SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

MENTAL HEALTH DOCUMENTATION MANUAL

FEBRUARY 2021 SAN MATEO COUNTY

BEHAVIORAL HEALTH SYSTEM OF CARE

This manual provides the documentation standards for mental health services provided by all BHRS programs including our contracted providers. The manual provides a general description of services and service definitions, and is a day-to-day resource for both clinical and administrative support staff. Additional resources include the Management Information System (MIS) Coding Manual, and State and Federal regulatory documents.

BHRS documentation standards were established to fulfill a core value of our system—the commitment to clinical and service excellence. Furthermore, accurate and complete documentation protects us from risk in legal proceedings, helps us to comply with regulatory requirements when we submit claims for services, and enables professionals to discharge their legal and ethical duties. All of our services are documented using Medi-Cal and Medicare documentation standards, regardless of funding source. Services for clients with co-occurring mental health and substance use disorders are documented using the rules presented in this manual.

HOW TO GET HELP

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

Find information on how to sign up for our online and Live Webinar documentation trainings at www.smchealth.org/bhrs/providers/ontrain

Access our recorded webinars and other useful information at

www.smhealth.org/bhrs/qm

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

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

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

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

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

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COMPLIANCE ISSUES

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

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

Every service entry shall:

- Be legible.
- Accurately reflect the activity, location, and duration of each service.
- Use Service Code 55 or 550 for services that are not claimable (see "Non-Reimbursable Activities..
- Be signed legibly with your discipline, or signed in the electronic medical record.

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

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

Progress notes completed more than 30 days (for MH) after the service date are considered excessively late and must be coded as non-billable (55/550) unless otherwise approved by BHRS Quality Management.

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

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

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

All services must be based on a current client treatment plan that is updated at least annually for MH (see Client Treatment and Recovery Plan.)

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

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

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

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

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

MEDICAL NECESSITY

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

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

2. One or more **Significant Impairments** that have an impact on functioning present (or expected if untreated) that are the direct result of an included diagnosis.

3. Interventions proposed (on the *Client Plan*) and **actual interventions provided** (documented in a *Progress Note*) that address the goals and objectives of the Client Plan. The Interventions must be linked to the symptoms/impairments of the client's diagnosis. If the proposed intervention is not included on the Client Plan, it may not be billed in a Progress Note.

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

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

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

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

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

The Progress Note - Progress Notes document delivered services that are linked to an intervention identified on the Client Treatment & Recovery Plan. Progress Notes document progress the client is making toward their objectives.

The Clinical Loop is not a one-time activity. The Clinical Loop occurs throughout the client's treatment and should be reviewed and updated on a regular basis to ensure that interventions are consistent with current symptoms/impairments and behaviors documented in the Clinical Record. ***Document all elements of Medical Necessity in the Progress Note.*** There should be sufficient documentation in the Clinical Record to support the interventions recorded in the Progress Note.

MEDICAL NECESSITY

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

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

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

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

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

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

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

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

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

LIST OF INCLUDED DIAGNOSES Mental Health:

https://www.smchealth.org/sites/main/files/file-attachments/billabledx-enclosures_2_in_18-053_icd-10.pdf?1563303359

Selecting Correct Diagnosis in Avatar, with list of included diagnoses:

https://www.smchealth.org/sites/main/files/file-attachments/selectingcorrectdiagnosisavatar.pdf?1559748212

REQUIREMENTS OVERVIEW

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

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

Timelines are mandated and fixed for each client.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DIAGNOSIS AND MENTAL STATUS

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

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

Determining a diagnosis is within the scope of practice for the following provider types: Physician, Psychologist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist, and Advanced Practice Nurses (in accordance with the Board of Registered Nursing.)

The diagnosis, mental status exam, medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider operating in his/her scope of practice under California State law. The provider must be licensed, waivered, and/or under the direction of a licensed mental health professional. However, the MHP may designate certain other qualified providers to complete parts of an assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks and barriers to achieving goals. Behavioral health trainees sign an assessment as "authorized clinical staff", and they may provide a diagnosis and mental status exam under the supervision of a licensed clinician (LMHP/LPHA) in one of the disciplines noted above. The supervisor must then sign the assessment as the "assessor."

