This manual provides documentation standards for outpatient Medi-Cal Specialty Mental Health Services provided or contracted by the Santa Cruz County Mental Health Plan (MHP). The manual provides a general description of services and service definitions and is a day-to-day resource for clinical and supervisorial staff.

The MHP establishes documentation standards in order to help realize the commitment to clinical and service excellence. In addition, accurate and complete documentation protects us from risk in legal proceedings, helps us to comply with all regulatory requirements when we claim for services and enables professionals to discharge their legal and ethical duties.

The MHP submits a claim for each covered service provided by each staff member.

All services are documented using Medi-Cal Specialty Mental Health documentation rules, regardless of beneficiary status. Services for clients with co-occurring mental health and substance use disorders are documented using the rules presented in this manual. However, this manual does not address specific documentation rules for services that are claimed to Drug Medi-Cal or Medicare.

HOW TO GET HELP

This Documentation Manual reflects MHP policy and is the source for all documentation issues in addition to MHSUDS Info Notices from DHCS. The Quality Improvement Team provides resources as well as trainings, guides and other helpful documents. The QI Team offers basic documentation training to new employees as well as specialized training for teams. QI encourages questions and comments at any time.

AskQI@santacruzcounty.us
COMPLIANCE ISSUES

The MHP has adopted a Compliance Plan to express commitment to providing high quality health care services in compliance 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.

The Compliance Plan ensures that any services provided that do not meet these standards and requirements will not be submitted for reimbursement. It is the personal responsibility of every provider to submit a complete and accurate record of the services they provide, and to document services in compliance with all applicable laws and regulations.

NOTES MUST BE ACCURATE AND FACTUAL

- It is critical for all staff to be aware that they have an essential role to play in ensuring the compliance of our services with all pertinent laws. The progress note is used to record the services that result in claims. Please remember 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 an incorrect location or service code) directly affect our ability to submit true and accurate claims. For this reason, compliance is the personal responsibility of all clinical and administrative staff within the MHP.

COMPLIANCE & BILLING

All services shall be documented as described in this Documentation Manual.

To ensure compliance, all services, and the charting of all services, must observe the following overriding rules:

- All services shall be documented in a timely manner. A late entry shall be clearly identified in the documentation.
- Be signed with discipline, license or with job class.
- All services shall be based on a current assessment, updated annually. All charts must contain an assessment and, as indicated, a current updated assessment.
- Services provided without a current assessment and treatment plan may not be submitted for reimbursement.
- Planned services provided after the expiration of the Treatment Plan will not be submitted for reimbursement to the state.
- Services shall be provided within the staff person’s scope of practice as specified in this manual. Progress notes should reflect actual duration of the intervention, e.g. 23 minutes, no rounding up.

Every service entry shall:

- Accurately reflect the activity, location, and duration for each service.
- Use Non-Billable Service Codes for services that are not claimable (see “Non-Reimbursable Activities.”)
- Be signed with discipline, license or job class.
ADMISSION DATE
The Admission date is the first date of claimed outpatient services for a “new” client opened to the LE. A “new” client is any individual admitted for outpatient services for whom there is not a current outpatient treatment LE episode. The individual may have received previous services from the MHP and still be considered a “new” client.

INTAKE PERIOD
The Intake Period is 60 days following the Admission Date. During this time, a thorough assessment is completed within 30 days and a Treatment Plan is completed within 60 days. The availability of community resources and social support systems to meet the individual’s needs are evaluated.

ASSESSMENT DATE
The Assessment is updated on an annual basis for the LE. Significant changes should be indicated on the annual update. This must be performed every year while the client continues to receive services.

TREATMENT PLAN
The Treatment Plan should be completed within 60 days of opening to LE. However, urgent/crisis services may be provided and should be coded based on the service provided. Assessment, Plan Development and Case Management (ICC) may be claimed before the Treatment Plan is completed to ensure necessary referral and linkage to services.

WHEN INDIVIDUALS WHO ARE ALREADY MHP CLIENTS BEGIN TO RECEIVE A NEW SERVICE
If a new LE episode is opened with a new provider, the new service provider needs to complete a new Treatment Plan. A client who is transferred from one team to another within an LE does not need an updated treatment plan unless a new problem, goal, objective or intervention is indicated or annual update is due.

CLIENT RETURNING FOR SERVICES
When a client returns to services after all episodes have been closed, the client must be admitted with a new intake date to the LE. Within 30 days of the new intake date, a Youth or Adult Assessment must be completed, and a treatment plan must be completed within 60 days.

Summary
A chart must have all of the following items completed on time to avoid disallowance of services:
• Admission Assessment completed within 30 days of the Admission Date.
• Initial Treatment Plan completed within 60 days of the Admission Date.
• When an existing client is opened to a new LE, the new provider must complete a treatment plan within 60 days of opening to their LE.
• Assessment updated annually.
• The Treatment Plan updated annually prior to the 12-month anniversary of LPHA signature date.
State DHCS requires MHP to establish and observe timelines for documentation.

<table>
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<tr>
<th>FORM</th>
<th>PURPOSE</th>
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<tr>
<td>INITIAL PSYCHO-SOCIAL ASSESSMENT</td>
<td>Documents Client’s: Presenting Problem Strengths Current Resources/Living Situation Family/Relationship Issues Psychiatric &amp; Medical History including trauma Risk Assessment if needed Substance Use History &amp; current pattern of use Past/present victim/perpetrator of abuse and or violence Vocational &amp; Educational History Outside Provider Involvement Mental Status Exam Diagnosis</td>
<td>Assessor Authorized clinical staff</td>
<td>Within 30 days of admission date</td>
<td>Dated and signed updates must be performed at least annually.</td>
</tr>
<tr>
<td>ANNUAL ASSESSMENT (Youth and Adult)</td>
<td>Reviews previous Assessment(s) Provides current status</td>
<td>Evaluator Co-signature (as necessary)</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>CLIENT TREATMENT PLAN</td>
<td>Describes goals related to problem(s)/functional impairment(s). Has specific, observable, quantifiable (measurable) objectives with baselines. Identifies the proposed type(s) of intervention, consistent with the goals/objectives. Has a proposed duration &amp; frequency of the intervention(s) to address problem. Is consistent with the diagnosis.</td>
<td>Client /Legal Guardian Staff member One of following if staff member providing service is not LPHA: MD Psychologist/waivered LCSW/registered MFT/registered LPCC/registered Nurse Practitioner</td>
<td>Within 60 days of admission date.</td>
<td>Within 12 months of the LPHA signature date. May be revised at any time which can change LPHA signature date.</td>
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</table>

These timelines are mandated and fixed for each client. Assessments may be amended or have additional material added at any time and Treatment Plans may be amended at any time. The LPHA signature date for the revised/updated Treatment Plan may change the 12-month effective period.
MEDICAL NECESSITY

To be eligible for Medi-Cal reimbursement for Outpatient Specialty Mental Health Services, a service must meet all 3 criteria for medical necessity (diagnostic, impairment, & intervention related):

A. DIAGNOSTIC CRITERIA The focus of the service should be directed to functional impairments related to an Included Diagnosis. Refer to MHSUDS Information Notice 18-053 and MHSUDS Information Notice 16-051. The primary diagnosis must be an included one. The client may also have an excluded diagnosis but interventions must focus on the primary diagnosis. When a mental health diagnosis and a substance use disorder diagnosis are both present, the mental health diagnosis must be the “Primary” diagnosis.

