _____

Address: _____ Phone #: _____ Relation to Client: _____

DOB: _____ Gender/Sex: _____ Employer: _____

Secondary Insurance/Contract Information:

Effective Date: _____ Policyholder ID#: _____ Group/Plan #: _____

Plan Name: _____ Policyholder's Name: _____

Address: _____ Phone #: _____ Relation to Client: _____

DOB: _____ Gender/Sex: _____ Employer: _____

I hereby consent to evaluation & treatment by HCMMMHC Provider or Humboldt County Mental Health as prescribed by the attending physician and/or other professionals. I further authorize HCMMMHC Provider or Humboldt County Mental Health to bill directly for services received, and to release any information requested by insurance companies and/or Medicare for claims billed on my behalf. I also authorize payments of medical benefits directly to HCMMMHC Provider or Humboldt County Mental Health for all services they provided. I also understand that I am responsible to pay HCMMMHC Provider or Humboldt County Mental Health for charges as calculated under the State of California=s UMDAP sliding fee scale system.

Client=s Signature: _____ Guardian/Resp Party Signature: _____ Date_____

****

THIS SECTION COMPLETED BY SERVICE PROVIDER/ORGANIZATION

Service Provider_____Contract Organization:_____

Date client admitted to services:_____ Date client discharged from services:_____

Complete the client=s current DSM IV Diagnosis as requested below using DSM-IV CODE and Indicate Primary & Secondary diagnoses and ARule Out@ diagnoses:

Axis I: [ ] _____ [ ] _____ Axis II: [ ] _____ [ ] _____

Axis IV: A / B / C / D / E / F / G / H / I / J Axis V: Current GAF: ____ Highest GAF Past Year: ____

LEVEL of Care Assigned: I II III (circle one)

HCMMMHC-MCO-CIF (Rev 1/16/04) Distribution: [ ] patient chart [ ] Managed Care Claim Office [ ] Business Office

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH
720 Wood Street, Eureka, CA 95501

First
Last
Client ID
Date of Service M M - D D - Y Y

11101

1014 CLIENT SERVICE PLAN

TYPE OF SERVICE: [ ]Indiv Therapy [ ]Grp Therapy [ ]MHS-Rehab [ ]DT Intensive [ ]DT Rehab [ ]TBS [ ]BC [ ]MEDS [ ] CMB
LOCATION OF SERVICE: [ ] MHB-Main [ ] CYFS [ ] Garberville MH [ ] TRTF [ ] Org Provider [ ] Pvt Provider [ ] Field

Section 1.

TREATMENT/SERVICE GOALS

GOAL #1
A. Specific Observable Quantifiable Goal:
B. Interventions:
C. Duration of Interventions:
D. Termination Date/Changes to Goal:

GOAL #2
A. Specific Observable Quantifiable Goal:
B. Interventions:
C. Duration of Interventions:
D. Termination Date/Changes to Goal:

GOAL #3
A. Specific Observable Quantifiable Goal:
B. Interventions:
C. Duration of Interventions:
D. Termination Date/Changes to Goal:

Section 2. OTHER COMMUNITY SERVICES INVOLVED (i.e., RCRC, DSS, PROB, REHAB, Special Ed, Med Support, Other)
Other SMH Services: [ ] TBS: Is TBS Treatment Plan a component of the overall MH Client Plan? [ ] Yes:
[ ] Medications [ ] Case Management Brokerage [ ] Other:

Section 3.
1. The above Client Plan is consistent with the assessment diagnosis & the level of impairment criteria: [ ] Yes
2. The focus of intervention is consistent with the Client Plan goals: [ ] Yes

Individual/Client Signature (If none, see progress note dated: _____) **Date** **Updated Client Signature** Date

Family/Support Person/Conservator (If applicable) Date Updated Family/Support Person/Conservator Date

Provider Signature & Title **Date** **Updated Provider Signature & Title** **Date**
(Co-Signature required only if staff providing services are not in the approved category: Physician, licensed/waivered Psychologist, licensed Registered Nurse, licensed/registered/waivered Social Worker, licensed/registered/waivered Marriage & Family Child counselor.)

Co-Signature/Name & title (if applicable) Date **Co-Signature/Name & title (if applicable)** Date

Client Problem Resolution Forms are available at the Front Offices of all sites, or may be requested by calling the Quality Improvement Coordinator at (707) 268-2955, option 2, or the toll-free number for Mental Health at 1-888-849-5728, and asking for the Quality Improvement Department.

Forms may be mailed to:

Quality Improvement Coordinator
Coordinador de Augmento de Calidad
Humboldt County Mental Health
720 Wood Street
Eureka, CA 95501
Phone: (707) 268-2955, option 2

Forms may also be given to HCMH staff members for forwarding to the Quality Improvement Coordinator.

Here are some other people who can help you:

Patients' Rights Advocate
Defensor de Derechos de Pacientes
(707) 268-2995

State Ombudsman
1-800-896-4042
TTY 1-800-896-2521

Revised April 2006

CLIENT PROBLEM RESOLUTION GUIDE

Humboldt County
Department of Health and Human Services
Mental Health Branch
720 Wood Street
Eureka, CA 95501

(707) 268-2900 Toll-Free 1-888-849-5728

YOUR RIGHTS IN THE PROBLEM RESOLUTION PROCESS:

- You can ask for information about the problem resolution process at any time from any staff member or by calling the 800 number.
- You can have your legal representative or someone else make a complaint or file a grievance and appeal for you.
- You can ask for a Humboldt County Mental Health staff person to help you.
- You will not be discriminated against in any way if you make a complaint, grievance or appeal.
- We will respect your confidentiality.

GRIEVANCES

- You can file a Grievance either by talking or in writing. Probably the best and fastest way to do it is to use the Client Problem Resolution Form available at all sites. We may also need an Authorization to Release Information Form, which is also available at all sites.
  You can have someone help you with this, and you can add any other written material that you think will be helpful. You can also request to review your records.
- The Grievance will be sent to the Quality Improvement Coordinator, who will let you know that your grievance has been received, and start the process of investigating the problem.
- Staff members who have not been involved in the issue will investigate and talk to you about the problem.
- You can call the Quality Improvement Coordinator at any time to find out the status of your Grievance (707-268-2955, option 2).
- Within at least 60 days of receiving the grievance, we will send you a letter explaining what we have done to resolve the issue. If you do not have an address, we will try to reach you by phone.

APPEALS

You can file an appeal if you feel that Humboldt County Mental Health has taken one of the following actions:

1. denied, reduced, suspended, or terminated your services,
2. failed to provide services to you in a timely manner, or
3. failed to respond to your Grievance within 60 days.

If you are a Medi-Cal beneficiary, you have the right to request a State Fair Hearing after the Appeal process has been completed if the Appeal has not been granted. Information about how to do this is included in this brochure.

- Appeals must be filed in writing within 90 days of the date of the action (listed under Appeals).
- You may begin the process by stating your Appeal verbally to the Quality Improvement Coordinator, but if you are making a Standard Appeal, you must then send in a written and signed Appeal. You can use the Client Problem Resolution Form for this purpose. You may also request to review your records.
- The appeal is a request for us to review the action that we have taken, and we must respond to your request within 45 days of receiving the appeal. We will send you a letter notifying you of the results of our review of the action.
- In some cases when you feel that the Standard Appeal process could jeopardize your life or health and we agree, we will follow the Expedited Appeal process. Expedited Appeals do not have to be submitted in writing, and you can tell any staff member that you wish to make an Expedited Appeal. We will review the action and notify you're of our decision within 3 working days of receiving the Expedited Appeal request.
- Medi-Cal beneficiaries whose appeal was not granted or who have received a Notice of Action indicating their services have been denied, reduced, or terminated, may request a State Fair Hearing. You can also request that you continue to receive services while the State Fair Hearing is pending.

You may request a State Fair Hearing by calling this number:
1-800-952-5253.

You may ask for further information about or assistance with filing for a State Fair Hearing by calling either the Quality Improvement Coordinator at (707) 268-2955, option 2, or the State Ombudsman at 1-800-896-4042.

HUMBOLDT COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH BRANCH

CLIENT PROBLEM RESOLUTION REQUEST FORM

Grievance [ ] Standard Appeal [ ] Expedited Appeal [ ]

Date_____

Client Name_____Phone#_____

Mailing Address_____

Name of person filing Request if not the client:

_____Relationship_____

Phone #_____Mailing Address_____

Request:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach another sheet or other documentation that we may need to resolve your issue.)

Client signature_____Date_____

(or signature of staff recording the request) ROI obtained [ ]

Send form to: Quality Improvement Coordinator
Humboldt County DHHS Mental Health Branch
720 Wood St.
Eureka, CA 95501

If you have questions, call: (707) 268-2955, option 2

QIC: Date received:_____Date forwarded_____To_____

Date initial letter sent to client:_____ **Due Date**_____

Resolution/Action Taken:_____

_____

_____

_____

_____

_____

_____

Signature of Manager_____Date_____

Date Client notified:_____

Date QIC notified:_____ (include copy of documentation)

HUMBOLDT COUNTY MENTAL HEALTH (HCMH) SERVICES

CONSENT FOR EVALUATION AND/OR TREATMENT OF A MINOR
(Do Not Use If Minor Is Legally Authorized to Consent Except Emancipated)

AUTORIZACION PARA AVALUACION Y TRATAMIENTO DE UN MENOR

I, the undersigned, hereby consent to mental health/alcohol or other substance abuse evaluation and treatment for
Yo, con me firma, doy mi permiso para avaluacion y tratamiento de salud mental/abuso de alcohol o otra droga para

by HCMH at
_____ *por HCMH en* _____

California, as prescribed by the attending physician and other professionals.
___*_____, California, segun como prescribe el medico presente y los otros profesionales.*

Signature: Relationship to Patient:
Firma: _____ *Relacion al Paciente:*_____

Witness: Date:
Testigo: _____ *Fecha:* _____

==========

EMANCIPATED MINOR - INFORMATION
(Do Not Use If Emancipation Judicially Determined)
INFORMACION DE MENOR EMANCIPADO

For the purposes of obtaining evaluation and treatment by HCMH at the
Por los propositos de obtener avaluacion y tratamiento por HCMH en _____

the undersigned certifies the following facts are true.
_____*, yo, con mi firma, certifico que los siguentes son verdaderos.*

1. I am living separate and apart from my parents or legal guardian.
   Vivo separado y afuera de la casa de mis padres o guardian legal.

2. I am managing my own financial affairs regardless of source of income.
   Yo manejo mis propios negocios financiales sin importar el origen del ingreso.

3. I am years of age, having been born on the day of 19
   Tengo _____ anos de edad, nacido el _____ dia de _____, 19_____.

Signature:
Firma: _____

Witness: Date:
Testigo: _____ *Fecha:* _____

==========

EXCHANGE OF INFORMATION

CAMBIO DE INFORMACION

I hereby authorize HCMH and to exchange pertinent medical, social,
Yo, por lo presente, autorizo a HCMH y a _____ *a cambiar informacion pertinente*

and psychiatric findings concerning the mental health/alcohol or other substance abuse evaluation and treatment of:
(medica, social y psiquiatrica) tocante a la avaluacion y tratamiento de la salud mental/abuso de alcohol o otra droga de:

_____

Signature: Relationship to Patient:
Firma: _____ *Relacion al Paciente:*_____

Witness: Date:
Testigo: _____ *Fecha:* _____

COMPLETE AT LEAST ANNUALLY (*COMPLETA A LO MENOS ANUALMENTE*)

HCMH:CON.TX.MINOR (Revised 9/25/92)

HUMBOLDT COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH BRANCH
CONTRACT PROVIDER PATIENT INCIDENT REPORT

NAME OF ORGANIZATION _____
DATE/TIME OF INCIDENT _____ INCIDENT LOCATION _____

PATIENT INFORMATION
NAME_____SEX___DOB_____SSN_____
ADDRESS _____
TELEPHONE NUMBER _____

DESCRIBE INCIDENT:
_____
_____
_____
_____
_____
_____

STAFF ACTION (DESCRIBE THE ACTIONS TAKEN BY STAFF FOLLOWING THE INCIDENT):
_____
_____
_____
_____
_____

WAS THIS INCIDENT REPORTED TO ANY OTHER AGENCY? (E.G. DHS, COMMUNITY CARE LICENSING, ETC.) YES [ ] WHICH AGENCY? _____
NO [ ]

PERSON COMPLETING THIS FORM:
NAME _____ TITLE _____ DATE _____
SIGNATURE _____

SIGNATURE OF HEAD OF SERVICE OR CEO
_____ TITLE _____ DATE _____

PLEASE FAX WITHIN ONE WORKING DAY OF INCIDENT TO:
HUMBOLDT COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH BRANCH
QUALITY IMPROVEMENT DIVISION
FAX (707) 476-4096

IF YOU HAVE ANY QUESTIONS, CALL THE QUALITY IMPROVEMENT DIVISION AT (707) 268-2955, OPTION 2

Organizational Provider Patient Incident Report Form April 17, 2006

DEFINITION OF TERMS

The following terms shall have the meaning set forth below:

1. "Authorization Form" a.k.a. "*Levels Form*" shall mean the approved Request for Specialty Mental Health Services form with number evidencing an authorization by HCMMMHC to render Day Treatment and Therapeutic Behavioral Services and other authorized Covered Services to Beneficiaries.
2. "Assessment" shall mean a service activity which includes a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; and diagnosis.
3. "Behavioral Coach Services" (see Therapeutic Behavioral Services) shall mean one-to-one therapeutic contact between a mental health provider and a beneficiary for a specified short-term period of time which is designed to maintain the child/youth's residential placement at the lower appropriate level of care by resolving target behaviors and achieving short-term treatment goals, provided while the client is in a lockout service, like Sempervirens or Crisis Stabilization.
4. "Beneficiary" shall mean any person who has been determined to be eligible to receive Medi-Cal benefits by any of the Branches of the Humboldt County Department of Health and Human Services, the State of California, or the Social Security Administration and is used synonymously with "patient" and "client".
5. "Case Management/Brokerage" shall mean services provided by staff to assist beneficiaries and their families to access and maintain access to medical, educational, social, pre-vocational, vocational, rehabilitative or other needed community services
6. "Collateral" shall mean a service activity to a significant support person(s) in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.
7. "Contracting Provider" and/or "Provider" shall mean any mental health professional provider and/or organizational provider licensed in the State of California and certified by the State of California's Medi-Cal Program to render services to Beneficiaries and contracting with HCMMMHC to render certain Covered Services to Beneficiaries
8. "Covered Services" shall mean those specialty mental health services as defined in Title 9, CCR, §1810.345 (psychiatric nursing facility services are not included), rendered by individual and organizational providers who meet the appropriate licensure requirements to render Covered Services and these services have been authorized by HCMMMHC to be provided to Medi-Cal beneficiaries. Covered services are outlined in *Addendum A* of the Service Agreement.
9. "Crisis Intervention" shall mean a service to a beneficiary for a condition which requires more timely response than a regularly scheduled visit because the beneficiary is experiencing a mental health crisis.
10. "Day Treatment Intensive - Full Day" shall mean a structured multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available more than four hours each day the program is open.
11. "Day Treatment Intensive - Half Day" shall mean a structured multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with

services available at least three hours each day the program is open.