All diagnoses—the primary diagnosis and any secondary diagnoses—must be included on the assessment form. The presence of non-included diagnoses, including "By history", "Rule Out" and "Provisional", do not impact claims for services as long as there is a primary, included diagnosis that is the focus of treatment. *BHRS requires that any substance use diagnosis found will also be listed.*

Other Diagnosis-Related Issues

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

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

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

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

CHANGE OF DIAGNOSIS:

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

DIAGNOSIS & TREATMENT WITHOUT MEDICAL NECESSITY :

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

If the client does not have an included mental health diagnosis, the program supervisor is required to inform BHRS Quality Management at HS_BHRS_ASK_QM@smcgov.org

ASSESSMENT COMPONENTS

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

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

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

ASSESSMENT TIMELINES

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

If the client is already open to a treatment program, an additional program accepting a client is responsible for ensuring that there is a current and accurate assessment in the clinical record.

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

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

When additional information is gathered, an addendum to the assessment is required. However, it does not restart the timeline. Each program is required to ensure that the assessment documents demonstrate a client's Medical Necessity. To use the addendum, there must be a pre-existing assessment less than 3 years old (if completed after January 1, 2016.) This does not count as a full assessment and does not re-start the timeline.

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

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

At any time, if there are significant changes in level of care, disruption of services, or any major psychosocial events, a reassessment is recommended to re-evaluate that the client still meets medical necessity for services.

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

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

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

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

ASSESSMENT: CANS & LOCUS

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CANS (Youth Clients): The CANS is a structured assessment used for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes. Clinical staff will complete the California CANS (CANS-50) through a collaborative process which includes, at a minimum, children and youth, ages 6 to age 20, and their caregivers.

PSC-35 : The PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional and behavioral problems so that appropriate interventions may be initiated as early as possible. Parents/caregivers will complete PSC-35 (parent/caregiver version) for children and youth ages 3 to age 18. For the PSC-35, if the child/youth does not have a parent/caregiver or the parent/caregiver declines, then staff will document this in their progress notes. Please keep in mind that the PSC-35 can be found in Avatar utilizing the Generic Access Widget. For more information, see the PSC-35. Please make sure the completed PSC-35 forms are also scanned into the client's medical record.

Timeframe: The CANS-50 and PSC-35 are to be completed:
- at initial intake (within 60 days),
- ongoing and every 6 months,
- when there is clinically significant change,
- at the end of treatment.

Note: Client Admission date prior 10/01/18 – Do NOT complete CANS-50 or PSC-35. Client Admission date after 10/01/18 – YES, complete CANS-50 and PSC-35

BHRS Clinical Staff : All BHRS clinical staff are required to be CANS-certified before administering the CANS, and to maintain annual certification status. BHRS Quality Management will track that BHRS clinical staff are CANS-certified. To become CANS-certified, first create an account with the PRAED Foundation: https://www.schoox.com/academy/CANSAcademy/register and then contact HS_BHRS_ASK_QM@smcgov.org to access the CANS training code. You must provide the certificate of completion of the CANS training to QM immediately after completing/passing the online exam. The programs responsible for completing the assessment are also responsible for completing the CANS-50 and PSC-35. BHRS clinical staff will complete the CANS-50 directly in Avatar. A paper version may be utilized but the information must also be entered into Avatar. CANS-50 can be found in Avatar as the form titled: "Child and Adolescent Needs and Strengths."

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

Contractors with Avatar administrative access will utilize the paper version of the forms and will either have their administrative staff enter the information into Avatar or submit the documentation to the BHRS MIS department to be entered, depending on their agency's work flow. Paper versions will be kept in their agency's official medical record. Contractor Clinical Staff will complete the CANS in their official medical record and submit the CANS-50 data set to their administrative staff for entry into Avatar, or it may be sent to BHRS MIS for entry into Avatar.

LOCUS (Adult Clients) BHRS uses the "Levels of Care Utilization System" (LOCUS) as a treatment planning and utilization management tool for adult clients. Scores on the LOCUS are based on the clinical needs of the clients. They help ensure that clients receive the type and amount of service that corresponds to the clinical need. These tools are now an important part of our clinical and utilization management system and have been integrated into the timeline structure for all important clinical documents.