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

1. A significant impairment in an important area of life functioning, or 2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

C. INTERVENTION RELATED CRITERIA Must have all 3:

1. The focus of the proposed intervention is to address the condition identified in impairment criteria “B” above, and
2. It is expected the proposed intervention will benefit the client by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare-based treatment.

EPSDT SERVICES

Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additional medically necessary services. EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to, the attainment of the specialty mental health treatment.
A diagnosis and mental status exam can only be provided by a psychiatrist, licensed/waivered psychologist, licensed/registered clinical social worker, licensed/registered marriage and family therapist, licensed/registered professional clinical counselor, Nurse Practitioner and nurse with Master’s Degree in Nursing with a Psychiatric Certification. These clinicians are often referred to as a Licensed Practitioner of the Healing Arts (LPHA). The LPHA is responsible for conducting the mental status exam and providing the diagnosis while other staff may contribute to and conduct other portions of the assessment. Per DHCS, “the diagnosis should be signed off by the person who made the diagnosis instead of being ‘noted’ by another staff person.” (MHSUD Info Notice 17-040).

All diagnoses - the primary diagnosis and any secondary diagnoses – should be noted. The presence of a non-eligible diagnosis does not affect claiming for services as long as there is a primary eligible diagnosis that is the focus of treatment. It is the expectation of the MHP that any substance use diagnosis found should be listed. The diagnosis should be ascertained by using DSM 5 criteria and then referencing the same/similar diagnosis in ICD-10 CM. For example, individual meets DSM 5 criteria for Major Depressive Disorder, recurrent, with moderate severity which corresponds to ICD-10 Code F33.1 (Major depressive disorder, recurrent, moderate). For youth, DSM 5 should be used except for diagnoses formerly under the heading of Pervasive Developmental Disorders such as Asperger’s Disorder, Childhood Disintegrative Disorder or PDD NOS which should be determined using DSM IV criteria using only ICD-10 Codes that correspond to these diagnoses. See MHSUD Information Notice 18-053 for outpatient Medi-Cal Specialty Mental Health Diagnostic Listings and MHSUDS Information Notice 16-051 regarding use of DSM 5 and PDD diagnostic categories.

**CHANGE OF DIAGNOSIS**

Diagnoses may be changed at any time during the course of treatment and should be reviewed and updated annually along with other elements of the assessment.
ASSESSMENTS

The Admission Assessment is designed to provide a comprehensive clinical picture of the client, to establish medical necessity, to help treatment teams and clients define goals and objectives, and to fulfill State and Federal requirements. ADMISSION ASSESSMENT INCLUDES:

- Presenting problems and relevant conditions affecting the client’s physical health and mental health status, for example: precipitating event, intensity, duration and response as well as current living situation, daily activities, and social support.

- A mental health history, including: previous treatment dates, providers, therapeutic interventions and responses (including medications), sources of clinical data, relevant family information and results of relevant lab tests and consultation reports, history of trauma.

- Documentation of medications that have been prescribed by MHP psychiatric providers, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.

- Client self-report of allergies and adverse reactions to medications, or if none, the lack of any known allergies/sensitivities.

- Cultural, linguistic, religious/spiritual, legal and other relevant factors affecting service delivery should be included where appropriate.

- Information concerning client sexual/gender identity issues.

- For children and adolescents, prenatal and perinatal events and a complete developmental history.

- Relevant physical health conditions reported by the client, prominently identified and updated as appropriate including PCP and medications if any.

- For clients of all ages, information concerning past and present use of tobacco, alcohol, caffeine, and illicit, prescribed, and over-the-counter drugs; an initial SUD screening tool may be utilized as a first step, with a more comprehensive assessment provided as indicated.

- Information about the client’s being a past and/or present victim and/or perpetrator of abuse and/or violence.

- Special status situations that present a risk to the client, or others, prominently documented and updated as appropriate.

- Description of client strengths in achieving client’s treatment and recovery goals. Identify the strengths inherent in the client/family or available through established community supports.

- Mental Status Examination

- A diagnosis derived from DSM 5 associated to ICD-10 Code, consistent with the presenting problems and other assessment data. This should reflect approved codes noted in MHSUDS Info Notice 18-053. See page 6.

New information may be added to the chart, at any time, by completing an Assessment Update or including the new material in the next Annual Assessment.

ANNUAL/UPDATE ASSESSMENTS

Annual Assessments are required to ensure that changes in the client’s symptoms, behaviors and diagnoses, as well as the development of additional strengths, are documented. Intervening crises, and hospitalizations are also documented. Note that these assessments must be completed at least annually, however, updates can be performed at any time. The Assessment is completed by the current clinical staff with supervision by LPHA as needed. The summary should describe behavior/mental health condition that continues to meet medical necessity criteria. Only the diagnosis and MSE requires signature of LPHA who completed these tasks.

Updates that occur at times other than during the annual renewal period do not affect the requirement for an annual update. Updates can be documented in a progress note. Annual Assessment Updates will be completed on the Psychosocial Assessment form along with updates to MSE and Diagnosis.
ASSESSMENT TIMELINES

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

ASSESSMENT TIMELINES

- The Admission Assessment is due within 30 days of Admission to the LE.
- The Adult Access Team, Child/Youth Access Team provide completed assessments for clients who are then referred to county or contract clinical teams and other services. When a client with an assessment completed by these teams is referred to a clinical team, the following procedure applies:
  - The assessment may be accepted as the Admission Assessment by the receiving team. Any additional or amended information shall be recorded on the assessment by an eligible clinical staff member, with identifying date and signature.

ADMISSION ASSESSMENTS

The admission assessment consists of the following: the main assessment for age group, diagnosis, MSE and substance use history/risk assessment (as needed). All of these assessment components are required as part of the admission assessment.

ANNUAL/UPDATE ASSESSMENTS

There are two different annual/update assessments: the Adult Annual/Update Assessment and the Child/Youth Annual/Update Assessment. These are accessed by clicking on the Adult MH or Child MH radio button at top of Psychosocial Assessment form. Staff should ensure a current comprehensive assessment is present in all client records annually.