12. "Day Rehabilitation - Full Day" shall mean a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries, with services available for more than four hours each day the program is open.
13. "Day Rehabilitation - Half Day" shall mean a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries, with services available at least three hours each day the program is open.
14. "Evaluation" shall mean a face-to-face meeting with the beneficiary to assess the client's mental, emotional, or behavioral disorder and need for services. It may include a diagnostic impression if done by a non-Licensed Practitioner of the Healing Arts level staff member.
15. "Excluded Services" shall mean those services for which HCMMMHC is not responsible and not reflected in the Service Description of the Service Agreement.
16. "Collateral Therapy" shall mean a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments of beneficiary and the quality of family relationships performed with the family group.
17. "Group Therapy" shall mean a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments, provided to a group of beneficiaries.
18. "HCMMMHC" shall mean Humboldt County Medi-Cal Managed Mental Health Care, serving Humboldt County Medi-Cal Beneficiaries.
19. "Humboldt County Medi-Cal Managed Mental Health Care Provider Manual" shall mean this manual issued to each mental health provider by HCMMMHC.
20. "Individual Therapy" shall mean a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments, provided to an individual beneficiary.
21. "*Levels Form*" a.k.a. "*Authorization Form"* shall mean the approved Request for Specialty Mental Health Services form with number evidencing an authorization by HCMMMHC to render Day Treatment and Therapeutic Behavioral Services and other authorized Covered Services to Beneficiaries.
22. "Medi-Cal Provider Manual" shall mean the Medical/Allied Health Services Provider Manual of the Department of Health Services, issued by the Department's Fiscal Intermediary.
23. "Medi-Cal Rates" shall mean the schedule of Medi-Cal maximum allowances and rates of payment reflected in the Service Agreement for physician and non-physician services in effect for Humboldt County's Medi-Cal program at the time the services were rendered
24. "Medical Director" shall mean the Medical Director of HCMMMHC or the designee of the Medical Director
25. "Managed Care Organization (MCO)" shall mean Humboldt County Medi-Cal Managed Mental Health Care (HCMMMHC), which has entered in to an agreement with the State Department of Mental Health to arrange for and/or provide specialty mental health services to beneficiaries in Humboldt County.
26. "Member" shall mean any Beneficiary who is enrolled with HCMMMHC. The terms Member and Beneficiary may be used interchangeably.

27. "Mental Health Plan" (MHP) refers to HCMMMHC
28. "Mental Health Service Plan Development" shall mean a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
29. "Mental Health Services" shall mean those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities include assessment, plan development, therapy, rehabilitation and collateral.
30. "Mental Health Rehabilitation Services" shall include any of the following services that are integral to achieving the beneficiary's goals: assistance in restoring or maintaining an Individual's or group of Individual's a) functional skills, b) daily living skills, c) social skills, d) grooming and personal hygiene skills, e) meal preparation skills, f) medication compliance, and g) support resources.
31. Necessary" shall mean a service or services determined by HCMMMHC to be appropriate treatment/s and required for general benefit of the patient according to accepted standards of medical practice and not primarily for the convenience of the Beneficiary or participating provider
32. NOA-A (Notice of Action) is a letter issued by HCMMMHC to a beneficiary when HCMMMHC or its Providers determine that the beneficiary does not meet medical necessity criteria and is not entitled to any specialty mental health service.
33. NOA-B is a letter issued by HCMMMHC to the beneficiary when HCMMMHC denies, modifies, or defers (beyond timelines) a payment authorization request from a provider for specialty mental health services.
34. "Organizational Provider" shall mean any Mental Health organization which is certified as meeting Short Doyle/Medi-Cal provisions by Humboldt County Mental Health or the State Department of Mental Health.
35. "Physician" shall mean either an Attending Physician or a Primary Care Physician duly licensed and certified in the State of California.
36. "Provider" shall mean any psychiatrist, mental health professional, or organization certified to render Covered Services to Beneficiaries and contracting with HCMMMHC.
36. "Psychiatrist" shall mean those licensed physician specialists in the State of California who maintain a Specialty Code designation of 26 Psychiatry (child), 27 Psychiatry, Neurology and 36 Psychiatry.37. "Psychologist" shall mean a licensed Psychologist with two (2) years post licensure experience.
39. "Therapeutic Behavioral Services (TBS) is an intensive one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional disturbances who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

County of Humboldt
Deptment of Health and Human Services
Mental Health/Alcohol and Other Drug Branch
Policies and Procedures

Policy Title	Approved by Mental Health Branch Director on
Duty to Warn/Tarasoff Warnings	_____day of_____, 200___
Effective Date ?	Printed Name of Director
Revisions 04/26/1996 10/2005	Signature of Director

POLICY:

It is the policy of Humboldt County Department of Health and Human Services Mental Health Branch staff (including, but not limited to: psychotherapists, physicians, licensed nurses, social workers, crisis workers) to take appropriate actions in notifying affected parties where threatening statements, letters or other forms of communication are received from patients.

Definition: Section 5328 (r) of the California Welfare and Institution Code indicates that if a psychiatric patient "presents a serious danger of violence to a reasonably foreseeable victim" the Mental Health Department staff may release information about that patient "to that person or persons and to law enforcement".

The Tarasoff decision deals with responsibility of the psychotherapist to warn victims of potential violence by clients. Simply stated, this means that the psychotherapist-patient privilege is overshadowed by the therapist's responsibility to warn an intended victim.

PROCEDURE:

1. In situations where threatening statements, letters, or other forms of communications are directed toward a specific person with a specific intent of harm or bodily injury, staff is required to:

a. Document in the patient's medical record, the statement made by the patient with specific quotations

b. Notify immediate supervisor, charge nurse, and attending physician

c. A determination will be made if the statement requires a "Tarasoff Warning"

d. An attempt to notify, by telephone, the individual being threatened must be made and documented in the medical record. This would include a notification at the residence and/or business of the person being threatened

e. Law enforcement agencies with jurisdiction over the areas of residence of the person being threatened as well as the person making the threats must be notified by telephone and documented in the medical record

f. A letter will be mailed to the individual being threatened via Certified Mail, Return Receipt Requested, confirming the telephone notification (or attempt to notify by telephone) and restating the threat. This letter will identify the patient's name and address. It will also identify the law enforcement agencies notified. (Refer to attached sample letter.)

g. A letter will be mailed to the law enforcement agencies contacted confirming the telephone conversation which reported the threat. (Refer to attached sample Law Enforcement letter.)

h. Copies of the Tarasoff letters will be maintained in the patient's record and the Office of the Medical Staff Secretary. Copies of the letters will be sent to the Director of Mental Health Branch.

2. A written incident Quality of Care report must always be completed by clinical staff and distributed through appropriate Quality Improvement channels when a Tarasoff warning has taken place. This report would include the name of the staff member issuing the warning, the name of the supervisor and any other persons involved in the decision, as well as the circumstances surrounding the warning. In addition, the report must indicate:

1. The patient communicated to the psychotherapist a threat of physical violence.

2. That this threat was a serious one.

3. The reasons why the victim or victims were reasonably identifiable. The report must be received at Mental Health Branch Administration within one working day of the incident or sooner as possible.

If a therapist makes a Tarasoff warning by making reasonable efforts to communicate the threat to the victim/s and to a law enforcement agency, the therapist is immune from suit by the victim/s even if the victim is subsequently injured. Civil Code §43.92 (b). Moreover, such disclosures are authorized by law, Welfare & Institutions code 5328 (r) and do not breach client/therapist confidentiality rules.

REFERENCE:

Section 5328 (r) of the California Welfare and Institution Code

The general legal requirements for MHB staff in regard to Tarasoff warnings follow:

a. The psychotherapist's duty does not arise only where the psychotherapist has actual knowledge of danger. It arises whenever the therapist determines, or pursuant to standards of the profession should determine, that the patient presents a serious danger to another. If a patient threatens physical violence against someone, the threat must be a serious one and the victim or victims must be reasonably identifiable. Some examples of when a victim is "reasonably identifiable" include: a) the victim is specifically named by patient (ex. Bob Smith of 123 Sesame Street); b) the victim is easily identifiable by their relationship to the patient (ex: my mother, brother, employer, colleague, competitor, etc.); or c) other easily recognizable trait (ex.: the Mayor, my congressman, the anchor for the Channel 6 p.m. news hour). In order to discharge the duty to warn, the psychotherapist must make reasonable efforts to communicate the threat to the victim or victims and must notify a law enforcement agency.

b. Persons to be notified in a Tarasoff situation must include the intended victim, and the police. The therapist must take all necessary steps to warn the victim of the

circumstances such as attempting to contact the potential victim by telephone and/or letter. This may include telling other persons who are in a position to warn the victim. It is reasonable to provide the name and address of the client making the threats and the nature of the violence that the client has threatened. It is not permissible to provide the police or the victim access to confidential patient records without a valid court order, however.

c. Serious consideration should be given to initiating a 72-hour involuntary evaluation hold pursuant to Welfare & Institutions Code 5150 on the patient.

d. Once a decision has been made as to how the situation will be handled clinically, this should be carefully charted. The therapist needs to chart what information was disclosed, to whom, when and why.

e. The name and location of the law enforcement agency contacted and the name and badge number of the officer must also be included in the chart.

Policy author printed name/ title **Mary Johnson LCSW**	**Date**
Contact person printed name	**Contact telephone number**
Distribution to Administrative Manual Administrative Manual Holders Quality Improvement Manual	**Distribution to All Programs**

ELIGIBILITY VERIFICATION

Individual Medi-Cal eligibility is established monthly by the State Department of Social Services. Beneficiaries are classified into different eligibility aid codes. Some aid codes exclude specialty mental health service reimbursement.

Medi-Cal recipient/beneficiaries with identification numbers beginning with any number other than "12" (Humboldt County) are excluded from service coverage by the HCMMMHC.

The HCMMMHC service authorization, hereinafter referred to as Service Authorization, is not a guarantee of payment; service providers are responsible for verifying beneficiaries' Medi-Cal eligibility. AT THIS TIME, ONLY BENEFICIARIES WITH NO OTHER HEALTH COVERAGE EXCEPT MEDI-CAL WITH MENTAL HEALTH SERVICE BENEFITS, ARE INCLUDED.

Please contact HCMMMHC if a beneficiary for whom services are authorized:

1) is no longer eligible for Medi-Cal and/or;
2) the aid code indicates reimbursement of specialty mental health services is not allowed; and/or,
3) the County of responsibility changes.

The EDS Point of Service (POS) Device/Network/Internet or Automated Eligibility Verification System (AEVS) may be utilized to verify Medi-Cal eligibility. The Provider is required to maintain proof of eligibility for every month of service, and attach a copy to the claims upon submission to HCMMMHC. DO NOT CONTACT HCMMMHC TO VERIFY ELIGIBILITY.

Beneficiaries' Medi-Cal identification number, names, and dates of birth on claims must match Medi-Cal eligibility records. Inconsistent entries will be returned to the provider for correction.

EDS POINT OF SERVICE (POS) DEVICE/NETWORK/INTERNET

Internet transaction is strongly preferred to POS network transaction as it provides more information relative to verification.

Our Billing Unit highly recommends that Providers enroll and gain access to the Medical Point of Service (POS) Network/Internet. It will allow you to determine client Medi-Cal eligibility and Share of Cost at any given point in time.

You may download the procedure and forms by performing the following steps:

Go to https://www.medi-cal.ca.gov
Click on Transaction Services
Click on Sign Up for Medi-Cal Internet Transactions

The top segment will list the following: Eligibility Share of Cost, Medi-Services,

Medicare Drug Pricing, Automated Provider Services, Batch Eligibility.

This section also states: Must have a Medi-Cal Provider number and PIN and have a Medi-Cal POS Network/Internet Agreement form on file.

For information on Provider Enrollment, www.Medi-cal.ca.gov.

Please call the **POS Help Desk at 1-800-427-12**95 for more information.

The Provider must keep a hardcopy of the data retrieved in order to meet HCMMMHC claiming requirement.

AUTOMATED ELIGIBILITY VERIFICATION SYSTEM

To verify Client/Beneficiary Medi-Cal eligibility through AEVS: Call 1-800-456-2387 (1-800-456-AEVS).
Automated-phone system will welcome you and ask for Provider Identification Number PIN) followed by the # sign.
Automated message will confirm your Provider number which is 00000+4 digits. If that is correct, press "I" to continue.

Listen and follow the phone tree.
To verify eligibility, press "1".

You will need the following information prior to calling the AEVS #:
Client's/Beneficiary's 1.D. which is either their Social Security number (9 digits) or Medi-Cal number (14 digits)followed by the # sign.

Client's/Beneficiary's birth date entered mmddyyyy (example: 061982 for June 16, 1982).
Date of service entered mmddyyyy (example: 05292001 for May 29, 2001).
The recording will give the following information: (Have pen and paper ready to write down the following information.)

Client's/Beneficiary's first 6 letters of last name
Client's/Beneficiary's first initial of first name
County Code
Primary Aid Code
Eligibility Status with or without Share of Cost
Share of Cost amount and amount remaining
Other Health Insurance and Health Insurance Claim number
Medi-Cal Verification Eligibility Confirmation number

To repeat the information, press "1 ".
Press "2" to verify eligibility of another client.

Start from Step 5 (Press "1" for eligibility) and re-enter the necessary recipient information.