WHO COMPLETES THE LOCUS? The LOCUS should be completed by clinicians who have been trained on how to utilize it. The initial LOCUS is a component of the Admission Assessment. Subsequently, the form should be completed every three years by the clinic or team assigned as the care coordinator for the client. The LOCUS may be completed at other times by other clinicians as an aid to treatment or as a component of a utilization management process.

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

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

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

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

TREATMENT PLANNING/SERVICE DELIVERY

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

PROGRESS NOTES

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

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

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

CLIENT TREATMENT & RECOVERY PLAN

The Client Treatment & Recovery Plan is a primary way of involving clients in their own care. The development of the Client Plan is a collaborative process between the client and their treatment team.

It is designed to establish the client's treatment goals, develop a set of objectives to help realize these goals, and reach agreement on the services we will provide. Program goals should be consistent with the client's/family's goals as well as the diagnosis and assessment. The client plan must include documentation of the client's participation in the development of and agreement with the client plan.

CLIENT PARTICIPATION

Client participation in the formulation of the treatment plan is documented by obtaining the signature or verbal approval of the client/parent/guardian and when possible providing a copy of the plan to the client/family member, and, most importantly, documenting in a Plan Development or medication support progress note how the client/parent/guardian participated in developing and approving the treatment plan.

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

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

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

The 9 elements required by the current Client Plan

1. Statement of the problem to be addressed;

2. An expected frequency for each proposed intervention;

3. An expected duration for each proposed intervention and dates;

4. Specific behavioral interventions (description) for each proposed service and how it will ameliorate diagnosis;

5. Observable and measurable goals and objectives; SMART (*See p. 15)

6. Provider's signature with Degree/ License or job title, and signature date, and co-signature of LPHA if applicable;

7. Adequate documentation that the beneficiary was offered a copy of the Plan;

8. Client's dated signature (or progress note documenting verbal approval);

9. Documentation that the beneficiary participated in development of and agreed to the Plan

TREATMENT PLAN TIMELINES

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

For all programs the treatment plan must be completed within 60 days from admission to your program. A new treatment plan should be completed before the previous plan expires; there should be no gap between treatment plans.

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

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

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

UPDATES TO TREATMENT PLAN

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

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

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

TREATMENT PLAN SIGNATURES

The client's verbal approval and/or signature or the verbal approval and/or signature of the client's parent required on the client plan when the client is expected to be in long-term treatment **and** when the plan indicates that the client will be receiving more than one Specialty Mental Health Service. Verbal approval, with a progress note documenting agreement, from client or client's caregiver is acceptable. The definition of "**Long-Term Treatment**" is a client that is seen for more than one treatment session. And a "**Long-Term Client**" is any client admitted to an outpatient treatment episode.

REFUSAL TO SIGN OR UNAVAILABILITY TO SIGN

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

MINORS CAN SIGN (OR GIVE VERBAL APPROVAL) TO THEIR OWN CLIENT PLANS

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

In order to update a plan without a client signature, the clinician must document the **client's involvement in plan development**—e.g., a telephone discussion about the plan—and document this involvement (and approval of the plan) by the client on the treatment plan AND in a Plan Development progress note. It is not sufficient to document this client involvement only on the plan itself; a Plan Development or medication support note must be written whenever you work with a client to formulate/review/obtain approval for a treatment plan.

STAFF THAT MUST SIGN THE CLIENT PLAN

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

- Physician
- Licensed/waivered Psychologist
- Licensed/registered/waivered Clinical Social Worker
- Licensed/registered/waivered Marriage & Family Therapist
- Licensed/registered/waivered Professional Clinical Counselor
- Registered Nurse, Nurse Practitioner (NP), Clinical Nurse Specialist

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

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

When the covered period lapses and the next client plan is completed late, there will be unauthorized days that are not claimable (e.g., the renewal date was July 1 but the plan is completed on July 7, so all services provided July 1-6 would be unauthorized.) This is considered a *gap* in services.