CONTRACT PROVIDER ASSESSMENT

An Admission Assessment by county MH staff may be used when a client is referred or transferred to a contract provider when the client is already open to the MHP. Otherwise the contractor must complete this assessment form within 30 days of opening to their LE. Annual Assessment Updates are required of contractors if client is closed to county LE or is a County “Meds Only” client.

Person Centered Services:

Person Centeredness is often inserted at the wrong point in the clinical process. Starting at the Service Planning Process with questions like “What would you like to work on?” “What goals do you have for treatment?” This ignores the assessed needs identified in the assessment process. In therapeutic sessions where discussions routinely focus around whatever the client wants to discuss rather than working on the mutually developed service plan. If the plan isn’t relevant—change it.

From Bill Schmelter PhD
During the initial assessment and every 6 months thereafter, a Child & Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths (ANSA) evaluation will be completed. CANS/ANSA will also be completed at discharge and may be updated when a significant event occurs. These tools are designed to support decision making, including level of care and service planning. In addition, they are intended to monitor outcomes of service delivery, communicate between multi-provider systems as well as be meaningful to youth, families and adult clients in the development of their treatment plan goals.

The way CANS/ANSA works is that each item suggests different pathways for service planning. There are four levels of each item with specific definitions that are designed to translate into action levels. For needs: 0 - indicates no evidence, no need for action; 1 - indicates watchful waiting/prevention; 2 - indicates action; 3 - indicates immediate/intensive action. For strengths: 0 - indicates a centerpiece strength, something so powerful it can be the focus of a strength-based plan; 1 - indicates a useful strength; 2 - indicates that a potential strength has been identified but must be developed; 3 - indicates no strength or no information has been identified.

The CANS is also unique in that: 1. It is about the child not about the service. If a child is receiving services that are masking a need, this is factored into the ratings. 2. Culture and development are considered before establishing the action levels. It is in this way that cultural sensitivity is embedded into the CANS and how it can be useful across the development of childhood and adolescence. 3. With the exception of two items (traumatic grief and adjustment to trauma), there are no assumptions of cause and effect. The CANS is intended to be descriptive. The occurrence of the behavior, not the reason for it. DHCS has established that CANS 50 is to be completed for youth under 21 according to EPSDT standards.

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed for adult’s behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized treatment plans including the application of evidence-based practices. The ANSA is useful to clients, family members, providers and other partners in the service system since it provides a common language for all involved. The way the ANSA works is that each item suggests different pathways for service planning similar to CANS.

**FOR NEEDS:**

0 No evidence, no information
1 Watchful waiting/prevention
2 Action
3 Immediate/Intensive Action

**FOR STRENGTHS:**

0 Centerpiece strength
1 Strength that you can use in planning
2 Identified-strength-must be built
3 No strength identified, no information
CO-OCCURRING SUBSTANCE USE DISORDERS

Clients may present in any behavioral health setting with any combination of mental health and substance use symptoms or disorders. Further, the mental health disorders may or may not be substance-induced, and the mental health and substance use conditions may be active or in remission.

MHP assesses co-occurring disorders (including substance use and trauma related conditions). The presence of a co-occurring substance use disorder will not, in and of itself, trigger disallowance of specialty mental health Medi-Cal claiming. All diagnoses for mental illness and substance use disorders shall be documented in the MHP chart when criteria are present.

Substance use, including tobacco and caffeine, shall 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 Plans for clients (including youth) with co-occurring disorders shall address substance use issues as they affect the mental health condition. The goals for these issues will be tailored as to the effect on the client’s mental health condition and presenting problem with readiness to address those issues.

PROGRESS NOTES

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

DEFINITIONS

Co-occurring Disorder: Youth, adults, and older adults are considered to have a co-occurring disorder when they exhibit the co-occurrence of mental health and substance use problems, whether or not they have already been diagnosed. Co-occurring disorders vary according to severity, duration, recurrence, and degree of impairment in functioning.
CLIENT TREATMENT PLAN

The plan of care is a primary way of involving clients in their own care. The development of the Client Treatment Plan is an interactive process between the client and the treatment team designed to establish the client’s treatment goals, to develop a set of objectives to help realize these goals, and to reach agreement on the type(s) of services that will be provided. This should be in the client’s/family’s preferred language.

Treatment goals should also be consistent with the diagnosis and assessment. The client’s participation in and understanding of all elements of the plan is essential and is expected by DHCS reviewers. At a minimum, client participation is documented by obtaining the signature of the client/parent/guardian and providing a copy of the plan to the client/family member. Giving a copy of the plan to the client/family member is an important acknowledgment of their participation in its development and of the clinician’s commitment to involving clients/families as full participants in their own recovery process.

TRAITS OF EFFECTIVE CLIENT TREATMENT PLANS

- Both the client and provider agree on the conditions that indicate when a goal is met.
- Flexible; capable of being changed.
- Support the client’s needs, taking into account the appropriate level of care and length of treatment.
- Realistic; objectives are achievable, observable, and measurable (with baselines).
- Simple; clients, family and staff can understand them. The plan is written in plain, non-technical language.
- Useful; objectives provide clear indicators of progress.
- Identify clinical responsibilities; staff know what they should do, with whom and how often.
- Identify the type and frequency of interventions (i.e. methods, approaches with duration & frequency).
- Facilitate interdisciplinary collaboration.

SIGNATURES

The client and/or parent/guardian are expected to sign the plan. If a client refuses, or is unavailable to sign, a progress note must document the situation. The client should be encouraged to sign at a later date. In order to update a plan without a client signature, the clinician must identify client involvement in plan development (e.g. a telephone discussion) and must seek to obtain, and document efforts to obtain, the signature at the next visit. Services provided beyond this point without documentation of attempts to obtain the signature are subject to disallowance.

The staff person providing the service(s), or a person representing a team or program providing services must sign the plan. When the clinical staff person signing is not licensed, registered, or waivered, the plan must be co-signed by one of the following LPHA’s:

- Licensed Psychiatrist
- Waivered Clinical Psychologist
- Licensed/Registered Clinical Social Worker
- Licensed/Registered Marriage and Family Therapist
- Licensed/Registered Professional Clinical Counselor
- Nurse Practitioner

TREATMENT PLAN TIMELINES

The initial Treatment Plan is due within 60 days of Admission to the LE. Treatment Plan(s) are renewed at least every 12-months from LPHA signature date by every team/clinician providing services to the client under that LE.

The Treatment Plan can be revised at any time. It must have a new client/parent signature and dated LPHA signature. The Treatment Plan must be updated prior to the 12-month anniversary of LPHA signature date. If the client is not available to sign the Treatment Plan, the progress note must clearly indicate that the client was not available and subsequent progress notes must reflect efforts to obtain the client’s signature once the client returns to service.