MEDI-CAL ELIGIBILITY VERIFICATION

1) Go to *www.medi-cal.ca.gov*

2) Click on Transaction Services

3) Login:

If you are MD, your User ID is ……. 000001234
" PhD, " ……. 000001235
" LCSW, " ……. 000001236
" MFT, " ……. 000001237
" RN, " ……. 000001238
" Mix Spec. Group …….. 000001239
" Org Provider ..... 00000xxxx"
(your 4 digit state provider #)

Type your Password. If you are FFS provider, please contact Provider Relations Coordinator at (707) 268-2955, Option #1, Then Option 2 to obtain a password. If you are Org Provider you should receive a password in the mail directly from the State Department of Mental Health.

4) Select "Single Subscriber" and perform eligibility transaction.

Swipe Card: (Not Required) leave blank
Subscriber ID: (Required) Client's SSN
Subscriber Birth Date: (Required)
Issue Date: (Required) Enter today's date
Service Date: (Required) Enter date of service – today or prior

5) Print Eligibility Response for your record. You are also required to send a copy of this sheet with your claim: Make sure the traffic light is green, and view "Eligibility Message" on the bottom. It should show "MEDI-CAL ELIGIBLE W/ NO SOC". If it shows "OTHER HEALTH INSURANCE COVERAGE", you must obtain insurance information from the client and pursue reimbursement from other funding sources. Medi-Cal will cover only when you receive a denial from all other possible funding sources. Partial approval or non-denied claims will not be processed.

If you have any further questions regarding eligibility verification or other claim related issues, please call Claims Processing at (707) 441-5449.

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HIPAA Update

Welcome to the Medi-Cal Web site. This site provides access to provider bulletins, manuals, regulations and forms for enrolling in the Medi-Cal program. A variety of transactions can also be performed through this site including: Recipient Eligibility, CMC Uploads, Checkwrite Information and much more.

System Status Alert!

There has been a change to the system status of the **Medi-Cal Web site**. To view details ▸ Click Here

HIPAA Update

HIPAA Update Page | HIPAA Frequently Asked Questions Page

- **270/271 Real-Time Internet Eligibility (RTIE) Screen Changes** — On March 22, 2004, selected field names used in the 270/271 Real-Time Internet Eligibility (RTIE) transactions (previously called "Determine Patient's Eligibility and Internet Batch Eligibility [IBEA] Processing") changed to comply with transaction standards mandated by the Health Insurance Portability and Accountability Act (HIPAA).
- **ASC X12N 837 and 835 Version 4010A1 Companion Guides Finalized** — Medi-Cal has finalized its ASC X12N 837 Version 4010A1 Health Care Claim and 835 Version 4010A1 Electronic Health Care Claim Payment/Advice Companion Guides and developed a new Web page to access this information.

What's New

We are continually striving to improve this site and offer new services and information.
Please check back here often for updates and information on new features!

- **Medi-Cal is now better able to serve you with a new Telephone Service Center (TSC)** The TSC consolidates the Provider Support Center and other Help Desks and services under one convenient number. ▸ more...
- **Medi-Cal Unveils New OPT OUT Service** When you OPT OUT of hard copy (printed) bulletins, you will receive e-mail notices with direct links to monthly *Medi-Cal Updates*, manual pages and training information on the Medi-Cal Web site, customized to your provider community. ▸ more...

Previous Articles

For more information about recent updates, please select a topic from the following menu:

Select a topic

Services
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▸ CMC on the Internet
▸ Publications
▸ HIPAA Update
▸ Medi-Cal Rates
▸ Automated Provider Services
▸ Drug Use Review (DUR)
▸ Provider Enrollment
▸ BCCTP Overview
▸ Provider Relations Organization

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Login to Medi-Cal

Login Center for Transaction Services

Please enter your User ID and Password. Click Submit when done.

Learn how to Sign Up for Medi-Cal Internet Transactions.

Please enter your User ID:

Please enter your Password:

Submit Clear

Be careful to protect your user ID and password to prevent unauthorized use.

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Server:medi-cal.ca.gov |File:/Eligibility/Login.asp |Last Modified:11/17/2003 9:24:21 AM

Transaction Services

You are logged in as:

Real Time Internet Eligibility (RTIE)
Determine monthly Patient (Subscriber) Eligibility and obtain an Eligibility Verification Confirmation (EVC) Number
Single Subscriber
Multiple Subscribers

Perform SOC (Spend Down) Transactions
Apply or Reverse Subscriber's Share of Cost (Spend Down) Amount

Perform Medical Services Reservation Transactions
Make or Reverse a Medical Services Reservation (Medi-Services)

Perform Automated Provider Services (a.k.a. PTN on Web)
Perform various transactions including Checkwrite, Claim Status, Issue Status, and Procedure Code inquiries

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Server:medi-cal.ca.gov |File:/Eligibility/Menu.asp |Last Modified:3/22/2004 7:57:41 AM

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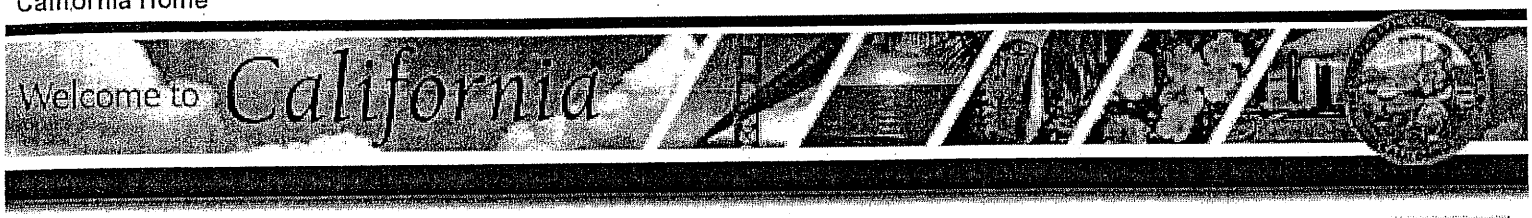

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Perform Eligibility Transaction

You are logged in as:

Swipe Card:
*Subscriber ID:
*Subscriber Birth Date:
*Issue Date:
*Service Date:

* Indicates Required Field

SUBMIT CLEAR

Recall data from last transaction

Click here for help on button usage.

For help on fields, place the cursor in the desired field and click on the Help link on the left.

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Server:medi-cal.ca.gov |File:/Eligibility/Eligibility.asp |Last Modified:3/12/2004 8:23:34 AM

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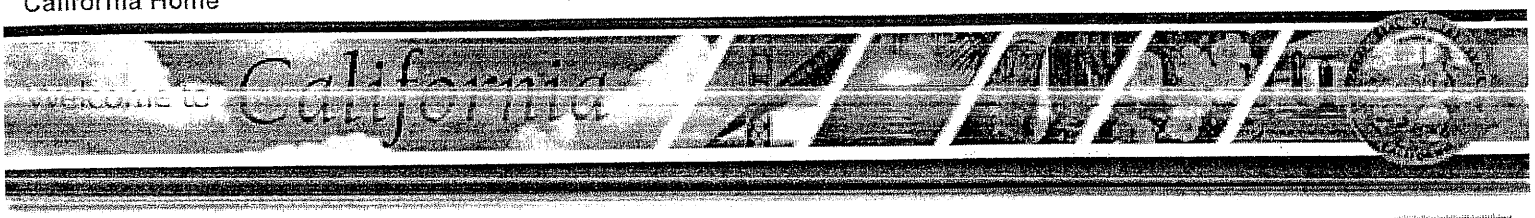

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Eligibility Response

Eligibility transaction performed by provider: 000001201
on Tuesday, May 04, 2004 at 1:49:59 PM

Name: SMITH, JOHN		
Subscriber ID: 111-22-3333		
Service Date: 05/01/2004	Subscriber Birth Date: 07/08/1988	Issue Date: 05/04/2004
Primary Aid Code:	First Special Aid Code: 03	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 12 - Humboldt	HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number): 274HGHX231		
Eligibility Message: LAST NAME: SMITH . EVC #: 274HGHX231. CNTY CODE: 12. 1ST SPECIAL AID CODE: 03. MEDI-CAL ELIGIBLE W/ NO SOC.		

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Eligibility Response

Eligibility transaction performed by provider: 000001201
on Tuesday, May 04, 2004 at 1:56:39 PM

Name: DOE , JANE		
Subscriber ID: 444-55-6666		
Service Date: 05/01/2004	Subscriber Birth Date: 05/01/1991	Issue Date: 05/04/2004
Primary Aid Code: 40	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 12 - Humboldt	HIC Number:	
Primary Care Physician Phone #:	Service Type: OIM V	
Trace Number (Eligibility Verification Confirmation (EVC) Number): 2543NCJT71		
Eligibility Message: LAST NAME: DOE . EVC #: 2543NCJT71. CNTY CODE: 12. PRMY AID CODE: 40. MEDI-CAL ELIGIBLE W/ NO SOC. OTHER HEALTH INSURANCE COVERAGE UNDER CODE A. CARRIER NAME: BLUE CROSS OF CALIFORNIA PPO. ID: MGT:D/DE:D53/HS:DZK. COV: OIM V.		

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EXPEDITED REVIEW REQUEST
Mental Health Plan Payment Authorization
For Therapeutic Behavioral Services
Mental Health Plan Name: _____

Initial Authorization Request _____ Reauthorization Request _____

Provider Information	**Beneficiary Information**
Provider Name	Beneficiary Name
Provider Address	Beneficiary Medi-Cal Number
Provider Number_____ Phone Number _____	DOB _____

Provider Certification:

I certify under penalty of perjury that an expedited review of the accompanying MHP payment authorization request is necessary because the standard 14 day authorization timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

Signature of Provider _____ Date _____

Examples of Reasons for an Expedited Request

Without TBS, the beneficiary is likely to be placed at a higher level of care or to require acute psychiatric hospitalization within the next 14 days.

The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.

The request is for the continuation of previous TBS authorization which will end in 14 days or less, resulting in a gap in services, and the request is being made before the end of the previously authorized service period.

FORMS CHECKLIST FOR ORG PROVIDERS

Form# or Code	Form Name	Comments	√
HCMMMHC.SRVCREQ.FRM 11/00	Request for Access to Services		
HCMMMHC-MCO-CIF 1/16/04	Client Information Form	Opening and closing	
1028	Health History Questionnaire		
HCMH.CON.TX.MINOR 9/25/92	Consent for Evaluation and/or Treatment of a Minor		
DHHS-MHB:AcknowledgementNOPP 4/14/03	Acknowledgement of Receipt of Notice of Privacy Practices		
1006	Authorization for Use/Disclosure of Confidential Information/PH Information		
1007	Authorization for Use/Disclosure of Confidential Information – Interagency		
1096	Assessment (Comprehensive)		
1058	Outpatient Services – Progress Note Form	Opening & Closing Note	
1038	Medical Necessity Authorization & Levels – Adult		
1039	Medical Necessity Authorization & Levels - Minor		
1014	Client Service Plan	Provider to complete with beneficiary signature and Parent/Caregiver Signature	
HCMH:TXSUMM.FRM 2/98	Treatment Summary	Closing	
TBS Assessment	TBS Assessment		
TBS Notice of Closure (NOC)/ Version 2/ 3/18/05	TBS Notice of Closure		
HCMH:TBSPN.FRM (Rev 6/12/00)	TBS Progress Note		
TBS Reauthorization 7-03/tbs/jp	TBS Re-authorization Form Summary		
TBS Team Mtg Sign Sht Rev 03/16/05	TBS Treatment Plan Signature Sheet		
TBS Treatment Plan Rev 8-02B/tbs/la	TBS Treatment Plan		

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH
720 Wood Street, Eureka, CA 95501

First
Last
Client ID
11101

Date of Service M M - D D - Y Y

1028 HEALTH HISTORY QUESTIONNAIRE

Current Physical Health (client) is: ☐Good ☐ Poor ☐Has changed in past year? Yes No ***(circle one)***

Have you ever had any of the following illnesses?

☐High Blood Pressure	☐Hypothyroidism	☐Rheumatic fever	☐HIV	☐Arthritis
☐Congestive Heart Failure	☐Diabetes	☐Seizure Disorder	☐Cancer_____	☐Bone/joint disease
☐Heart Disease	☐Stroke	☐Chronic Lung Disorder	☐Tuberculosis	☐Nervousness
☐Cardiac (other)	☐Asthma	☐Neurological (Other)	☐Sexual difficulties	☐Hyperthyroidism
☐Hepatitis	☐Meningitis	☐Jaundice	☐Gonorrhea or Syphilis	☐_____

Comments: _____

WOMEN ONLY: are you pregnant currently? No Yes Don't know Last menstrual cycle was on:_____

Have you ever had any of the following problems?