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

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

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

- Assessment (5)
- Plan Development (6)
- Crisis Intervention (2)
- Medication Support Services (14) —for assessment, evaluation, or plan development; or *if there is an urgent need (which must be documented)*; Medication Support Urgent RN (15U) for nurses
- Targeted Case Management (52) and Intensive Care Coordination (ICC-52) for assessment, plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services

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

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

TREATMENT PLAN ELEMENTS:

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

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

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

GOAL –The removal or reduction of the problem.

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

OBJECTIVE(S) – What the client will do to reach the goal.

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

Examples: Recovery Barrier/ Problems linked to Diagnosis

Auditory hallucinations leading to self-harm and hospitalization.

Exhibits angry behavior in class; refuses to complete tasks or accept help; learning disabilities impede progress in school.

Examples of Goals

Reduce auditory hallucinations and improve symptom management.

Get along better with others at school, without physical aggression.

Examples of Objectives

From a baseline of 0, I will meet with MD 1x/month to discus positive and negative impact of medication over the next 12 months.

Within 12 months, I will identify at least 2 activities, from a baseline of 0 activities, that will help me not listen to negative voices.

Within 12 months, I will have at least one friendly talk with peers 2-3 times per week from a baseline of 0 friendly talks weekly.

Examples of Interventions

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

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

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

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

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

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

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

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

Examples of specific, diagnosis-related interventions:

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

Every proposed intervention for each service type—such as Individual Therapy, Medication Support and/or Targeted Case Management—must be listed and described in detail. Any intervention added during the course of treatment (e.g., TBS) must be written and dated on the plan. If a proposed intervention is not included on the treatment plan, that service cannot be provided and billed for.

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

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

FREQUENCY OF INTERVENTION

Use of terms such as "as needed" or "ad hoc" do not meet the requirement that a client plan contain a proposed frequency for interventions. The proposed frequency must be stated specifically (e.g., daily, weekly, etc.) or as a frequency range (e.g., 1-4 x per month).

PROGRESS NOTES

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

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

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

TIMELINESS OF DOCUMENTATION OF SERVICES

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

PROGRESS NOTE CONTENT

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

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

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

Progress Notes Should Include:

Documentation of all referrals to community resources and other agencies.

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

Follow-up care/Plan which includes next steps on part of clinician or client, or discharge summary.

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

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

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

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

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

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

TIPS FOR WRITING PROGRESS NOTES

Progress notes are used to inform the on-duty clinician and other clinicians about the client's treatment, to document and claim for services, and to provide a legal record. Progress notes may be read by clients/family members and should be written in a manner that supports client-centered, recovery-based and culturally competent services. Aim for clarity, brevity, and objectivity when writing notes; lengthy narrative notes are discouraged when recording ongoing services.

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

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

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

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

CONFIDENTIALITY

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

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

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

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

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

PROGRESS NOTE FIELDS

PROGRESS NOTE FOR: Select New Service.

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

LOCATION: Record where the service took place.

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

PROGRESS NOTE TYPE: Choose New Service.

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

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

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

SIGNATURE

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

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

CO-PROVIDED SERVICES

When services are co-provided by two clinicians, each person must write their own progress note (unless the service is a group). You may bill a co-provider only for group services.

Frequency of Progress Notes

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

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

Weekly summaries must be completed for the following services:

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

DOCUMENTING A SERVICE INVOLVING TWO OR MORE PEOPLE

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

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

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

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

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

NON-REIMBURSABLE SERVICES

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

SERVICES THAT ARE NOT BILLABLE

The following are examples of activities that are not claimable for reimbursement (do not claim if these are documented; use one of the non-reimbursable codes, 55 or 550)

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

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

Academic/Educational Situations

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

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

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

Recreational Situations

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

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

Vocational Situations

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

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

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

BLOCK BILLING WITH LOCATION CODES AND NON-BILLABLE SERVICE CODES

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

NON-BILLABLE SERVICE CHARGE CODES

DIRECT CLIENT CARE UNCLAIMABLE (55) AND UNCLAIMABLE GROUPS (550) are the codes used for services provided to clients and their families that are not claimable to Medi-Cal. These services are meant to include the wide variety of services deemed necessary for recovery and resiliency, but not reimbursable as mental health or other claimable clinical services. This category is intended to permit flexibility in treatment planning on the part of clinical teams and to promote the adoption of recovery-based services to individual clients. These services may be documented by all members of the clinical teams working with clients. Unclaimable services include:

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

Please review a more comprehensive list of non-billable services/activities on p. 21 of this manual.