NOTE: Only Crisis, Assessment, Case Management* (includes ICC) and Plan Development services may be provided until the Treatment Plan is complete.

*Assessment, plan development, referral/linkage to services only.
CLIENT TREATMENT PLAN PARTS

SERVICE STRATEGIES - Broad categories describing an underlying concept or fundamental approach by a team or program. A service strategy will be checked 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.

Psychoeducation – services providing education re: 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 & self-support.

Delivered in Partnership with Law Enforcement – services integrated or coordinated with law enforcement, probation, or courts (e.g., mental health courts, diversion) to provide an alternative 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 Use Disorder Services – services integrated or coordinated with substance use services, including co-location or collaboration with providers and sites offering substance use services.

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 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 developmental disability.

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, 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.

<table>
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<th>Broad Goals</th>
<th>Specific Objectives</th>
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<tr>
<td>Improve problem solving</td>
<td>Will use behavior management skills learnt in therapy, reporting decrease in conflicts to no more than 2 per month. Has conflicts with peers 3X week.</td>
</tr>
<tr>
<td>Increase socialization</td>
<td>Will attend one social function a week for three consecutive weeks. Will initiate one social activity within 6 months. Predominately isolates at home.</td>
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<tr>
<td>Increase independence</td>
<td>Will get ready for school and not be late to class for 5 consecutive days. Will attend to homework with no more than 1 reminder. Relies on caregiver excessively for reminders to stay on task.</td>
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<tr>
<td>Improve personal hygiene</td>
<td>Will bathe, brush teeth daily w/out being reminded for three days/week, then gradually increase to seven days/week. Hampered by perseveration and repetitive thoughts.</td>
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<tr>
<td>Improve emotional regulation</td>
<td>Will report using positive self-regulation skills at least once per week and decrease self-injurious behaviors such as cutting (5X month).</td>
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<tr>
<td>Increase activity to improve depressive behavior</td>
<td>Will use Behavioral Activation diary daily to track changes in activity levels. Will identify at least 3 areas to improve activity level. Diary to be reviewed weekly for improvement. Oversleeps, overeats, watches TV excessively daily.</td>
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PLAN ELEMENTS

CLIENT’S OVERALL GOALS/DESIRED OUTCOMES - *The client’s desired outcome of successful treatment.*

The reason the client is seeking treatment. The overall goals should be clear to the client and the treatment team, reflecting the client’s desired outcome and strengths. These goals should speak to the client’s ability to manage or recover from his/her mental health condition and achieve major developmental milestones.

RECOVERY BARRIER/PROBLEM – *The primary diagnosis signs/symptoms & other barriers/life domain challenges.* This is a statement of the behavioral health symptoms/signs that are the focus of treatment. Rehab staff should use SNOMED Problem Codes to describe functional impairment, licensed/registered staff may use diagnosis.

GOALS (at least two*) – *Skills needed to remove or reduce the barrier.*

The goals address the problem. The goals include 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. Individual goals are generally related to important areas of functioning affected by the client’s mental health condition, such as living situation, daily activities, school, work, social support, legal issues, safety, physical health, substance use, and psychiatric symptoms. Goals must relate to the assessment, diagnosis and formulation.

OBJECTIVES (at least two *) – *How client will obtain skills.*

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

INTERVENTION(S) – *Services that staff will provide.*

These are all of the service types that will be utilized (e.g., Individual Therapy, Case Management, Rehabilitation Counseling, etc). Separately list all that apply.

Interventions describe actions to be taken by MHP providers (i.e., services or service modality) to assist clients in achieving their goals. Actions to be taken by clients are not interventions. Interventions should clearly express planned services such as “bi-weekly individual CBT therapy to improve reality testing,” or “weekly individual rehab counseling focusing on interpersonal skill building” or “bi-weekly case management to evaluate progress in treatment program.” Every planned intervention including Case Management must be listed on the treatment plan or the service will be disallowed. An intervention added in the course of treatment must be written and dated on the plan with appropriate signatures as an update.

DURATION OF INTERVENTION - *Usually this will be 12 months, but may be 3, 6, or 9 months if appropriate.*

*Except for Telos & EDC Res

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Examples of Recovery Barrier/Problems:

- Auditory hallucinations leading to self-harm and hospitalization
- Exhibits angry behavior in class; refuses tasks and help; learning disabilities make it difficult to do well in school

Examples of Goals:

- Reduce negative response to auditory hallucinations and improve symptom management
- Will get along better with others at school (no incidents of physical fighting)

Examples of Objectives:

- Will identify & use at least 2 actions client can do to not listen to the voices. (is distracted by voices at least twice daily or more).
- Will have at least one friendly talk with peers daily within 3 months and 2-3 times daily within 12 months. (has none now).

Examples of Interventions:

- Rehabilitation counseling weekly for 12 months to support ADL’s.
- Case Management services monthly for 6 months to monitor progress in treatment program.
- Individual therapy using CBT 1X week for 9 months to decrease paranoia.
- Individual with Family using Systemic Family Therapy bi-weekly for 12 months.
PROGRESS NOTES

There must be a brief written description in the client record each time services are provided. Progress notes provide a clear, on-going record of the client’s condition, the interventions attempted, the client’s response to the care provided, and the progress the client is making toward realizing his/her goals and objectives. Notes also facilitate the coordination of care and communication between team members. Progress notes should record an appropriate service for every billing, show evidence of collaboration with community resources including primary care, demonstrate on-going medical necessity, and show that the time billed is appropriate for the service provided and signed by the clinician.

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 the completeness of documentation, progress notes must be completed in a timely manner, i.e. as soon as possible after the service has occurred. When a service is recorded, clinicians can claim both the time it takes to provide the service and the time it takes to write the note. Notes written after seven days from date of service are considered a late entry and should be indicated as such. Notes entered after ten days will be disallowed if they are not claimed as a non-billable service. NOTE: As of January 1, 2019, notes written after 7 business days should be recorded as “late entry” using a non-billable code or they will be disallowed.

PROGRESS NOTE CONTENT

Progress notes record the date, location, duration, and services provided, and include a brief narrative. The narrative describes the client’s symptoms/behaviors as well as the client’s strengths, the provider’s intervention and the client’s response to the intervention, a plan for subsequent service, progress toward goals or objectives, and description of significant changes in the client’s status. Medication support progress notes should document the client’s response to medications, side effects, adherence 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 specific elements required in a progress note are as follows:

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

Documentation of all referrals to community resources and other agencies.

Documentation of any changes to the Treatment Plan, goals, objectives and interventions. Changes to the plan should also be recorded on the Client Treatment Plan with all necessary signatures.

Plan for follow-up care or discharge summary.