☐Eye Disease, injury or impaired sight	☐Memory problems	☐Varicose veins	☐Appendicitis
☐Ear disease, injury, or impaired hearing	☐Difficulty concentrating	☐Shortness of breath	☐Liver or gallbladder disease
☐Head Injury	☐Extreme tiredness or weakness	☐Palpitations/fluttering heart	☐Colitis or other bowel disease
☐Loss of Consciousness	☐Hallucinations	☐Back, arm or leg problems	☐Hemorrhoids/rectal bleeding
☐Fainting spells	☐Crying spells	☐Kidney disease or stones	☐Constipation or diarrhea
☐Convulsions	☐Suicidal thoughts	☐Bladder disease	☐Other:_____
☐Paralysis	☐Loss of appetite	☐Swelling of hands, feet or ankles	_____
☐Dizziness	☐Enlarged glands	☐Protein, sugar, blood in urine	_____
☐Frequent or severe headaches	☐Enlarged thyroid or goiter	☐Difficulty urinating	_____
☐Trouble with nose, sinuses, mouth or throat	☐Skin disease	☐Abnormal thirst	_____
☐Depression or anxiety	☐Chronic or frequent cough	☐Frequent urination	_____
	☐Chest pain or angina	☐Stomach trouble or ulcer	
	☐Coughing up blood	☐Indigestion	
	☐Night sweats		

Family History: Has anyone in your immediate family had any of the following illnesses? *(Please √ box if yes)*

☐Diabetes ☐Cancer ☐Heart Disease ☐Overweight ☐Stroke ☐High Blood Pressure ☐Seizure

☐Other Neurological disorder: _____

Additional Information, Other Significant Illnesses, etc: _____

Current Health Care Provider's Name:_____

Address: _____

Last date of physical exam, or other evaluation: _____

Release of Information signed to allow sharing of information? ☐Yes ☐No

Are you currently under the care of a doctor? ☐No ☐Yes, condition:_____

Allergies: Do you have allergies to, or have reacted adversely to, any of the following items? ☐**No Known Allergies** *(Please √ box if yes)*

☐Local anesthesia or dental anesthetics	☐Penicillin or other antibiotics	☐Sulfa drugs
☐Barbiturates, sedatives or sleeping pills	☐Aspirin	☐Iodine

☐Allergies/reactions to any other drugs or food: please list:_____

CONTINUED TO REVERSE SIDE OF FORM

Health History Questionnaire (contd): **Client Name**: _____ Date**:** _____

Personal History: Please check & explain as appropriate if you have any history of treatment for the following illnesses listed below:

	Depression	Schizophrenia	Bipolar	Substance Abuse	Suicide Attempt(s)	Other
Self (client)						
Treatment History:						

Family History: Please check if there is any history or treatment for the following illnesses for your family members:

	Depression	Schizophrenia	Bipolar	Substance Abuse	Suicide	Other
Parent						
Sibling						
Children						
Aunt/Uncle						
Grandparent						

# of Psychiatric Hospitalizations (best estimate) for self during: Past Year: ___ Past 5 years: ____ Lifetime: ___

Medication History:

Please provide medications for the past two years, record the highest dose given	Currently taking? (√ box)	Dose	Freq.	Start/Stop Date(s)	Prescribed By	How effective are these medications at treating your symptoms? (√ box)	Well Tolerated? (√ box)
1	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
2	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
3	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
4	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
5	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
6	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
7	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
8	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
9	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No
10	□ Yes □No					□Full □Partial □Minimal □None	□Yes □No

Comment(s) – Please make additional comments to clarify: _____

_____

_____

_____

Patient's Signature: _____ Date: _____

Staff Signature (reviewing w/client)_____ Date: _____

MD Review (if client has been referred to Medications Clinic): _____

_____

_____

_____

_____

_____

_____

MD Signature: _____Date: _____

JUSTIFICATION for RE-AUTHORIZATION

Diagnoses: *("Change of Diagnosis" form must be submitted if different from initial assessment diagnosis*)_____

_____

_____

Presenting problem / Diagnosis-related Impairments: (*Must be reflected on the Client Plan)* _____

_____

_____

Goal#	Synopsis of progress towards goals during treatment	Obstacles to goal attainment during treatment
1		
2		
3		
4		

Prognosis for progress during extension of services (*For example: What will signify appropriate termination? What, specifically, will be different with more sessions? Are goals attainable in the Brief Intervention model? Have community support connections been established? Are substance abuse issues addressed?*)

_____

_____

_____

_____

_____

Number of Sessions (from 1 to 12) projected for treatment termination _____ *(Use this number on Request form*)

Staff/title _____Date _____

HCMH/HCMMMHC To be submitted with Request for Re-authorization File: Re-auth Request Justification (1/24/01)	_____ Agency/Provider Name (legibly printed) _____ Address Phone#	_____ Client Name: Last First Case # _____ D.O.B. _____

HCMH:REAUTHMCO.FRM (Rev 1/24/01)

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH
720 Wood Street, Eureka, CA 95501

First
Last
Client ID
Date of Service M M - D D - Y Y

11101

1038 MEDICAL NECESSITY AUTHORIZATION & LEVELS - ADULT

LEVEL 1
Criteria: [ ] Meets Specialty Mental Health DSM-IV Diagnoses Current GAF is _____

LEVEL 2
Criteria: ☐ Meets Specialty Mental Health DSM-IV Diagnoses Current GAF is _____

LEVEL 3
Criteria: ☐ Meets Specialty Mental Health DSM-IV Diagnoses Current GAF is _____

IMPAIRMENT CRITERIA CHECKLIST

Level I - Current GAF 1 to 30	Level II - Current GAF 31 to 50	Level III - Current GAF 50 to 70	Does **NOT** Meet Specialty Mental Health Criteria
21-30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriate, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends). 11-20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute). 1-10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death	41-50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job) 31-40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgement, thinking or, mood (e.g., depressed man avoids friends, unable to work neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).	61-70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational or school functioning (e.g., occasional truancy, or theft within the household), but generally functions pretty well, has some meaningful interpersonal relationships. 51-60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational , or school functioning (e.g., few friends, conflicts with peers or coworkers).	100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms 90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members). 71-80 If symptoms are present, they are transient and expectable reactions to psycho social stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social occupational or school functioning (e.g., temporarily falling behind in schoolwork)

INTERVENTION RELATED CRITERIA: In addition, Humboldt County Mental Health Services Level 1, 2, or 3 clients must meet **ALL** of the intervention related criteria listed below:

☐ The focus of proposed intervention is to address the condition identified in the appropriate impairment criteria section

AND ☐ It is expected the beneficiary will benefit from the proposed intervention as documented by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning.

AND ☐ The condition would not be responsive to physical health care based treatment

Signature/Title/Staff License: _____ Date: _____

THIS SECTION COMPLETED BY REQUESTING PROVIDER OF SERVICES

MEDICAL NECESSITY CRITERIA: This client meets the Medical Necessity Criteria as indicated below for EACH category of A, B, and C:

A. DIAGNOSES: Must have ONE of the following DM IV diagnoses, which will be the focus of the intervention being provided:

INCLUDED DIAGNOSES:

- ☐ Pervasive Developmental Disorders, except Autistic Disorder which is excluded.
- ☐ Attention Deficit & Disruptive Behavior Disorders
- ☐ Feeding & Eating Disorders of Infancy or Early Childhood
- ☐ Elimination Disorders
- ☐ Other Disorders of Infancy, Childhood or Adolescence
- ☐ Schizophrenia & 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

EXCLUDED DIAGNOSES:

- ☐ Mental Retardation
- ☐ Learning Disorders
- ☐ Motor Skills Disorder
- ☐ Communication Disorders
- ☐ Autistic Disorder (Other Pervasive Developmental Disorders are incl)
- ☐ Tic Disorders
- ☐ Delirium, Dementia, and Amnestic & Other Cognitive Disorders
- ☐ Mental Disorders Due to a General Medical Condition
- ☐ Substance-Related Disorders
- ☐ Sexual Dysfunctions
- ☐ Sleep Disorders
- ☐ Antisocial Personality Disorder
- ☐ Other Conditions That May Be A Focus Of Clinical Attention, except Medication Induced Movement Disorders which are included

NOTE: A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. IMPAIRMENT CRITERIA: **Must have ONE of the following (1, 2, OR 3)** as a result of the mental disorder(s) identified in the diagnostic ("A") criteria.

1. A significant impairment in an important area of life functioning, OR
2. A probability of significant deterioration in an important area of life functioning, OR
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. INTERVENTION RELATED CRITERIA: **Must have ALL, 1, 2, AND 3 below**:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, AND
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), AND
3. The condition would not be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

☐ Initial Request ☐ Re-Authorization Request

Primary Clinician (full name & license/discipline):_____ Program:_____

Date of Request: _____ # of Visits Requested: _____ # of Hours Requested: _____

Type of Request:

☐ Assessment _____ ☐ Group Therapy_____ ☐Medication Management___ ☐Individual/Family Therapy_____

☐ Case Management Services: ( ) Brokerage_____ ( ) Rehabilitation

☐ Day Treatment: ( )Intensive Day Treatment or ( )Rehabilitative Day Treatment # days/wk ____ S M T W Th F Sa #Requested

Program Staff Signature&Title:_____ Program Name:_____ Date:_____

DO NOT WRITE BELOW THIS LINE – FOR HCMMMHC COMPLETION ONLY

Authorization #: _____

I. Decision (select A OR B):

A. ☐ Client does not meet medical necessity criteria. Reason: _____

1. For Initial Assessment: Date NOA-A Sent: _____ 2. For Re-authorization Request: Date NOA-B Sent: _____

B. ☐ Client does meet Medical Necessity criteria.

1. Requested Re-Authorization Modified: NOA-B Sent/Delivered: _____
2. Approved for following services:

☐Assessment. #Auth:_____ Expires on _____ ☐ Group therapy: #Auth:_____ Expires on _____

☐ Individual/Family Therapy #Auth:_____ Expires on_____ ☐ Medication Mgmt: #Auth:_____ Expires on _____

☐ Case Management Brokerage #Auth:_____ Expires on _____ ☐ Rehabilitation: #Auth:_____ Expires on_____

☐ Day Treatment ( ) Intensive ( ) Rehabilitative # days/week ___(Circle) S M T W T h F Sa Total #Auth:_____ Expires on _____

II. Referrals (select A OR B):

A. ☐ Referred to current/requesting provider. Name/Address:_____

B. ☐ Referred to other provider. Name/Address:_____

Reason (code): _____ **Key**: 1 - Current provider not Medi-Cal eligible. 2 - Current provider not locally credentialed
3 - Current provider requests transfer 4 - Client requests alternate provider
5 - HCMMMHC decision. Specify: _____

Staff Signature & Title:_____ Date:_____

Client Name: _____ DOB: _____ Case #: _____ DHHS-MHB: 1038 (Rev 4/29/05) Page 2 of 2

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH
720 Wood Street, Eureka, CA 95501

First

Last

Client ID

11101

Date of Service M M - D D - Y Y

1039 MEDICAL NECESSITY AUTHORIZATION & LEVELS - MINOR

HCMMMHC - MEDICAL NECESSITY CHECKLIST - CHILDREN & YOUTH

LEVEL 1

[ ] SED Child/Adolescent (Under age 18) **[ ] SED Transition Age Youth (age 18-20)**

I. **Criteria**:
[ ] A primary DSM-IV Mental Health Disorder which meets Specialty Mental Health Target Population.

II. **AND** displays a significant and substantial impairment in at least TWO of the following areas:
[ ] Self care
[ ] Ability to function in the community
[ ] School functioning
[ ] Family relationships
[ ] An important area of life functioning: Specify:

III. **AND** at least ONE of the following:
[ ] The child is at risk of removal from the home or has been removed from the home.
[ ] The mental disorder and impairments have been present for more than one year or are likely to continue without treatment.
[ ] The child/adolescent displays one of the following:
- [ ] psychotic features
- [ ] risk of suicide
- [ ] risk of violence due to a mental disorder

[ ] The child/youth meets Special Education eligibility requirements under Chapter 26.5 of the Government Code

LEVEL 2
SED Child/Adolescent (Under the age of 21)

I. **Criteria**:
[ ] A primary DSM-IV Mental Health Disorder which meets Specialty Mental Health Target Population.

II. **AND** displays at least ONE of the following impairment criteria:
[ ] A significant impairment in an important area of life functioning (Specify:).
[ ] A probability of significant deterioration in an important area of life functioning. (Specify:)

LEVEL 3
Child/Adolescent (Under age 21)

I. **Criteria**:
[ ] A primary DSM-IV Mental Health Disorder which meets Specialty Mental Health Target Population.

II. **AND** displays the following impairment criteria:
[ ] There is a probability that the child/adolescent will not progress developmentally as individually appropriate as a result of a mental health disorder which can be corrected or ameliorated.

INTERVENTION RELATED CRITERIA

In addition, Humboldt County Mental Health Children, Youth and Family Services Level 1, 2 or 3 clients must meet **ALL** of the intervention related criteria listed below:

[ ] The focus of proposed intervention is to address the condition identified in the appropriate impairment criteria section
AND
[ ] It is expected the child/adolescent will benefit from the intervention as documented by significantly diminishing the impairment, or preventing significant impairment in an important area of life functioning (specify):
[ ] ***and/or*** it is probable, for level 3 clients, the child will progress developmentally as individually appropriate or can be corrected or ameliorated (specify):
AND
[ ] The condition would not be responsive to physical health care based treatment.

Signature/Title/Staff License: _____ Date: _____

THIS SECTION COMPLETED BY REQUESTING PROVIDER OF SERVICES

MEDICAL NECESSITY CRITERIA: This client meets the Medical Necessity Criteria as indicated below for EACH category of A, B, and C:

A. DIAGNOSES: Must have ONE of the following DM IV diagnoses, which will be the focus of the intervention being provided:

INCLUDED DIAGNOSES:

- ☐ Pervasive Developmental Disorders, except Autistic Disorder which is excluded.
- ☐ Attention Deficit & Disruptive Behavior Disorders
- ☐ Feeding & Eating Disorders of Infancy or Early Childhood
- ☐ Elimination Disorders
- ☐ Other Disorders of Infancy, Childhood or Adolescence
- ☐ Schizophrenia & 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

EXCLUDED DIAGNOSES:

- ☐ Mental Retardation
- ☐ Learning Disorders
- ☐ Motor Skills Disorder
- ☐ Communication Disorders
- ☐ Autistic Disorder (Other Pervasive Developmental Disorders are incl)
- ☐ Tic Disorders
- ☐ Delirium, Dementia, and Amnestic & Other Cognitive Disorders
- ☐ Mental Disorders Due to a General Medical Condition
- ☐ Substance-Related Disorders
- ☐ Sexual Dysfunctions
- ☐ Sleep Disorders
- ☐ Antisocial Personality Disorder
- ☐ Other Conditions That May Be A Focus Of Clinical Attention, except Medication Induced Movement Disorders which are included

NOTE: A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. IMPAIRMENT CRITERIA: **Must have ONE of the following (1, 2, OR 3)** as a result of the mental disorder(s) identified in the diagnostic ("A") criteria.