LOCATION LOCKOUTS

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

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

IMD (Client's location)

JAIL/YOUTH SERVICES CENTER (Client's location)

MISSED VISIT (No Show/Client not at home)

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

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

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

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

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

BILLING LIMITATIONS BY LOCATION

LOCKOUTS, OVERRIDES, COMPUTER EDITS & OTHER LIMITATIONS

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

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

TRANSFER/DISCHARGE REQUEST

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

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

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

- Complete the Transfer/Discharge Request.

MENTAL HEALTH SERVICES

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

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

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

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

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

PLANNED SERVICES

Planned service may only be provided with an assessment and treatment plan in place.

UNPLANNED SERVICES

May be provided as needed. However, after 60 days from admission to any program, all services are blocked from billing if there is no treatment plan.

Medi-Cal will reimburse an MHP for some services provided to a beneficiary prior to both the assessment and client plan being approved with the required staff signature(s).

Unplanned Services are reimbursable prior to the completion of the treatment plan for the first 60 days after the client is opened to a program.

Unplanned Services:

- Assessment (5)
- Plan Development (6)
- Crisis Intervention (2)
- Crisis Stabilization (PES)
- Medication Support Services (if there is an emergency or immediate need which must be documented)
- *Some* Targeted Case Management Services (52)

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

1. *Targeted case management services to access medical, educational, social or other services.*
2. *Referral and Related Activities to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services.*
3. Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's needs.

After 60 days from admission, however, Medi-Cal will disallow payment for ALL services if the beneficiary being treated still does not have both the assessment and approved client plan in place.

Planned Services:

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

- Therapy, groups, family therapy, collateral, rehabilitation, medication support (except for emergency), case management not geared toward assessment/plan development.
- Day treatment intensive (must have completed client plan within 5 days of admission).
- Day rehabilitation (must have completed client plan within 5 days of admission).
- Adult residential treatment services (must have completed client plan within 5 days of admission).
- Crisis residential treatment services (except crisis intervention services, assessment and client plan development). Must have completed client plan within 5 days of admission.

Telehealth and Phone Services:

Video conferencing (Telehealth) services with client are entered in "Service to Client Present in Person" time and location code is "Telehealth," *unless client is in a lockout location.*

Services with client over the phone (without video) should be entered in "Other Billable" time with location code of "Phone," *unless client is in a lockout location.*

Video conferencing services with caregiver/providers without client present (e.g., treatment team meeting), is entered in "Other Billable" time and location code is "Phone."

- *For MD/NPs*: Use Code 15/15U for Medication Support provided in-person or via Telehealth; Code 17 for Medication Support provided over phone (without video) or when the client is NOT present face-to-face ; Code 14 with the corresponding Location code (Telehealth, Phone, Office, etc.) for Initial Assessment;
- *For RNs*: RNs may provide Medication Support and use code 15U/15 via phone, video conferencing or in person.

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

ASSESSMENT (5)

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

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

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

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

PLAN DEVELOPMENT (6)

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

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

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

A PLAN DEVELOPMENT PROGRESS NOTE DESCRIBES:

Developing

Approving

Modifying

the client treatment plan

PROGRESS NOTES DESCRIBE:

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

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

CRISIS INTERVENTION (CODE 2)

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

Crisis Intervention (2) is a service lasting less than 24 hours. Examples of Crisis Intervention include services to clients experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves (including provision/utilization of food, clothing and shelter) due to a mental disorder.

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

CRISIS INTERVENTION

PROGRESS NOTES DESCRIBE:

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

EXAMPLE OF CRISIS INTERVENTION ACTIVITIES:

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

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

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

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

REHABILITATION (7)

This code is used to document the following services and can be delivered by any clinical staff member to an individual or to a group of clients. **Rehabilitation includes:** Services related to the mental health issues to assistance in improving, maintaining, or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication compliance.

- Counseling of the client including psychosocial education aimed at helping to achieve the individual's goals.
- Monitoring medication compliance by non-medical staff.