Documentation of client encounters, including relevant clinical decisions and interventions.
**TIPS FOR WRITING PROGRESS NOTES**

Use your judgment; progress notes are used to inform 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 appropriate services. Aim for clarity and brevity when writing notes – lengthy narrative notes are discouraged when recording ongoing services.

**PROGRESS NOTES ADDRESS THE BEHAVIOR, GOAL, INTERVENTIONS, RESPONSES, AND PLAN.**

The chart should document facts, staff’s interventions, and the client’s acuity.

**PROGRESS NOTES DESCRIBE:** The BEHAVIOR and GOAL ADDRESSED. Include observations, the client’s self-report, and report from others. Do document reports made by others involved in the care; state that the report was offered by the parent, or state that the client reported. Remember that if it is not written, it did not happen. You may be asked to describe the client’s behavior or reports from others at a later date.

Always document your INTERVENTIONS. This is how you show that you addressed the client’s need with the standard of care. Include the PURPOSE of the intervention. For example, “a safety plan was developed to stabilize the crisis.”

Describe the client’s RESPONSE to the intervention or the outcome or result of the service. Also, include a follow-up PLAN. The Plan addresses any immediate needs that must be addressed before the next session or in the next session such as client homework. This is a good way to communicate to other providers involved in the care. It is helpful to know the next steps needed. An example is, “will refer client to peer support group.”

**CONFIDENTIALITY**

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

- Do not write another client’s name (e.g. classmate or peer) in any other client’s chart.
- Names of family members/support persons should be recorded only when needed to complete assessment, registration and financial documents.
- On progress notes and most assessments, refer to the relationship - mother, husband, friend, but do not use names.
- Use a first name or initials of another person only when needed for clarification.
- Be judicious in entering any mental health diagnosis reported by a parent/spouse/other about themselves or family members/support persons. Usually, this will appear in the assessment (indicate “reported by...”).

**INTERACTION/PROGRESS NOTES**

**Importance of Treatment Plan Awareness!**

- Be aware of the Treatment Plan BEFORE the session and know what Goal(s) and/or Objectives you plan to work on with client/family.
- Your plan may need to change but you should have a plan.
- Focusing on the Treatment Plan reinforces the value of the Plan.
- If the plan becomes irrelevant, change it.

**Interventions/Interactions**

**How Are You Doing?**

- When you ask, “How are you doing?” people will generally answer the question “How is the world treating you?”
- This can often move the focus of a session to a discussion of recent events, mini crises, etc. (meandering with the client).
- By preparing for intervention you can keep the focus on “How are you doing?” (e.g., “How are you applying what you’ve learned to this new situation?”).

From Schmelter
Medical Necessity and the Golden Thread

Assessment Data:
- Diagnoses
- Strengths
- Personal Goals
- Assessed Needs

Treatment Plan Goals

Treatment Plan Objectives

Interventions and Services

Interactions Directed by Treatment Plan Recorded in Progress Notes

Person Centered Services:
Focus on the person/family in the context of their personal/life goals, individual strengths, unique barriers, etc.

Person Driven Services:
Involving the individual/family in directing the plan of care (developing, reviewing, updating treatment planning)

Where is the Golden Thread?

Assessing with the client
- Completing Assessment Form

Planning with the client
- Completing the Treatment Plan

Working with the client
- Writing Progress Notes

Golden Thread Shadow - Documentation Linkage (from B. Schmelter)
PROGRESS NOTE DETAILS

PROGRESS NOTE FIELDS

CLIENT NAME, ID NUMBER

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

LOCATION: Record where the service took place.

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

SERVICE DURATION (In Minutes): Record the amount of time spent for this service, in minutes. Include time spent in travel, providing the service, and documentation of the service. Give actual time to the minute; do not uniformly record 5-10-15 minute time periods. Separate into face-to-face & indirect time.

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

NOTE: Write the summary of the service that you provided. A format such as DIR-P (Data-objective info about client, Intervention, Response to intervention/progress toward goals, Plan-action plan between meetings e.g. client homework) is highly recommended.

CLINICIAN SIGNATURE

Your signature will attach to the note once you submit the progress note as final. As needed, obtain co-signature. (See “Scope of Practice” for more information.)

CO-PROVIDED SERVICES

When services are co-provided by two clinicians, the content of the notes must indicate the specific contributions of each clinician who participated in the provision of the service. Notes must include specific time of each provider’s involvement in the group including documentation time.

Both co-providers must have scope of practice eligibility to claim the service. For example, only another licensed clinician may be a co-provider on a group therapy note.

Each provider’s involvement shall document how service addressed mental health needs of the client. See MHSUD Info Notice 18-002.

Frequency of Progress Notes

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

- Assessment
- Individual and Family Therapy
- Group Services
- Collateral
- Rehabilitation or Intensive Home Based Services (“Katie A” services)
- Medication Support Services
- Crisis Intervention
- Plan Development
- Case Management or Intensive Care Coordination (“Katie A” services)
- Crisis Residential (Daily Note)
- 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)

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 role of the professional for example: Social Worker, Probation Officer etc.

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 – Use relationship of family member; parent, sibling etc. Limit what you say about family members. It is not their chart. Describe type of support person, i.e., coach or CASA worker.

When the Service Involves Two or more Clients Who Are Also Family Members - Write a note for each & split the time accordingly.
NON-REIMBURSABLE SERVICES

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

SERVICES THAT ARE NOT BILLABLE

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

- Reviewing a chart for assignment of therapist.
- Any documentation after client is deceased.
- Preparing documents for court testimony.
- Listening to or leaving voicemail or email message.
- Mandated reporting such as CPS or APS reports.
- No service provided: Missed visit. Waiting for a “no show”. Documenting that a client missed an appointment. Traveling to a site when no service is provided due to a “no show”. Leaving a note on the door of a client or leaving 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 or transportation.
- Purely clerical activities (faxing, copying, calling to reschedule appointment, etc.)
- Recreation or general play.
- Socialization - generalized social activities which do not provide individualized feedback.
- Academic/Educational services- actually teaching math or reading, etc.
- Vocational services which have, as a purpose, actual work or work training.
- Multiple Staff in Case Conference: Only staff directly involved in the client’s care may claim for their services, and each staff member’s unique contribution to the meeting must be clearly noted.
- Supervision: Supervision of clinical staff or trainees is not reimbursable. Reviewing and amending/updating the treatment plan with a supervisor is reimbursable.
- Utilization management, peer review, or other quality improvement activities.
- Interpretation/Translation only.

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:

Meeting with the client at a community college 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 Peer Drop-In Center and debriefing his/her visit is reimbursable.

Teaching the individual how to use a computer is not reimbursable.

Vocational Situations:

Visiting the client’s job site to teach him/her how to flip hamburgers is not reimbursable.

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

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

Multiple Staff in Case Conference:

Team meeting discussions of clients are non-billable. IEP discussions of care may be claimable providing each staff has unique contribution clearly noted.