1. A significant impairment in an important area of life functioning, OR
2. A probability of significant deterioration in an important area of life functioning, OR
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. INTERVENTION RELATED CRITERIA: **Must have ALL, 1, 2, AND 3 below**:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, AND
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), AND
3. The condition would not be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

☐ Initial Request ☐ Re-Authorization Request

Primary Clinician (full name & license/discipline):_____ Program:_____

Date of Request: _____ # of Visits Requested: _____ # of Hours Requested: _____

Type of Request:

☐ Assessment _____ ☐ Group Therapy_____ ☐Medication Management___ ☐Individual/Family Therapy_____

☐ Group Home MD Visits____ Case Management Services: ( ) Brokerage_____ ( ) Rehabilitation

☐ Day Treatment: ( )Intensive Day Treatment or ( )Rehabilitative Day Treatment # days/wk ____ S M T W Th F Sa #Requested

Program Staff Signature&Title:_____ Program Name:_____ Date:_____

DO NOT WRITE BELOW THIS LINE – FOR HCMMMHC COMPLETION ONLY

Authorization #: _____

I. Decision (select A OR B):

A. ☐ Client does not meet medical necessity criteria. Reason: _____

1. For Initial Assessment: Date NOA-A Sent: _____ 2. For Re-authorization Request: Date NOA-B Sent: _____

B. ☐ Client does meet Medical Necessity criteria.

1. Requested Re-Authorization Modified: NOA-B Sent/Delivered: _____
2. Approved for following services:

☐Assessment. #Auth:_____ Expires on _____ ☐ Group Home MD Visit: #Auth:_____Expires on:_____

☐ Group therapy: #Auth:_____ Expires on _____ ☐ MHS-Plan Dev't: #Auth:_____Expires on:_____

☐ Individual/Family Therapy #Auth:_____ Expires on_____ ☐ Medication Mgmt: #Auth:_____ Expires on _____

☐ Case Management Brokerage #Auth:_____ Expires on _____ ☐ Rehabilitation: #Auth:_____ Expires on_____

☐ Day Treatment ( ) Intensive ( ) Rehabilitative # days/week ___(Circle) S M T W T h F Sa Total #Auth:_____ Expires on _____

II. Referrals (select A OR B):

A. ☐ Referred to current/requesting provider. Name/Address:_____

B. ☐ Referred to other provider. Name/Address:_____

Reason (code): _____ **Key**: 1 - Current provider not Medi-Cal eligible. 2 - Current provider not locally credentialed
3 - Current provider requests transfer 4 - Client requests alternate provider
5 - HCMMMHC decision. Specify: _____

Staff Signature & Title:_____ Date:_____

Client Name: _____ DOB: _____ Case #: _____ DHHS – MHB: 1039 (Rev 4/29/05) Page 2 of 2

MEDICAL NECESSITY CRITERIA FOR OUTPATIENT SPECIALTY MENTAL HEALTH SERVICES

Must have ALL A, B and C.

A. DIAGNOSIS

Must have at least ONE of the following DSM IV diagnoses, which will be the focus of the intervention being provided:
Included Diagnoses:

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

B. IMPAIRMENT CRITERIA

Must have AT LEAST ONE of the following as a result of the mental disorders(s) identified in the diagnostic ("A") criteria;

1. A significant impairment in an important area of life functions; or
2. A probability of significant deterioration in an important area of life functions; or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated.

1. INTERVENTION-RELATED CRITERIA

Must have ALL of the following:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above;
2. It is expected the beneficiary will benefit from the proposed intervention by significant diminishment of the impairment, or prevention of significant deterioration in an impairment area of life functioning, and/or for children it is probable that the child will progress developmentally as individually appropriate; and
3. The condition would not be responsive to physical health-case based treatment.

Humboldt County Medi-Cal Managed Mental Health Care
Notice of Inquiries

Issue Date:

Provider Name
Address

Dear Provider,

Humboldt County Medi-Cal Managed Mental Health Care was unable to process the following claim(s) due to insufficient information. **Please re-submit 1) your original claim(s), 2) a copy of this letter with 3) complete information checked below** to HCMMMHC 720 Wood Street, Eureka, CA 95501. If we do not receive all requested information within 30 days from the date of this notice, the service(s) will be considered denied.

Credential Document / Rate Schedule

_____ A copy of the rate schedule from the_____County Mental Health Plan.
_____ A copy of the letter from the facility stating that you are a contracted and credentialed provider.
_____ A copy of the letter from the _____County Mental Health showing that you are contracted and credentialed provider under their Managed Care plan.
_____ A copy of your current California License.
_____ A copy of your current DEA.
_____ A copy of your professional liability insurance coverage.

If you have any questions regarding the credential documentation and the rate schedule, please contact Jojo Gilbaugh, Provider Relations Coordinator @ (707) 268-2934.

Claims

_____ The original claim correctly completed on HCFA 1500 form.
_____ A copy of the letter from the primary insurance or other payer sources showing they have denied the claimed services. If the claimed services were fully or partially approved by the other payer sources, the unpaid balance cannot be honored by HCMMMHC.
_____ Other:

Client Registration

_____ A copy of the client information form correctly completed.

If you have any questions regarding the claims and prior authorizations, please contact the Claims Processing line at (707) 441-5449

Sincerely,

Leah Berti
Claims Processing

Effective Date: April 14, 2003
Revised Date: October 7, 2003_

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:

County of Humboldt
Department of Health and Human Services
Privacy Office
507 F Street
Eureka, CA 95501
(707) 441-5570

WHO WILL FOLLOW THIS NOTICE

This notice describes the Humboldt County Department of Health and Human Services, Mental Health Branch practices:

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from the Department of Health and Human Services. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private (with certain exceptions);
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information.

For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other department personnel who are involved in providing you services.

For Payment

We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about services you received so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a service you are going to receive to obtain prior approval or to determine whether your plan will cover the services.

For Health Care Operations

We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the department and make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many clients to decide what additional services the department should offer, what services are not needed, and whether certain new services are effective. We may also disclose information to doctors, nurses, technicians and other staff for review and learning purposes. We may also combine the medical information we have with medical information from other agencies to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific clients are.

Appointment Reminders

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may use and disclose medical information to tell you about our health-related products or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care

We may release medical information about you to a friend or family member who is involved

in your medical care. We may also give information to someone who helps pay for your care.

We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Research

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the department. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required by Law

We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone the threat was made against, and any law enforcement agencies as required by law.

SPECIAL SITUATIONS

Workers' Compensation

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders and dependent adults;

- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release medical information to a coroner or medical examiner. This may be necessary,

for example, to identify a deceased person or determine the cause of death. We may also release medical information about clients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons of foreign heads of state or conduct special investigations.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

When responding to the rights in this notice, the address where you can send your requests depends on where you are receiving services – please choose one of the following addresses:

Adults:

Medical Records
Attn: Request Desk
720 Wood Street
Eureka, CA 95501

Children & Families:

Medical Records
Attn: Request Desk
1711 3rd Street
Eureka, CA 95501

Right to Inspect and Copy

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the appropriate address listed above.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Another licensed health care professional chosen by the department will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the department.

To request an amendment, your request must be made in writing and submitted to the appropriate address listed above. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the department;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosure." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other expectations according to the law.

To request this list or accounting of disclosures, you must submit your request in writing to one of the appropriate addresses listed for Medical Records on page one of this notice. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had.

We are not required t agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to one of the appropriate addresses listed for Medical Records on page one of this notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to one of the appropriate addresses listed for Medical Records on page one of this notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website: _____

To obtain a paper copy of this notice, please ask a receptionist at the front desk, or ask any other staff you have an appointment with for a copy of it.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the department. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you apply to the department for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the County

of Humboldt Department of Health and Human Services, the County of Humboldt General Services Department or in writhing with U.S. Department of Health and Human Services at the following:

County of Humboldt
Dept. of Health and
Human Services
Privacy Office
507 F Street
Eureka, CA 95501
(707) 441-5570

County of Humboldt
General Services Department
825 5th Street
Eureka, Ca 95501
(707) 268-2544

Office for Civil Rights
U.S. Dept. of Health and
Human Services
50 United Nations Plaza
Room 322
San Francisco, CA 94102
(415) 437-8310

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. We are not allowed to condition your treatment upon you agreeing to sign an authorization to release your records to someone else.

COUNTY OF HUMBOLDT
DHHS - MHB
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient or Subscriber Name:_____
(Please print patient or subscriber name)

I,_____**,**
(Print name of patient, subscriber, conservator, parent or legal guardian signing below)

acknowledge receipt of the Notice of Privacy Practices, which explains ways in which the County may use or disclose my health information at: Mental Health Branch .

Signed:_____ **Date:**_____

If not signed by patient, indicate relationship:_____

NOTE: Parents must have legal custody. Legal guardians and conservators must show proof.

****

THIS SECTION TO BE FILLED OUT ONLY BY THE COUNTY OF HUMBOLDT

Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgment of Receipt because:

- ☐ **Patient left office before Acknowledgment could be signed.**
- ☐ **Patient does not wish to sign this form.**
- ☐ **Patient cannot sign this form because:**_____

Patient did not receive the Notice of Privacy Practices because:

- ☐ **Patient required emergency treatment.**
- ☐ **Patient declined the Notice and signing this Acknowledgment.**
- ☐ **Other:**_____

Staff Signature:_____ **Date:**_____
(Signature of provider or support staff presenting form to patient)

Client Name: _____ **Case #:** _____ **DOB:** _____

DHHS-MHB:AcknowledgementNOPP (4/14/03)

COUNTY OF HUMBOLDT – DHHS, MENTAL HEALTH BRANCH
720 Wood Street. Eureka. CA 95501

First

Last

Client ID Event RU Staff ID

Date of Service M M - D D - Y Y 1058 OUTPATIENT SERVICES – PROGRESS NOTE

Start	End	Duration	Service Code	Service Code Description
:	:	:		

Location of Services: ☐ Office ☐ Field ☐ Phone ☐ Other: _____

M (Medical Necessity)/ S (Service Necessity)/ I (interventions)/ R (Response) / P (Plan)

Signature &
Title/Licensure:_____

DHHS-MHB-1058 (Rev 10/7/04)

PROVIDER PROBLEM RESOLUTION PROCESS

Good relations between Humboldt County Mental Health Plan and the Providers are essential to the effective delivery of mental health services. The following outlines the mechanism by which Providers may address their concerns to Humboldt County MHP on any issue including payment for services, service authorization and processing delays.

Grievances and Appeals must be in writing and submitted to:

Quality Improvement Coordinator
Humboldt County Mental Health
720 Wood Street
Eureka, CA 95501
(707) 268-2955 Fax (707) 476-4096

Providers may use the Provider Problem Resolution Form (see Attachments).

The Humboldt County Mental Health Plan Provider Problem Resolution Process provides for two types of problem resolution:

Grievance - an expression of dissatisfaction with Humboldt County MHP regarding contract interpretation, policies, authorization process, timeliness of payment, or any situation believed to be unjust or inequitable in the relations between the provider and the MHP.

Appeal – an appeal of denial or modification of an authorization request, or denial of payment for services by Humboldt County MHP.

GRIEVANCE PROCEDURE

There shall be a sixty (60) working day resolution period during which time the responsible MHP staff shall review the grievance issue(s) and make a decision regarding resolution. The decision will be communicated in writing to the Provider within the sixty day timeframe.
If no satisfactory resolution is proposed, the Provider may request review of the Grievance by the Mental Health Director, whose decision shall be final.

APPEAL PROCEDURE

A provider may appeal a denied or modified request for treatment authorization or a denial of payment of a claim within 90 calendar days of the provider's receipt of the decision. The appeal must be in writing and include supporting documentation. Supporting documentation shall include, but is not limited to:

- A copy of the original decision received from Humboldt County MHP
- Any documentation supporting allegations related to timeliness, if at issue, including copies of fax records, phone records or memos.
- Clinical records supporting the existence of medical necessity, if at issue.
- A summary of reasons why the MHP should have approved treatment authorization or a more intensive level of treatment.
- A contact person(s) name, address and phone number.

There shall be a sixty (60) working day resolution period during which time MHP staff shall review the appeal and make a decision regarding resolution. The decision will be communicated in writing within the sixty day timeframe, and will address each issue raised by the provider, and any action required by the provider to implement the decision.

If the appeal concerns the denial or modification of a payment authorization request due to lack of medical necessity, Humboldt County MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

If the Appeal is granted, the Provider has thirty (30) calendar days from the date of receipt of Humboldt County's decision to submit a revised request for payment authorization.

If Humboldt County MHP does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied.

Exception to this Appeals Process: Providers who receive payment from the State's fiscal intermediary, currently Electronic Data Systems, may file appeals concerning the processing or payment of those claims directly to the fiscal intermediary.

HUMBOLDT COUNTY MEDI-CAL MANAGED MENTAL HEALTH CARE

PROVIDER PROBLEM RESOLUTION REQUEST FORM

(Please check one) ☐ Complaint ☐ Formal Grievance

Provider Name_____ Phone# _____

Mailing Address _____

Name and Title of Person Filing Complaint/Grievance _____

_____ Phone# _____

Is this an appeal of a denied or modified request for services? ☐ Yes ☐ No

Is this a dispute concerning the processing of payment of a claim? ☐ Yes ☐ No

---

Complaint _____

_____

_____

_____

_____

Provider Signature _____ Date _____

Attach documentation for request for authorization or denied/disputed claims.