COLLATERAL (12)

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

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

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

A COLLATERAL PROGRESS NOTE DESCRIBES:

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

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

INDIVIDUAL THERAPY (9)

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

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

FAMILY THERAPY (41)

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

GROUP THERAPY (10)

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

SCOPE OF PRACTICE

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

THERAPY PROGRESS NOTES:

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

CASE MANAGEMENT (CODE 51, VRS51, 52)

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

A CASE MANAGEMENT

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

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

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

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

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

Locating and securing an appropriate living environment.

- Locating and securing funding.
- Pre-placement visit(s).
- Negotiation of housing or placement contracts.
- Placement and placement follow-up.
- Accessing services necessary to secure placement.

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

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

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

IN CASE MANAGEMENT NOTES:

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

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

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

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

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

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

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

INTENSIVE CARE COORDINATION (ICC-51)

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

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

INTENSIVE HOME BASED SERVICES (IHBS-7)

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

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

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

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

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

ICC-51
Follows basic documentation rules for Case Management

CFT ICC
Documents CFT meetings

IHBS-7
Follows basic documentation rules for Rehabilitation

GROUP SERVICES

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

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

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

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

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

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

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

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

Group Non-Billable—billing code (550).

Group Documentation:

- Group progress notes are documented in AVATAR using the BHRS Outpatient Progress Note.
- Enter the number of clients *present*, not the total number of clients normally enrolled in the group.
- Indicate any co-provider/therapist who participated.
- Indicate how much time each therapist spent on the group and any documentation/travel time; therapists may spend unequal times with the group.
- The computer will calculate the correct time to allocate for each member.
- Indicate the overall group focus in each note, unique to that group and not a generalized blurb that repeats week to week. **Document the client's participation** *in that specific group on that day.* Address behaviors/goals, interventions, the client's responses, and plan **as related to the client's diagnosis—its symptoms/impairments**.
- Co-providers: The participation of both must be documented according to Medical Necessity, i.e., why each provider was necessary and what each did that was unique in addressing the client's mental health/Dx. Not every group needs more than one provider but when necessary, justify the reason based on the clients' needs, not the clinicians' needs.

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

Coding Examples:

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

Note: Family Therapy is *not* a Group

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

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

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

When providing a service that is not primarily medication support, physicians and nurses must use the relevant service charge code. Example: Case Management (51) services.

TYPES OF MEDICATION SUPPORT SERVICES

MEDICATION INITIAL MD/NP ASSESSMENT (14) is used for initial assessments (PINs) and for urgent needs (non-injection) prior to treatment plan completed, up to 60 days from admission. Must describe the urgent need.

MEDICATION SUPPORT (15) is used for:

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

URGENT MEDICATION SUPPORT (14)

- For urgent needs (non-injection) prior to treatment plan completed, up to 60 days from admission. Must describe the urgent need. RNs - use Urgent Medication Support (15U).

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

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

MDs and NPs use only Medication Support (15) for face-to-face or telehealth with video services with clients. MDs and NPs use Medication Support MD/NP ***not*** face-to-face (17) when providing a service that is not billable to Medicare (when the client is not present).