Supervision:

Supervision of clinical staff or trainees is not reimbursable.

Reviewing and amending/updating the treatment plan with a supervisor is reimbursable.
## LOCKOUTS & OTHER LIMITATIONS

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**L** Lockout

**A** Lockout except for day of admission

**P** Placement services only within 30 days prior to discharge

**T** This is only a Lockout for the same day treatment/day rehab staff during the day treatment/rehab programs hours of operation. Day Treatment/Day Rehab staff may not bill for Mental Health Services 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
**BLOCK BILLING BY USING NON-BILLABLE SERVICE CODES**

All staff must understand how services are claimed and know that some services are not claimable. Non-Reimbursable codes block the service from being billed. Location is where the client is. Progress notes entered into the medical record result in claims for service unless a non-billable service is selected.

**NON-BILLABLE SERVICES**

**DIRECT CLIENT CARE**

**UNCLAIMABLE** means services provided to clients and their families that are not claimable to Medi-Cal. These services are meant to include the wide variety of potential services deemed to be necessary to recovery and resiliency but that are not reimbursable to Medi-Cal 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 can be documented by all members of the clinical teams working with clients.

- Transportation of client (without a service)
- Leaving or listening to voicemail messages and sending/receiving faxes, texts 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
- Writing a discharge note without client present
- Reviewing and preparing records for an authorized release
- Use service code M001 for non-billable services

**LOCATION LOCKOUTS**

The setting in which an individual resides may make services non-reimbursable.

- **IMD** (Client’s location – Block Billing)

- **JAIL/JUVENILE HALL** (Client’s location – Block Billing)

- **PSYCHIATRIC HOSPITAL** (Client’s location – Block Billing unless Case Management for placement)

- **SKILLED NURSING FACILITY – PSYCH** (Client’s location – Block Billing)

**SEE LOCK-OUT GRID**
MENTAL HEALTH SERVICES

Services provided by the MHP are designed to improve behavioral health outcomes for clients and families with 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 his/her 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 his/her desired goals.

Mental Health Services are those individual, group, or family therapies and interventions that are designed to reduce mental health conditions 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/family’s goals and must be consistent with the current Client Treatment Plan. In this context, Mental Health Services is a term that includes the following services:

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

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

**Types of Mental Health Services**

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

**PROGRESS NOTES DESCRIBE:**

- People involved in the services and their role
- Goal/Behavior Addressed
- Interventions and Response
- Outcome of services
- Follow Up Plan (if needed)
<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>DESCRIPTION</th>
<th>EXAMPLES OF DOCUMENTATION IN NOTES</th>
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<tr>
<td><strong>ASSESSMENT-LPHA (M431)</strong></td>
<td>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 abuse, legal or other complicating factors. MSE and diagnosis.</td>
<td>Administered Mini-Mental Status Examination. Completed Annual Assessment.</td>
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<tr>
<td><strong>REHAB EVALUATION (M433)</strong></td>
<td>Evaluation by non-licensed staff based on personal/family history, mental health treatment, relevant medical, cultural, substance use, legal or other complicating issues.</td>
<td>Met with client and family to discuss history of mental health condition, previous treatment, social/family support system etc.</td>
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<tr>
<td><strong>PLAN DEVELOPMENT (M432)</strong></td>
<td>Development of client treatment plan Approval of client treatment plan Monitor the client’s progress towards goal accomplishment</td>
<td>Met with client to review Treatment Plan goals. Met with treatment team from group home to monitor client’s progress toward goals in program.</td>
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<tr>
<td><strong>COLLATERAL (WITH FAMILY M411/NON-FAMILY M412)</strong></td>
<td>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 of the client’s serious emotional disturbance.</td>
<td>Met with the father to help him understand and accept the client’s condition and involved him in treatment planning and provision of care. Met with teacher to insure client had classroom placement with few distractions.</td>
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<tr>
<td><strong>REHABILITATION (INDIVIDUAL M445/GROUP M455)</strong></td>
<td>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.</td>
<td>Helped client develop strategy for dealing with difficult roommate. Helped client prioritize activities to insure completion of ADL’s. Used role modeling to prepare for medical appointment s/he was over anxious about.</td>
</tr>
<tr>
<td><strong>INDIVIDUAL THERAPY M441 (GROUP THERAPY M451)</strong></td>
<td>Therapeutic interventions consistent with client’s goals and which focus primarily on symptom reduction in order to improve functioning.</td>
<td>Reviewed homework assigned in Cognitive Behavioral Therapy with client.</td>
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<tr>
<td><strong>INDIVIDUAL THERAPY WITH FAMILY (M442)</strong></td>
<td>Therapy/Rehab counseling directed toward the family system in which the client is present with at least one or more family members or significant support persons.</td>
<td>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.</td>
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<tr>
<td><strong>INDIVIDUAL REHAB WITH FAMILY (M448)</strong></td>
<td>Unplanned event that results in client’s need for immediate intervention. If untreated, presents an immediate threat to client or others.</td>
<td>Assessed acuity of symptoms, coordinated 5150 process. Assessed intent/plan for self-harm. Client denies plan and agrees to go to Crisis Res.</td>
</tr>
<tr>
<td><strong>CRISIS INTERVENTION M471)</strong></td>
<td>Identification and pursuit of resources necessary for the client to access service and treatment. Discharge planning and Placement services.</td>
<td>Coordinated placement with conservator to Adult Residential Treatment facility. Made a referral/called providers of needed service to determine availability &amp; necessary qualifications for teen group.</td>
</tr>
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</table>
MENTAL HEALTH SERVICES

ASSESSMENT

This service code is used to document the clinical analysis of the history and status of the individual’s mental, emotional, or behavioral condition. It includes appraisal of the individual’s functioning in the community such as living situation, daily activities, social support systems, and health history.

Assessment includes screening for substance use, establishing diagnoses and may include the use of testing procedures. Although assessment/evaluation services can be provided by any staff member, the mental status examination, diagnosis, psychological testing must be completed by a clinician consistent with his/her scope of practice. (See “Admission Assessment” and “Scope of Practice.”)

- All mental health services to gather information and complete both the admission assessment and the annual assessment update should be coded as assessment (or rehab evaluation for non-licensed waivered/registered staff).

- 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.

PLAN DEVELOPMENT

This service code is used to document the development of client treatment plans, approval of treatment plans, and/or monitoring of the clients’ progress related to the client treatment plan. Plan Development may be claimed by any clinical staff person. Plan development includes:

- Monitoring progress to evaluate if the client treatment plan needs modification.

- Monitoring progress requires a description of contact with client, significant support person(s) such as parent or other caregiver, to elicit their evaluation of client’s progress toward achieving their treatment plan goals.