FOR HCMMMHC INTERNAL USE ONLY:

Resolution/Action Taken _____

_____

Staff Signature _____ Date _____

Provider Problem Resolution Committee Decision _____

_____

_____

_____

Signature _____ Date _____

MAIL FORM TO: HUMBOLDT COUNTY MEDI-CAL MANAGED MENTAL HEALTH CARE
PROVIDER RELATIONS COORDINATOR
720 WOOD STREET
EUREKA, CA 95501

FOR ANY QUESTIONS, CALL:(707) 268-2955

HUMBOLDT COUNTY MEDI-CAL MANAGED MENTAL HEALTH CARE
REFERRAL FORM

Children, Youth & Family Services
1711 3rd Street
Eureka, CA 95501
Phone#: (707) 268-2800
Fax#: 445-7270

Adult Services
720 Wood Street
Eureka, CA 95501
Phone #: (707) 268-2900
Fax #: 445-7284

Referred By: _____ Today's Date: _____

Client Name: _____ _____ DOB:_____ Phone#:_____
Last Name First Name

Client's Address:_____

Name of Legal Guardian: _____

1. Referred to HCMH for: [ ] Adult Services
[ ] Childrens' Services
[ ] Assessment/Potential Therapy/Services
[ ] Medication treatment & follow-up with HCMH services
[ ] Consultation only and return to referring provider for services

2. Reason for referral:
A. Problem: _____
B. Duration: _____
C. Frequency: _____
D. Identified Triggers: _____

3. Previous Interventions:
A. Counseling? [ ]Yes [ ]No [ ]Currently receiving? ( )no ( )yes - Provider:_____
B. Current Medications, including psychotropic medications:

Medications	Dose	Duration (Dates)	Response	Side Effects	Prescribed By:

C. Previous Medications, including psychotropic medications:

Medications	Dose	Duration (Dates)	Response	Side Effects	Prescribed By:

4. Current Provider for medical problems:_____

5. Other relevant medical information:_____

6. **REQUIRED** ENCLOSURES:
[ ] Authorization for Release of Information (to/from), signed by patient or parent/guardian (if applicable)
[ ] Informed consent regarding medications currently prescribed, if available
[ ] Most recent Physical exam and lab results, if available

SIGNATURE LINE (Name & Signature of Person Completing Form):

_____

Printed Name **Signature & Title/License** **Date** **Phone #** **Fax #**

HCMMMHC:RFRL.FRM (Rev 12/97)

HUMBOLDT COUNTY MEDI-CAL MANAGED MENTAL HEALTH CARE
REQUEST FOR ACCESS TO SERVICES

SECTION I. CLIENT DEMOGRAPHICS & REQUEST SPECIFICS (Please complete Section I only & refer to Access)

CLIENT INFORMATION/DEMOGRAPHICS:

Type of Contact: PHONE: [ ] 800-Line [ ] Day Non-800 [ ] After hours Non-800 [ ] Walk In [ ] Other

Information collected by: _____ Date_____ Time____ am/ pm

CLIENT NAME:_____ _____
Last Name First Name M.I. Phone #

Is this an emergency? [ ] Y [Emergency] [ ] N [Non-emergency] [ ] U [Urgent] Previous HCMH Client? [ ] yes [ ] no

Is this a Medi-Cal ONLY client? [ ] no [ ] yes, Medi-Cal ID#_____ (attach copy) Age: ____ **Prim Language**:_____

SOURCE OF REFERRAL: [ ]Self [ ]Family/Significant Other [ ]Other (Mental Health Provider / Agency / Pvt Practitioner)

Specify _____

Initial Disposition/Referral: _____

DOB: _____ Sex: SSN: ___-____-_____ Address: _____
Street OR P.O. Box# City/State & Zip

Caller's Name if other than client: _____ Relationship to client: _____Phone #: _____

Caller=s Address: _____

Client's Legal Guardian_____MCO County 12

(Humboldt) eligible? [yes [ ] no Medi-Cal Verified by: _____Date_____Time

---

SERVICE REQUEST INFORMATION: Date_____Time_____ Collected by: _____

Client=s Ethnicity_____ Identified communication/language barrier:_____

Does beneficiary have an impairment which could create difficulty for accessing services? [ ] no [ ] yes, specify_____

Can we have your permission to contact family or significant others?

Contact Name: _____ Relationship _____ ROI completed? [ ] yes (copy in chart?) [ ] no

Specific Service Request: _____

Beneficiary's Preference for Service Provider(s): Specific Provider: _____

Criteria: [ ] Age [ ] Gender _____ [ ] Ethnicity _____[ ]Specialty_____ [ ] Geographic access _____

SECTION II. HCMMMHC REVIEW (To be completed by County Access/Review Team)

Stage I Review: Date_____ Time_____ [ ] telephone contact [ ] face-to-face screening Completed by: _____

Results of initial clinical screening: [ ] Emergency [ ] Urgent [ ] Other

Follow-up plan: _____

Stage II Review:

Date_____ Time_____ [ ] phone contact [ ]face-to-face evaluation [ ]review of clinical records Completed by:_____

Results of clinical assessment: [ ] Non-Mental Health [ ] Non-Specialty Mental Health

Referred to: [ ] Primary Care Provider. Specify Name/City: _____

[ ] Rural Health Clinic. Specify Name/City: _____

[ ] Private Mental Health Provider. Specify Name/City: _____

[ ] Community Resources. Specify Name/City: _____

[ ] Specialty Mental Health [ ] Emergency. Referral, time and date:_____

[ ] Non Emergency

LEVEL I II III [ ] SOC Access. Specify: [ ] A-SOC [ ] C-SOC

[ ] Out of County: Specify Name/City:_____

(circle one) [ ] Contract Provider Assessment. Specify Name/City:_____

Diagnosis: Primary Dx Code: Secondary Dx Code: Axis IV: GAF: /

HCMMMHC Request for Access to Services To be completed upon initial request for services. HCMMMHC:SRVCREQ.FRM (Rev 11/00) Original (HCMMMHC Med Record)	_____ Provider Name/Title (Legibly Printed) _____ Address Phone #	_____ Client's Name _____ Case # DOB

We encourage you to discuss issues regarding your mental health services directly with your service providers or with their supervisors.

You may also contact the following people for help in resolving problems:

Quality Improvement Coordinator
(707) 268-2955
or
Toll Free 1-888-849-5728

Patients' Rights Advocate
(707) 268-2995

HUMBOLDT COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH BRANCH

REQUEST FOR CHANGE OF SERVICE PROVIDER

Give this completed request form to the receptionist, or mail to:

Humboldt County Mental Health
Quality Improvement Coordinator
720 Wood Street
Eureka, CA 95501

HUMBOLDT COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH BRANCH

REQUEST FOR CHANGE OF SERVICE PROVIDER

Date: _____

Client Name: _____ Phone #: _____
Please print

Your Name (if different from client): _____ Relationship: _____
Please print

Client Address: _____
Street Address

_____
City, State, Zip Code

I request a change in my current service provider _____
Please print name

for the following reasons: _____

_____

_____

_____

_____

(Optional)I request a change to this provider: _____
Please print name

Check one: ☐ I have discussed my concerns with my current provider
☐ I have not discussed my concerns with my provider

Signature: _____ Phone #: _____

Mail form to: Humboldt County Mental Health
Quality Improvement Coordinator
720 Wood St.
Eureka, CA 95501
(707) 268-2955

****

FOR INTERNAL USE ONLY

Date received by Quality Improvement: _____ **Due Date**: _____
Date forwarded: _____ To: _____

Decision:
☐ Approved – New Provider: _____
Please print name

☐ Denied: _____
Reason

_____

Date client notified: _____ Date Provider(s) notified: _____

Signature of Manager or Designee: _____ Date: _____

Return completed and signed Form to QIC v.10/31/05

HUMBOLDT COUNTY DEPARTMENT OF HEALTH AND
HUMAN SERVICES
MENTAL HEALTH BRANCH

REQUEST FOR SECOND OPINION

We encourage you to discuss issues regarding your mental health services directly with your service providers or with their supervisors.

You may also contact the following people for help in resolving problems:

Quality Improvement Coordinator
(707) 268-2955
or
Toll Free 1-888-849-5728

Patients' Rights Advocate
(707) 268-2995

Give this completed request form to the receptionist, or mail to:
Humboldt County Mental Health
Quality Improvement Coordinator
720 Wood Street
Eureka, CA 95501

HUMBOLDT COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH BRANCH

REQUEST FOR SECOND OPINION

Date: _____

Client Name: _____ Phone #: _____
Please print

Your Name (if different from client): _____ Relationship: _____
Please print

Client Address: _____
Street Address

_____
City, State, Zip Code

I request a review of the following (please check one)

☐ Diagnosis _____

☐ Services _____

which have been decided by Humboldt County Mental Health.

I understand that I will not be penalized for this request, and that serious consideration will be given to this request.

Signature: _____ Phone #: _____

Mail form to: Humboldt County Mental Health
Quality Improvement Coordinator
720 Wood Street
Eureka, CA 95501
(707) 268-2955

****

FOR INTERNAL USE ONLY

Date received by Quality Improvement: _____ **Due Date:** _____
Date forwarded: _____ To: _____

Decision:

☐ Approved – appointment scheduled for _____ with _____.
Date Please print name

☐ Denied: _____
Reason

_____

Date client notified: _____ (please attach copy of letter if one was sent)

Signature of Manager of Designee: _____ Date: _____

Return completed and signed Form to QIC

v.10/31/05

How Did We Do Today?

Your comments about today's visit will help us give you the best possible care. By answering these questions, you can let us know if we are doing a good job and what we need to improve. This feedback is important to us.

Answer the questions in each section. Circle your answer—yes or no. Please use the Comments space to explain your answers. The more information we have about your concerns for better service, the better we can address your needs.

When you have answered the questions, please give this form to the receptionist at your clinic or mail it to:

Quality Improvement Department
Mental Health Administration
720 Wood Street
Eureka, CA 95501

It is the County's policy to make our programs and services accessible to the disabled.

County clinics serve children, adolescents, adults and seniors. Programs provide information and referral, rehabilitation, medication, therapy and crisis services.

Humboldt County Mental Health

Humboldt County Mental Health Services
720 Wood Street, Eureka, California

Administration	268-2990
Adult Services	268-2900
Children Youth and Family Services	268-2800
Crisis Intervention	445-7715
Garberville Outreach Clinic	923-2729
Sempervirens (Inpatient/Hospital)	445-7710
Patient Phone	445-7290
Managed Care	268-2955

Humboldt County Alcohol & Other Drugs Program
2922 I Street, Eureka, California

Alcohol & Other Drugs Program	445-6250
Prevention Services	441-5682
Patients Rights Advocate	268-2995

MH - 00-20-02

How are we doing?

Your Feelings Are Important to Us

You Have a Voice in Your Care!

Humboldt County Mental Health Services
Part of the
Mental Health System of Care
for Humboldt County

1

About Today's Visit

Please rate today's visit, taking into consideration everything that has happened since you arrived.

Circle one.

Great Very Helpful OK Unhelpful Awful

About You

Please answer the following questions about you.

Circle yes or no.

1.	Are you a client yourself?	yes	no
2.	Do you have a care coordinator	yes	no
3.	If you are not a client, are you a family member or significant other?	yes	no
4.	If so, does the client in question want you to be involved?	yes	no

Comments

Please explain.

_____

_____

_____

Your name and telephone number are optional.

Name_____

Phone Number_____

2

About County Mental Health

Please answer the following questions about our support staff and services.

Circle yes or no.

1.	Did we express genuine interest in your problems?	yes	no
2.	Did your provider/doctor fully discuss your problems and/or symptoms?	yes	no
3.	Did your provider/doctor treat you with courtesy and respect?	yes	no
4.	Did your provider/doctor explain your treatment plan and medication instructions?	yes	no
5.	Did you understand your provider/doctor's explanation?	yes	no
6.	Did your provider/doctor answer your questions?	yes	no
7.	Would you recommend your coordinator/doctor to someone who might need services?	yes	no
8.	Are you satisfied with the treatment you received?	yes	no

Comments

Please explain.

_____

_____

_____

_____

_____

_____

3

About Our Services

Please answer the following questions about our support staff and services.

Circle yes or no.

1.	Were you able to schedule an appointment at your convenience?	yes	no
2.	When you called our office, was our staff courteous and pleasant?	yes	no
3.	Are the days and hours the center is open convenient for you?	yes	no
4.	Did the front office staff treat you with courtesy and respect?	yes	no
5.	Were you provided with appropriate information about services and support that are available?	yes	no
6.	Are critical services you need missing? Please explain below.	yes	no

Comments

Please explain.

_____

_____

_____

You Have a Voice

in Your Care!

SCOPE OF PRACTICE MATRIX

	Physician	Licensed or Waivered Psychologist (post PhD)	Licensed or Registered (post MA/MS) CSW or MFT	Registered Nurse with Master's in Mental Health Nursing or related field	Mental Health Nurse Practitioner	Registered Nurse	Licensed Vocational Nurse or Licensed Psychiatric Technician	Trainee for CSW, MFCC, PhD (post BA/BS and pre MA/MS/PhD)	Staff with BA/BS in MH related field or with 2 years experience in Mental Health	Staff without license or BA/BS in Mental Health related field or 2 years experience in Mental Health
Assessment:										
History & Data	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes^	Yes	Yes^
MSE & 5 Axis Dx	Yes	Yes	Yes	Yes	Yes	No	No	Yes^	No	No
Approve Client Plan	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes^	Yes	Yes^
Medication Administration	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Medication Dispensing	Yes	No	No	Yes	Yes	Yes	No	No	No	No
Medication Prescribing or Furnishing	Yes	No	No	No	Yes*	No	No	No	No	No
Medication Support Services	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Psychological Testing	No	Yes	No~	No	No	No	No	No	No	No
Psychotherapy	Yes	Yes	Yes	Yes	Yes	No	No	Yes^	No	No
Rehabilitation Counseling	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes^	Yes	Yes^
Case Management Brokerage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes^
Therapeutic Behavioral Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes^

*Certified by BRN with active furnishing number

^Must be co-signed by supervisor or LPHA

April 2005

STATE REGULATIONS
FOR
DAY TREATMENT SERVICES

Requirements

1. Authorization

Provider shall request prior authorization from the MHP for Day Treatment Intensive and Rehabilitation.

- Providers shall request payment authorization from County for continuation of day treatment intensive at least every three (3) months and day rehabilitation at least every six (6) months.
- Provider shall request initial payment authorization from County for counseling, psychotherapy or other similar therapeutic interventions (mental health services as defined in Title 9, CCR, Section 1810.227), excluding services to treat emergency and urgent conditions and therapeutic behavioral services, that will be provided on the same day that day treatment intensive or day rehabilitation is being provided to the beneficiary. Provider shall, further, request payment authorization from County for continuation of these services on the same cycle required for continuation of day treatment intensive or day rehabilitation for the beneficiary.

2. Provider Hours of Operation, Contact and Staffing Requirements

- The hours of operation that establish day treatment intensive and day rehabilitation as a half-day or full-day program must be provided in a therapeutic milieu (Addendum B) and must be continuous. Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts.
- Beneficiaries are expected to be present for all scheduled hours of operation for each day. When a beneficiary is unavoidably absent for some part of the hours of operation, day treatment intensive and day rehabilitation for an individual beneficiary will only be eligible for Medi-Cal reimbursement if the beneficiary is present for at least 50 percent of the scheduled hours of operation that day. For example, if the beneficiary is present for less than one and a half hours of a three-hour half-day program because of illness, the service for that beneficiary for that day will not be Medi-Cal reimbursable.
- At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation. For day treatment intensive, staffing must include at least one staff person whose scope of practice includes psychotherapy. Staffing ratios for Day Treatment Intensive and Day Rehabilitation are 1:8 for Intensive and 1:10 for Rehabilitation.

- If day treatment intensive or day rehabilitation 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 required. There must be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

3. Provider Required Service Components

- The service components include a required daily community meeting, a therapedic milieu, a required number of hours for specified core service activities, standards for involvement with caregivers, the capability for on-site crisis response, a weekly schedule and the staffing requirements described above.

4. Provider Documentation Requirements

- Progress notes for day rehabilitation must be documented weekly.
- Documentation for day treatment intensive will be required to include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.

5. Certification Requirements

- The MHP will conduct a review of the Provider's program description to ensure that the day treatment intensive and day rehabilitation requirements in DMH Information Notice No. 02-06 are incorporated, or
- A Letter of Certification from Home County Mental Health Plan.

DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICE COMPONENTS

Therapeutic Milieu-Definition

The therapeutic milieu:

- Provides the foundation for the provision of day treatment intensive and day rehabilitation and differentiates these services from other specialty mental health services.
- Includes a therapeutic program that is structured by well-defined service components with specific activities being performed by identified staff.
- Takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program).
- Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction.
- Supports peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subject distress.
- Empowers clients through involvement in the overall program (such as the opportunity to lead community meetings and to provide feedback to peers) and the opportunity for risk taking in a supportive environment.
- Supports behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

Community/Milieu Meeting

Both day treatment intensive and day rehabilitation must provide for community meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the treatment milieu. The meeting must actively involve staff and clients. For day treatment intensive, the meeting must include a staff person whose scope of practice includes psychotherapy. For day rehabilitation, the meeting must include a staff person who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist. The content of the meeting should include a variety of items including, but not limited to: what the schedule for the day will be; any current events; individual issues clients or staff wish to discuss to elicit support of the group milieu process; conflict resolution within the milieu; planning for the day, the week, or for special events; old business from previous meetings or from previous day treatment experiences; and debriefing or wrap-up.

Therapeutic Milieu Service Components

The following menu of services must be made available during the course of the therapeutic

milieu for at least an average of three hours per day for full-day programs and an average of two hours per day for half-day programs. For example, a full-day program that operates five days per week would need to provide a minimum of 15 hours per week; a program that operates seven days per week would need to provide a minimum of 21 hours. (Please note that day treatment intensive and day rehabilitation also include components that occur outside the therapeutic milieu, e.g., family therapy, travel, documentation, and contacts with significant support persons.)

Day Rehabilitation

- Process Groups: Staff facilitate these groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing program-solving strategies and to assist one another in resolving behavioral and emotional problems. Process groups are based on the premise that much of human behavior and feeling involves the individual's adaptation and response to other people and that the group can assist individuals in making necessary changes by means of support, feedback and guidance. It is a process carried out by informally organized groups that seek change. Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.
- Skill Building Groups: Staff help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.
- Adjunctive Therapies: Staff and clients participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) As the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

Day Treatment Intensive

Day Treatment intensive programs must include the skill building groups and adjunctive therapies required of day rehabilitation and must also include psychotherapy as described below. Day treatment intensive may include process groups in addition to psychotherapy.

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

Contact with Significant Support Persons

Both day rehabilitation and day treatment intensive must allow for at least one contact (face-to-face or by an alternative method (e.g., e-mail, telephone, etc.)) per month with a family member, caregiver or other 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. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration.

Crisis Response

Both day rehabilitation and day treatment intensive must have an established protocol for responding to clients experiencing a mental health crisis. The protocol must assure the availability of appropriately trained and qualified staff and include agreed upon 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 (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff must have the capacity to handle the crisis until the client is linked to the outside crisis services.

Schedule

Day treatment intensive and day rehabilitation must have and make available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their responsibilities.

Staffing Ratios

Staffing ratios must be consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352; and, for day treatment intensive, must include at least one staff person whose scope of practice include psychotherapy.

STATE REGULATIONS FOR TBS

TBS is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Service as defined in Title 9 CCR Section 1810.215. TBS is an intensive one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional disturbances who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

TBS is intended to be a short-term intervention provided in the course of a child or youth's overall mental health treatment. The interventions are provided to address an immediate and specific need (behaviors or symptoms) in the child or youth's life that place the child or youth at risk of placement at a higher level of residential care or to enable a transition from any of those levels to a lower level of residential care. TBS should not be provided once the behaviors or symptoms TBS was intended to address have been resolved or reduced to an acceptable level and no additional behaviors or symptoms that place the child or youth at risk have been identified. However, TBS may be continued when a child has met the behavior goals in his or her TBS plan, but the provider determines that continuation of TBS is still necessary to stabilize the child's behavior and to reduce the risk of regression.

TBS must be therapeutic in nature. TBS may not be provided as a non-therapeutic safety monitoring or other types of attendant care. Caution must be taken, even with medically necessary TBS, to ensure that counter-productive dependency is not fostered.

Providers are required to request initial and on-going payment authorization from the County. Providers are required to submit payment authorization requests to County prior to the end of the specified hours or days in the current authorization period.

The County shall review the TBS component of a beneficiary's client plan at each request for re-authorization.

Authorization

1. Providers are required to request payment authorization for TBS in advance of the delivery of the services included in the authorization request. The requirement for approval in advance of the delivery of TBS applies to direct one-to-one TBS and related service activities, but does not include the initial assessment that determines whether or not TBS criteria are met or to the initial development of TBS client plan. The initial assessment may include observation of the beneficiary in the settings in which TBS is expected to be delivered to note baseline behaviors and make a preliminary assessment of likely interventions.

2. The County shall make a decision on payment authorization requests for TBS in advance of service delivery for the first authorization and subsequent reauthorizations of TBS.

3. The County shall issue a decision on a payment authorization request as expeditiously as the beneficiary's mental health condition requires and within 14 calendar days following receipt of the request of service.

4. In cases in which a provider indicates or the County determines that following the normal 14 calendar day time frame could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the County will follow an expedited authorization process.

For expedited authorization requests for TBS, the County must make the decision no later than three (3) working days after receipt of the request for payment authorization. The County may extend the three working day time period by up to 14 calendar days if:

a) The beneficiary requests the extension
b) The County determines a need for further information

Please see the Attachments for the **Expedited Review Request for TBS** form.

5. If a request for payment authorization is denied, modified, deferred, reduced or terminated, the County must provide the Provider and beneficiary with the appropriate Notice of Action (NOA). When applicable, the NOA must advise the Provider and beneficiary of the right to request continuation of previously authorized services pending the outcome of a Medi-Cal fair hearing if the request for hearing is timely.

6. If in the judgment of the Provider Therapeutic Behavioral Services may be indicated for a client, assistance with TBS assessments, authorizations and/or questions should be directed to the Children, Youth and Family Services Managed Care/Access Clinician of the County.

Initial Authorization

1. Except as provided in subsection 2 below, the County shall not approve an initial payment authorization request for direct one-to-one TBS that:

   1.1 Exceeds 30 days if the Provider is requesting authorization of direct one-to-one TBS that exceeds 12 hours per day.
   1.2 Exceeds 60 days if the Provider is requesting authorization of direct one-to-one TBS that is less than or equal to 12 hours per day.

2. The County shall permit Providers to submit initial payment authorization requests that include a TBS client plan that meets only criteria 3.1 to 3.5 below. If a provider does submit a TBS client plan that meets only these criteria, the County shall not approve an initial payment authorization request for direct one-to-one TBS that exceeds 30 days.

3. Except as provided in criteria 2 above, the County shall not approve a Provider's initial payment authorization request unless the Provider has submitted a TBS client plan that meets the criteria in 3.1 through 3.8 below:
   3.1. A TBS client plan may be a separate client plan for the delivery of TBS or a component of a more comprehensive client plan. The TBS client plan is

intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the beneficiary as identified by the assessment process.

3.2 Clearly identifies specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.

3.3 Includes a specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan.

3.4 Includes a specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.

3.5 Identifies a specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

3.6 Includes a transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving client plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.

3.7 As necessary, includes a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

3.8 If the beneficiary is between 18 and 21 years of age, includes notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

Reauthorization

1. The County shall not approve an payment authorization request for reauthorization of TBS that exceeds 30 days if the Provider is requesting authorization of direct one-to-one TBS that exceeds 12 hours per day or exceeds 60 days if the Provider is requesting authorization of direct one-to-one TBS that is less than or equal to 12 hours per day.

2. The County shall base decisions on payment authorization requests for reauthorization

of TBS on clear documentation of the following and any additional information from the TBS Provider required by the County:

2.1. The beneficiary's progress towards the specific goals and timeframes of the TBS client plan.

2.2. A strategy to decrease the intensity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness. A strategy to terminate services shall consider the intensity and duration of TBS necessary to stabilize the beneficiary's behavior and reduce the risk of regression.

2.3. If applicable, the beneficiary's lack of progress towards the specific goals and timeframes of the TBS client plan and changes needed to address the issue. If the TBS being provided to the beneficiary has not been effective and the beneficiary is not making progress as expected towards identified goals, the alternatives considered and the reason that only the approval of the requested additional hours/days for TBS instead of or in addition to the alternatives will be effective.

2.4. The review and the updating of the TBS client plan as necessary to address any significant changes in the beneficiary's environment (e.g. change in residence).

2.5. The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

3. If the initial payment authorization was approved pursuant to Initial Authorization section number 2 above, the County shall not approve the payment authorization request for reauthorization of TBS unless the provider has submitted a TBS client plan that meets criteria 3.1 thru 3.8 of Initial Authorization Section.

4. When the Provider requests a fourth payment authorization for TBS, the Provider is required to provide a summary of the TBS services provided, justification for the additional authorization and a termination plan with clearly established timelines and benchmarks, including a planned date for termination of TBS, which will be submitted to the County along with the payment authorization request. This will be forwarded to the County Mental Health Branch Director and Deputy Director of the State Department of Mental Health Children's System of Care.

Expedited TBS

1. Notwithstanding Title 9, CCR, Sections 1820.220 and 1830.215, the County shall act on authorization requests in accordance with the following timeframes:
   1.1 For authorization decisions other than expedited decisions described below, provide notice as expeditiously as the beneficiary's mental health condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the beneficiary or

the provider, requests extension; or if the County identifies a need for additional information and documents the need and how the extension if in the beneficiary's interest in its authorization records. If the County extends the timeframe, the County shall provide the beneficiary with written notice of the decision on the date the decision to extend is made. The notice to the beneficiary shall advise the beneficiary of the reason for the decision and the beneficiary's right to file a grievance if the beneficiary disagrees with the decision.

1.2 In accordance with Title 42, Code of Federal Regulations Section 438.210 (d) (2), for expedited authorization decisions in cases in which a Provider indicates, or the County determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain , or regain maximum function, the County will make an expedited authorization decision and provide notice as expeditiously as the beneficiary's mental health condition requires and no later than three working days after receipt of the request for payment authorization. The County may extend the three-working-day time period by up to 14 calendar days, consistent with the beneficiary's request, if the beneficiary requests an extension. If the County identifies a need for additional information and documents the need and how the extension is in the beneficiary's interest in the County's authorization records, the County may extend the three-working-day time period as follows:

1.2.1 When the payment authorization request is for therapeutic behavioral services (TBS), three working days from the date the additional information is received or 14 calendar days, whichever is less.

1.2.2 For all other services, up to 14 calendar days.

TBS Assessment

Assessment must:

1. Identify the child or youth's *specific* behaviors and/or symptoms that jeopardize continuation of the current residential placement or the *specific* behaviors and/or symptoms that are expected to interfere when a child or youth is transitioning to a lower level of residential placement.
2. Describe the critical nature of the situation, the severity of the child or youth's behaviors and/or symptoms, what other less intensive services have been tried and/or considered, and why these less intensive services are not or would not be appropriate.
3. Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement or to successfully transition to a lower level of residential placement and can be expected to provide a level of intervention necessary to stabilize the child or youth in the existing residential placement or to address behaviors and/or symptoms that jeopardize the child or youth's transition to a lower level of care.
4. Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated.
5. Identify skills and adaptive behaviors that the child or youth is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

Concrete identification of behaviors and interventions in the assessment process is the key component necessary to developing an effective TBS client plan.

TBS Client Plans

The TBS client plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the child or youth as identified by the assessment process. TBS client plans must include:

1. Clearly specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS;

2. A specific plan for intervention of each of the targeted behaviors or symptoms identified in the assessment and the client plan;

3. A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes;

4. A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results;

5. A transition plan that describes in measurable terms, how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving client plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued;

6. As necessary, a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case; and

7. If the beneficiary is between 18 and 21 years of age, notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager..

A clear and specific TBS client plan is a key component in ensuring effective delivery of TBS.

TBS Client Plan Addendum

A client plan addendum or other mechanism should be used to document the following

situations:

1. There have been significant changes in the child or youth's environment since the initial development of the TBS client plan; and
2. The TBS provided to the child or youth has not been effective and the child or youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the Provider indicating that they have considered alternatives, and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective.

TBS Progress Notes

Progress notes should clearly and specifically document the occurrence of the specific behaviors and/or symptoms that threaten the stability of the residential placement or prevent transition to a lower level of residential placement, the delivery of the significant interventions identified in the TBS client plan, and the progress being made in stabilizing the behaviors and/or symptoms by changing or eliminating maladaptive behaviors and increasing adaptive behaviors. Documentation continues to be required once each day that TBS is delivered. Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The time of service must be noted by contact/shift.

Coordination Between TBS and Other Services

TBS may only be provided to children and youth who are also receiving other specialty mental health services; therefore, there is a potential for the child or youth to be receiving TBS at the same time and location that the child or youth is participating in other programs. The potential for overlap presents both a risk and an opportunity. There is an opportunity to provide a blended array of complementary services to a child or youth as long as the purpose, roles and responsibilities of each program and Provider remain distinct enough to provide a clear audit trail. All specialty mental health services, including TBS, must be identified as the appropriate intervention necessary to support the beneficiary's efforts in attaining the objectives necessary to achieving the goals of their client plan(s).

The following information should be considered in situations where there is a risk of confusion about program functions and Provider roles:

- The role of the staff providing TBS is to implement the TBS client plan by providing the interventions addressing the specific problem behaviors and/or symptoms TBS is intended to resolve.
- TBS is provided face-to-face by one Provider to the one child or youth for whom the services are authorized.
- TBS involves proactive interventions, not general supervision.
- TBS must be provided in a manner that decreases the need of TBS and should not foster

dependency.