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

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

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

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

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

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

MEDICARE CLAIMING

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

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

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

MEDICATION SERVICES, PLANNED SERVICES

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

SERVICE	DESCRIPTION	EXAMPLES OF DOCUMENTATION IN NOTES
MEDICATION INITIAL MD/NP ASSESSMENT/ EVAL/PLAN DEV/ URGENT NEED (14)	Used for initial assessments (PINs). Urgent care before both the assessment and treatment plan are completed.	Completed Initial Assessment. Evaluated client for medications on an urgent basis, due to his having run out of meds previously prescribed, and an associated increase in psychotic symptoms and suicidal ideation.
MEDICATION SUPPORT (15)	**Services within the scope of practice of an MD or nurse including:** Clinical assessment follow-up or annual with evaluation of the need for medication. Evaluation of clinical effectiveness and side effects of medication. Obtaining informed consent for medication. Prescribing, administering, and/or dispensing medication. Medication education (risks, benefits, alternatives) with client or significant support person. Plan Development with client present. *Includes Telehealth services*	Evaluated client for anti-psychotic medications. Informed client of Prolixin's risks/benefits. Obtained informed consent for medication. Wrote the Physician Initial Note (PIN). Completed the Client Treatment Plan with the client; client signed and accepted a copy.
MEDICATION SUPPORT URGENT RN (15U)	Urgent care by RN before both the assessment and treatment plan are completed.	Met with new client who was experiencing severe psychotic symptoms. Referred to MD for med evaluation.
MEDICATION INJECTIONS (16)	Medication administered by injection.	Medication given IM, site, response, side effects...etc.
MEDICATION SUPPORT MD/NP NON FACE-TO-FACE (17)	**Services within the scope of practice of an MD or NP including:** Consultations with providers, team conferences. Phone calls to pharmacy. Plan Development when the client is not present.	Conferred with NP about impact of client's obesity on his mental health. Reviewed chart prior to meeting tomorrow with client.
MEDICATION RISPERDAL/ INVEGA INJECTIONS (19)	Risperdal Consta or Invega Sustenna medication administered by injection	Medication given IM, site, response, side effects...etc.

DAY TREATMENT SERVICES, PLANNED SERVICES

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

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

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

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

AUTHORIZATION REQUIREMENTS

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

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

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

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

DOCUMENTATION

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

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

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

LOCKOUTS

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

MENTAL HEALTH TBS PLANNED SERVICES

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

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

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

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

Two important components of delivering TBS are:

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

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

ELIGIBILITY FOR TBS

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

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

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

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

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

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

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

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

REQUIREMENTS

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

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

ADULT RESIDENTIAL TREATMENT SERVICES (TRANSITIONAL)

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

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

Weekly Summaries by the treatment staff are required. Residential treatment weekly summaries must address the following areas:

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

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

Staffing Ratios

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

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

CRISIS STABILIZATION - EMERGENCY ROOM

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

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

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

CRISIS RESIDENTIAL TREATMENT SERVICES

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

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

Staffing Ratios

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

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

Progress Notes

Crisis Residential Services require Daily Progress Notes.

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

MENTAL HEALTH SERVICES TABLE

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

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

See p. 31 for Katie A Services

CRITICAL INCIDENT REPORTS

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

CLIENT ALERTS & URGENT CARE PLAN

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

CLIENT ALERTS

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

CLIENT ALERT (Step 1)

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

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

URGENT CARE PLAN (Step 2)

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

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

SERVICE CHARGE CODE & ELIGIBLE PROVIDERS

CO-SIGNATURE

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

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

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

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

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

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

Service Charge Code	Eligible Providers
2-Crisis Intervention	All clinical staff
5-Assessment 50-Assessment Group	All clinical staff; **however, MSE, Clinical Formulation & Diagnosis** may only be provided by certain licensed/ registered/waivered staff and trainees.
6-Plan Development	All clinical staff
7-Rehabilitation Services 70-Rehabilitation Group Service 7-VRS Rehabilitation Services 7-Intensive Home Based Services (Katie A)	All clinical staff
9-Individual Therapy 10-Group Therapy	Licensed/registered/waivered staff and trainees; eligible RNs only (see scope of practice)
12-Collateral 120-Collateral Group	All clinical staff
15-Medication Support/ 15u Urgent Med Sup/150 Medication Group	MD/RN/NP/LPT/LVN
16-Medication Injection	MD/RN/NP/LPT/LVN
14-Medication Initial MD/NP Assessment 17-MD/NP, not Medicare-billable	MD/NP
19-Risperdal Consta/Invega Injection	MD/RN/NP/LPT/LVN
30-TBS Assessment	Licensed/registered/waivered staff and trainees
41-Family Therapy	Licensed/registered/waivered staff and trainees; eligible RNs only (see scope of practice)
51-Targeted Case Management 52- Targeted Case Management	All clinical staff
55/550-Direct Client Care Unclaimable	All clinical staff All clinical and administrative staff
58-TBS (Therapeutic Behavioral Services)	All clinical staff; staff not licensed/ registered/waivered must be under the direction of such staff

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

MENTAL HEALTH SCOPE OF PRACTICE

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

+ **Must be co-signed.**

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

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

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