Plan Development is expected to be provided during the development/approval of the initial treatment plan and subsequent treatment plans. However, Plan Development can be provided at other times, as clinically indicated. For example, when the client’s status changes (i.e., significant improvement or deterioration) and there may be a need to update the treatment plan.

Plan Development is reserved for clinical activities explicitly referenced in the Client Treatment Plan, safety plan, and other treatment planning.

A PLAN DEVELOPMENT PROGRESS NOTE DESCRIBES:
- Developing
- Approving
- Modifying
- client treatment plan or
- Monitoring treatment

PROGRESS NOTES DESCRIBE:
- People involved in the services and their role
- Interventions
- Outcomes
- Follow Up Plan (if needed)
MENTAL HEALTH SERVICES

REHABILITATION

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

Rehabilitation includes:

• Assistance in skill building to improve, maintain, or restore functional skills, daily living skills, social and leisure skills, personal hygiene skills and support resources.

• Counseling of the client or group as well as client and family including providing education/skills training aimed at helping individuals achieve their goals in various life domains.

COLLATERAL

This service code is used to document contact with any significant support person in the life of the client (e.g., family members, caregivers), with the intent of improving or maintaining the mental health of the beneficiary.

A significant support person is defined as someone who has/could have a significant role in the successful outcome of treatment, including but not limited to parents, legal guardian of a minor, person’s spouse or relatives of the beneficiary.

Collateral may include helping significant support persons understand and accept the client’s condition and involving them in planning and provision of care.

Collateral includes but may not be limited to:

• 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 of the client’s serious emotional disturbance.

• The client may or may not be present during service provision.

A COLLABORATIVE PROGRESS NOTE DESCRIBES:

Helping the significant support persons understand and accept the client’s condition and involving them in planning and provision of care.

COLLABORATIVE PROGRESS NOTES DESCRIBE:

• People involved in the services and their role

• Training/Counseling provided to the Significant Support Person

• How the Client’s Behavior/Mental Health Goals were Addressed

• Response to the Mental Health Interventions

• Follow Up Plan (if needed)
MENTAL HEALTH SERVICES

THERAPY

This service 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 or group.

Therapy services can only be provided by clinicians consistent with their scope of practice as follows: licensed psychiatrist, psychologist, LCSW, MFT, LPCC, registered Associate MFT, ASW or Associate PCC, waivered psychologist. (See Scope of Practice grid.)

INDIVIDUAL THERAPY WITH FAMILY

This service code is used to document therapy services, focused on the care and management of the client’s mental health condition within the family system, provided when a client and one or more family/significant support persons are present.

Therapy services can only be provided by clinicians consistent with their scope of practice as follows: licensed psychiatrist, psychologist, LCSW, MFT, LPCC, registered Associate MFT, ASW, Associate PCC, waivered psychologist. (See Scope of Practice grid.)

PROGRESS NOTES

DESCRIBE:

• People involved in the services and their role
• Behavior/mental status/presentation or symptoms
• How the service assists the client in improving/maintaining functioning
• The mental health interventions utilized and client's response
CRISIS INTERVENTION

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

Crisis Intervention 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.

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, evaluated for inpatient care.

- **Gravely disabled client/current danger to self** - provided therapeutic responses to stabilize crisis, evaluated for placement including inpatient care.

- **Client is an imminent danger to self/others** - was having a severe reaction to current stressors, developed Safety Plan, refer to Crisis Stabilization Program.

  Provided collateral services to the client's significant support person(s) involved in crisis 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 interventions used, and the client’s response and the overall outcome as well as any follow-up plans.

AN EXCELLENT CRISIS INTERVENTION PROGRESS NOTE contains a clear description of the crisis that distinguishes the situation from a more routine event, plus describes the clinician’s interventions to help stabilize the client’s situation.

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
CASE MANAGEMENT

Case Management (CM) is a service that assists 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 service and service delivery; monitoring of the client’s progress once he/she receives access to services; and development of the plan for accessing services. When CM services will be provided to support a client to reach their goals, it must be listed as an intervention on the client treatment plan.

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

- Inter-agency communication, coordination and referral.
- Monitoring service delivery to ensure an individual’s access to service and the service delivery system.
- Linkage, brokerage services focused on housing, education, training.

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

- Locating and securing an appropriate therapeutic living environment.
- Negotiation of housing or placement behavioral contracts.
- Placement and placement follow-up activities.
- Accessing services necessary to secure placement.

Institutional Reimbursement Limitations Case Management is billable when a client is in a psychiatric hospital for the following purpose ONLY:

- 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.

No other services may be claimed for clients in an acute psychiatric facility.
**ICC & IHBS**

Intensive Care Coordination and Intensive Home Based Services are provided through the EPSDT benefit to all children and youth who:
- Are under the age of 21
- Are eligible for the full scope of Medi-Cal services
- Meet medical necessity criteria for these Specialty Mental Health Services (SMHS) as set forth in CCR, Title 9, Section 1830.205 or Section 1830.210. Membership in Katie A. subclass is not a prerequisite for receiving ICC and IHBS. These services are appropriate for children and youth with more intensive needs or who are in or at risk of placement in residential or hospital settings, but who could be effectively served in the home and community.

Target Population and services are described in the current DHCS/DSS Medi-Cal Manual for ICC, IHBS and Therapeutic Foster Care.

**INTENSIVE CARE COORDINATION**

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

- ICC 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.

- 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**

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.

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

**EXCLUSIONS**

Intensive Home Based Services (IHBS) may not be provided at the same time as Day Treatment Rehabilitative or Day Treatment Intensive, Group Therapy and Therapeutic Behavioral Services (TBS).
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. One or more clinicians may provide these services, and the total time for intervention and documentation for all clinicians may be claimed (only 2 staff may be claimed). A varying amount of time may be claimed for each clinician. The time expended for each group needs to 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. That is, if the group is Therapy all group co-facilitators must be able to provide therapy.

All members of the group must be current clients of the County or of a contractor providing the service. The notes must indicate number of group members and length of time for the group. Each staff writes and signs/finalizes their own note. A number of group services that vary based on the primary focus of activities and interventions may be provided:

Group Rehabilitation: Groups focused on psycho-social rehabilitation.

Group Therapy: Groups focused primarily on symptom reduction in order to improve functionality and minimize impairments.

Family Therapy: Services focused on enhancing the family’s ability to address the client’s/youth’s mental health needs. Provided to parents or other caregivers in the life of clients. Family therapy assists members with the development of skills that are needed to specifically address clients’ mental health issues. Client must be present at the therapy session. All documentation will be in the chart of the client receiving services.