- TBS staff providing TBS to a child or youth may not provide services to another child or youth during the time period authorized for TBS.
- Transporting a child or youth is not a reimbursable TBS activity. Accompanying a child or youth who is being transported may be reimbursable, depending on the specific circumstances.
- TBS is not intended to supplant the child or youth's other mental health services provided by other mental health staff. For example, TBS staff activities are not reimbursable as TBS, if the TBS staff "fills" in the absence of a case manager to work with the child or youth on aspects of their mental health that are not the behaviors and/or symptoms TBS is expected to address. TBS must be clearly differentiated from other mental health services as stabilizing a situation in which a child or youth is at risk of placement in an Rate Classification Level (RCL) 12 to 14 group home or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.
- Direct TBS Providers delivering TBS in group homes may not be counted in the group home staffing ratio. The TBS Provider's function must be clearly differentiated. When the child or youth is a resident of the group home, the child or youth continues to be considered part of the group home census.
- Direct TBS Providers delivering TBS at day treatment intensive or day rehabilitation sites may not be counted in the day treatment intensive or day rehabilitation staffing ratio. The TBS Provider's function must be clearly differentiated. If the child or youth is receiving day treatment intensive or day rehabilitation as part of the child or youth's client plan, that child or youth would continue to be counted as an attendee in the day program. For example, if 24 clients are in a day treatment intensive program, three qualified staff are required to fulfill the staff-to-client ratio (1:8). If one of those 24 clients is also receiving TBS during some or all of the day treatment intensive hours, the TBS staff may <u>not</u> be included in the day treatment intensive staff-to-client (1:8) ratio. There must be a total of four staff present during the time TBS is being delivered - - one for TBS and three for day treatment intensive.
- It is expected that the direct TBS Provider would have contact with the child or youth's parents/caregivers. The TBS Provider would be delivering "collateral TBS" when working with the caregiver towards the goals of the child or youth's TBS client plan. Direct TBS Providers providing collateral service activities as part of TBS must ensure that the collateral contact meets the requirements to Title 9, CCR, Sections 1810.206 and 1840.314.
- The contact must be with individuals identified as significant in the child or youth's life and be directly related to the needs, goals and interventions of the child or youth as identified on the TBS client plan.

Staff providing TBS are not authorized to provide seclusion. Staff providing TBS will follow requirements regarding restraint that are applicable to the setting. TBS staff will not provide restraint, but will defer to the procedure of the agency.

Therapeutic Behavioral Services (TBS) Assessment

1. IDENTIFY THE TARGET BEHAVIOR: (Frequency of behavior: number of times a behavior occurs in a given period of time, what antecedent events increase or decrease frequency?; Intensity of behavior: severity of the behavior, likelihood to harm self or others, what antecedent events increase or decrease intensity?; Duration of behavior: total length of time of the behavior from start to finish, what antecedent events increase or decrease intensity?)

_____
_____
_____
_____
_____

2. **HISTORY OF BEHAVIOR:**

_____
_____
_____
_____

3. PREVIOUS INTERVENTIONS UTILIZED:

_____
_____
_____
_____

4. ANTECEDENT EVENTS: (Who is around when the behavior occurs?; What is the activity when the behavior occurs? ; When in the day or night do the behaviors occur?; Where do the behaviors occur?; Periods of time when the behavior never occurs?)

_____
_____
_____
_____
_____
_____

5. **CONSEQUENCES OF THE BEHAVIOR:** (What is the effect of the behavior?; How do others respond?; Are there any physiological effects?; Are there any social interaction effects? An increase or decrease in social demands?; Are there any effects in participation in or access to recreational activities?; Are there any self-stimulatory or self-regulation effects?; Is the youth getting anything tangible?; Is the youth avoiding anything undesirable?; Is the youth receiving additional attention?; Is the behavior self-regulating or self-stimulating?; Is the behavior playful or entertaining?)

_____
_____
_____
_____

HCMH/HCMMMHC TBS ASSESSMENT Completed by Provider with the initial TBS Authorization request for clients and updated as requested by HCMMMHC. Rev 1/03/tbs/kl Page 1 of 2	Provider Information _____ Name/Title (legibly printed) _____ Address Phone:	_____ Client's Full Name (Last & First) _____ Case # DOB klee/006

6. MEANING OF THE BEHAVIOR: (Working hypothesis about the function or goal of the behavior based on an analysis of the antecedent events, consequences, and mediating factors.; TBS assessment needs to document the "meaning" of the behavior including the relationship between antecedent events and consequences.; The assessment of behavior needs to occur in the context of the youth's gender and culture.)

_____
_____
_____
_____
_____
_____

7. MEDIATING FACTORS: (Does the youth experience difficulty with perception or interpretation?; Does the youth experience cognitive distortions or cognitive delays?; Does the youth adhere to maladaptive beliefs or attitude?; Is there documented evidence of brain injury or other neurological disorder?) TBS assessment needs to document mediating factors including the youth's perceptions, cognitions, expectations, etc.

_____
_____
_____
_____
_____
_____

8. REPLACEMENT BEHAVIORS:

_____
_____
_____
_____

9. SOURCES OF INFORMATION:
- ❑ Review of past assessments and other records.
- ❑ Interviews of key informants including parents, caregivers, teachers, other service providers.
- ❑ Interview of the youth.
- ❑ Observation of the youth in key settings including residence, school, and community.

_____ _____
Signature/Title Date

_____ _____
Signature/Title Date

_____ _____
Signature/Title Date

For HCMMMHC: _____ approved; _____does not meet approval, reason: _____

_____ _____
Signature/Title Date

HCMH/HCMMMHC TBS ASSESSMENT Completed by Provider with the initial TBS Authorization request for clients and updated as requested by HCMMMHC. Rev 1/03/tbs/kl Page 2 of 2	Provider Information _____ Name/Title (legibly printed) _____ Address Phone:	_____ Client's Full Name (Last & First) _____ Case # DOB klee/006

HUMBOLDT COUNTY MEDI-CAL MANAGED MENTAL HEALTH CARE

NOTICE OF CLOSURE (NOC)

Please complete and return when the beneficiary's **Therapeutic Behavioral Services (TBS)** are CLOSED.

FAX To:
CYFS ACCESS TEAM
FAX (707) 445-7270

(or)

Send To:
Department of Health and Human Services
Mental Health Branch
CYFS ACCESS TEAM
1711 3rd Street
Eureka, CA 95501
Phone: (707) 268-2800

Agency Name:_____

TBS has been CLOSED for:

Name of Client: _____

Client Date of Birth: _____

Date Services Closed: _____

Signature/Title of Staff: _____ Date: _____

For DHHS/MHB/CYFS staff only:

Date received: _____

Copy to MCO staff: _____

Copy to Chart: _____

TBS Notice of Closure (NOC)/ Version 2/ 3/18/05

THERAPEUTIC BEHAVIORAL SERVICES TREATMENT PLAN

Dates of Service Plan:

A. 1. Specific Target Behaviors which either: a.) jeopardize current placement, or b.) are a barrier to a lower level of residential care.

_____
_____
_____
_____
_____

A.2. Goals(which address each behavior):

Indicate if benchmark behavior is achieved.
YES / NO

_____
_____
_____
_____

A.3. TBS is a component of the overall client plan: ( ) YES; ( ) NO

B. 1.Specify interventions to be used:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

B. 2. Environmental Influences affecting behaviors:

_____
_____
_____
_____

B. 3. Plan to assist parents/caregiver with skills and strategies to provide continued care when TBS is discontinued. Include Family strengths/needs (as applicable), interventions, behavior plans, specific skills:

_____
_____
_____
_____
_____

HCMMMHC: TBS Treatment Plan TX Plan is reviewed/updated monthly New plan required if client changes residence Rev 8-02B/tbs/la Page 1 of 2	Provider Name/title Address Phone	Client's Full Name Case # DOB

THERAPEUTIC BEHAVIORAL SERVICES TREATMENT PLAN

C. 1.Specific outcome measures(to demonstrate a decline in target behaviors):

_____
_____
_____
_____
_____
_____
_____
_____

C.2. Adaptive replacement behaviors include:

_____
_____
_____
_____
_____

D. 1.Expected: Total service hours: ___ Weekly service hours: ___
Specify schedule: Su____ M____ T____ W____ TH____ F____ Sat____
2. Previous requested: Total service hours: _____ Weekly service hours: ___
3.Estimated duration of services: _____
4. These hours are an: __decrease; ___increase; or ___ maintenance of previous request.
5.These hours are an initial request by this provider: yes_____

E. Transition plan to decrease/discontinue TBS:

F. Transition plan to other Mental Health Services or Adult Services (if applicable):

G. Other SMH Services: [ ] Individual Therapy [ ] Group Therapy [ ] MHS-Rehab [ ] DT Intensive

[ ] DT Rehab [ ] Medications [ ] Case Management Brokerage [ ] Other:

Date of Treatment Team Meeting: **Next Meeting:**

Name/Signature	Agency	Name	Agency
1. Client:		6.	
2.Parent/Caregiver:		7.	
3.		8.	
4.		9.	
5.		10.	

HCMMMHC: TBS Treatment Plan
TX Plan is reviewed/updated monthly
New plan required if client changes residence
Rev 8-02B/tbs/la
Page 2 of 2

Provider Name/title

Address Phone

Client's Full Name

Case # DOB

Date & Time Service Began		**Date & Time Service Ended**		**Total Time Spent**	**Location of Services**	**Type of Srvc**	**DIRECTIONS:** **S** Service Necessity exists due to (bx/S&Sx) which interferes with (area of life functioning) **B** (TBS/BC)Each **Behavior** identified and addressed during this time span **I** Interventions by provider **R** Response of client (including +/- progress towards goals/milestones) **P** Plan
mm/dd/yy	≅	mm/dd/yy	≅	(incl doc & travel) Hrs:Min	(ie Field/ Home)		
				:		[ ]MHS-TBS [ ] Beh. Coach	
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HCMMMHC
PROGRESS NOTES FOR TBS/BC SERVICES
To be completed at the time of EACH contact
by EACH staff for EACH time span.
HCMH:TBSPN.FRM (Rev 6/12/00)

Provider Information
Name/Title:_____
(Legibly Printed)
Agency:_____
Phone:

Client's Name: _____

Case #: _____

CONFIDENTIAL PATIENT INFORMATION (See CA WIC 5328 & 42 CFR, Part 2)

Therapeutic Behavioral Services(TBS) Reauthorization Form Summary

This form **must** be completed on the fourth authorization submitted for a client receiving TBS. This form may be used by Humboldt County Medi-Cal Managed Mental Health Care (HCMMMHC) when further information is required for a client receiving TBS.

A. Summary of TBS services:

1. TBS start date:

2. Summary of hours previously authorized:

Dates of authorization	Number of hours/ authorized
1.	
2.	
3.	
4.	

3. Summary of interventions utilized:

Humboldt Co Medi-Cal Managed Mental Health Care (**HCMMMHC):TBS Reauthorization Summary.** Completed by Provider with the fourth TBS Authorization request for clients and updated as requested by HCMMMHC. Page 1 of 4 TBS Reauthorization 7-03/tbs/jp	**Provider Information** Name/Title (legibly printed) Address Phone	Client's Full Name (Last & First) Case # DOB

4. Response of client to interventions:

5. Response of care-provider to interventions

Therapeutic Behavioral Services(TBS) Reauthorization Form Summary

B. Justification for additional authorizations:

(please include any relevant information that has recently contributed to the client's behavior that you may want considered)

Humboldt Co Medi-Cal Managed Mental Health Care (HCMMMHC):TBS Reauthorization Summary. Completed by Provider with the fourth TBS Authorization request for clients and updated as requested by HCMMMHC. Page 2 of 4 TBS Reauthorization 7-03/tbs/jp	**Provider Information** _____ Name/Title (legibly printed) _____ Address _____ Phone	_____ Client's Full Name (Last & First) _____ _____ Case # DOB

C. Termination Plan

1. Timelines to meet goals related to target behaviors:

2. Benchmarks to be achieved in the specified timeline:

3. Planned date for termination of TBS

Provider Staff signature/title Date

Humboldt Co Medi-Cal Managed Mental Health Care (HCMMMHC):TBS Reauthorization Summary. Completed by Provider with the fourth TBS Authorization request for clients and updated as requested by HCMMMHC. Page 3 of 4 TBS Reauthorization 7-03/tbs/jp	**Provider Information** _____ Name/Title (legibly printed) _____ Address _____ Phone	_____ Client's Full Name (Last & First) _____ Case # DOB

For HCMMMHC only:

1.Progress towards the behavioral benchmarks is expected to be achieved in the clinical judgment of the MHP clinician: ( ) yes; ( ) no

2. Benchmarks have been reached as indicated on the TBS Treatment Plan:( )yes; ( ) no

3. Request for TBS is denied for the following reasons:

CYFS Staff signature/title Date

Please forward to:

Date	Staff Signature:	
1._____	_____	Client file
2._____	_____	Provider
3. _____	_____	MHB Director: 720 Wood St, Eureka, CA 95501
4. _____	_____	State DMH Deputy Director, SOC

Humboldt Co Medi-Cal Managed Mental Health Care (HCMMMHC):TBS Reauthorization Summary.	**Provider Information**	
Completed by Provider with the fourth TBS Authorization request for clients and updated as requested by HCMMMHC.	_____ Name/Title (legibly printed)	_____ Client's Full Name (Last & First)
	_____ Address	_____ Case # DOB
	_____ Phone	
Page 4 of 4 TBS Reauthorization 7-03/tbs/jp rev1203		

THERAPEUTIC BEHAVIORAL SERVICES
Treatment Plan Signature Sheet

DATE_____

Client: _____ **Tx Plan Date:**_____

Treatment Plan Participants:

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

Name:_____ **Title:**_____ **Agency:**_____ **Phone:**_____

***Please write your name and license if applicable.**

HCMH/HCMMMHC

TREATMENT SUMMARY

Client Name: _____ Provider Name: _____

Services Delivered: _____

Treatment Dates: From: ____/____/____ To: ____/____/____

1. Presenting Issues: _____

2. Current Primary Mental Health Diagnosis: _____

3. Medications utilized during treatment: Prescribed By: _____
[ ] No medications utilized during treatment

4. Resolution of presenting issues: _____

5. Reason for closure:
[ ] completed treatment successfully
[ ] non-compliant with treatment
[ ] referred to ancillary treatment modality, specify: _____
[ ] other, specify: _____

6. Closing Global Assessment of Functioning:
_____ at initial visit ____ Current (at time of discharge) _____ Highest past year

7. Prognosis: [ ] Good [ ] Fair [ ] Guarded

8. Termination plan/recommendation for future consideration: _____

Provider Staff Signature (full name) & Title

Date

Co-signature (if required) & Title Date

HCMH/HCMMMHC Treatment Summary To be completed by service provider at termination of services.	Provider Information Name/Title (legibly printed) Address Phone:	Client=s Full Name (Last & First) Case # DOB DHHS:MHB:TXSUMM (3/05)