Group Documentation:

- Group Progress notes are documented using the Group Progress Note.
- Include group member count and time duration of group.
- Indicate only the clients present, not all the clients normally enrolled in the group.
- Co-facilitator who participated in the group must write their own note describing their contribution to the group service.
- Indicate how much total time each facilitator spent in the group and any documentation/travel time.
- Facilitators may spend unequal times with the group.
- Indicate the overall group focus in each note. Then document the client’s participation. Address behaviors/goals, interventions, responses, and plan.

Example Calculation:

Set of Facts:
- Group: 100 minutes
- Providers: 2
- Participants: 10
- Provider 1: provides 100 minutes of a covered service
- Provider 2: provides 60 minutes of a covered service

Method: Divide each provider’s minutes providing a covered service by the number of group participants.
- Provider 1: 100/10 = 10
- Provider 2: 60/10 = 6

Result:
- Provider 1 would bill 10 minutes per Medi-Cal client
- Provider 2 would bill 6 minutes per Medi-Cal client.

MHSUDS Info Notice: 17-040

Coding Examples:

- Rehabilitation Group-dealing with stress/anxiety in social situations, mood disorders resulting in social isolation etc.
- Therapy Groups-DBT, Cognitive Behavioral Groups, Trauma Focused Therapy to address specific symptoms/ maladaptive behaviors, etc.
AUTHORIZATION REQUIREMENTS

The DHCS/MHP contract requires mental health plans to establish payment authorization systems for Day Treatment Intensive and Day Rehabilitation. MHP’s must require providers to request MHP payment authorization for Day Rehabilitation at least every six months and 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.

Requests for authorization and reauthorization of Day Treatment services and certain contracted outpatient mental health services shall be submitted to the MHP. If subsequent services are warranted, authorizations must be submitted every 3 months for DTI and every 6 months for DR. Requests must be complete and signed in order to prevent delays in authorization.

Contract agencies should consult their contract and/or MHP Liaison.
A key component of Day Treatment and Day Rehabilitation is contact with the client’s families at least once a month. All contact with families/support persons should be documented in the chart.

** DOCUMENTATION  
- For Day Rehabilitation, clinicians must provide a weekly summary. 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. Further, every service contact will be documented for any authorized mental health service.

- The weekly summary can only be signed by one of the following staff: Physician; Licensed, registered, waived, psychologist, clinical social worker, MFT, LPCC; Registered Nurse.

** THE BILLING UNIT  
- The Billing Unit is Half Day or Full Day of program time. The provider must keep an attendance log that verifies the hours of attendance.

- Services in Half Day programs must be available at least three hours each day the program is open. The client must attend more than one-half the day treatment day in order for the provider to claim for services.

- Full Day programs must have services available for over four hours each day. The client must attend at least one-half the day treatment day in order for the provider to claim for day treatment services.

- Individual Therapy is an included 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.

- Day Treatment programs may provide only one Full Day, or two Half Days, of Day Rehabilitation services daily.

- A client may not attend two Half Day programs on the same day.

Contract agencies should consult their contract and/or MHP Liaison.
Therapeutic Behavioral Services (TBS) are one-to-one therapeutic contacts between a mental health provider and a beneficiary for a specified period of time that are designed to maintain the child/youth’s 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 the behavior(s) or symptom(s) that act as barriers to achieving the lowest appropriate level of care. These activities should be claimed using the TBS Mode of Service (58).

Any Care Coordinator, family member or legal guardian associated with the client can request TBS services. The Coordinator will present the request to their supervisor with TBS Checklist and Referral for TBS Service Form. All referrals will be submitted to the TBS Coordinator to ensure request meets medical necessity criteria. The TBS Coordinator will then initiate services as appropriate.

The person providing TBS must be available on-site 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 depending upon the needs of the child/youth. TBS in excess of 20 hours per week needs to be reported to the TBS Coordinator.

- **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 that are the focus of treatment and the interventions that will be used to address the target behaviors.

TBS must be identified as an intervention by the primary therapist. TBS is not a stand-alone service.

For additional information contract agencies should consult their County Liaison.
TBS ELIGIBILITY

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 & 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 was 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 & 2.
1. The child/youth is receiving other specialty mental health services, and
2. It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of TBS that:
   • The child/youth will need to be placed in a higher level of residential care, including acute care, because of a change in the child/youth’s behaviors or symptoms which jeopardize continued placement in current facility; or
   • The child/youth needs this additional support to transition to a lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS is needed to stabilize the child in the new environment. (The MHP or its provider must docu-

REQUIREMENTS
TBS services must be authorized in accordance with the following timelines:
• Referrals from mental health service providers are reviewed by the County Supervisor for appropriateness. A completed TBS Checklist and TBS Referral Form must be included.
• The TBS Coordinator will authorize or deny TBS services within 3 working days. The TBS service provider will have up to 14 days after service initiation to complete a TBS assessment and Service Plan.
• The Care Coordinator must co-sign the TBS Service Plan within 30 days of TBS initiation.
• If TBS is required for extended periods of time, a new TBS Service Plan is required in the fourth month of TBS and every three months thereafter. The Coordinator must sign the TBS Service Plan renewal.
• For expedited authorization requests, the MHP will issue an authorization decision within 3 working days of receipt of an authorization request.

For additional information contract agencies should consult their County Liaison.
ADULT RESIDENTIAL TREATMENT SERVICES (TRANSITIONAL)

Adult Transitional Residential Treatment Services are rehabilitation services provided in a non-institutional, residential setting that supports 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. Medication Support Services shall be billed separately from Adult Residential Treatment Services.

**Weekly Summaries** by the residential staff are required and must be written, or co-signed, by a licensed/registered/waivered staff member.

**Outpatient Mental Health Services** follow standards for mental health services cited earlier in this manual.

**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.

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CRISIS STABILIZATION

Crisis Stabilization 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 program must be separate and distinct from services provided to clients in an Inpatient 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 in a 24-hour period, is 20 hours.

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CRISIS RESIDENTIAL TREATMENT SERVICES

Crisis Residential Treatment Services are therapeutic and/or rehabilitative services provided in a 24-hour residential treatment program (e.g., Telos) as an alternative to hospitalization for individuals experiencing an acute psychiatric episode or crisis, and 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.

**Note:** An individual admitted to Crisis Residential Treatment Services must receive a mental health and medical assessment, including a screening for medical complications which may contribute to his/her disability, within three days prior to or after admission.

**Service Activities** Service activities may include Assessment, Plan Development, Rehabilitation, Therapy, Group Therapy, Collateral, and Case Management. 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 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. Case Management Services may be claimed for a client receiving crisis residential services.
OTHER CHART DOCUMENTATION

TRANSFER/DISCHARGE

If you are discharging a client from your program and to all services (including meds) in your LE:

- Complete the Treatment/Discharge Summary Form.
- Write a progress note if the final contact involves billable services (termination session with client) or a non-billable progress note when client is not present (e.g. client drops out of service).
- Use code M401 (case management) for documenting any discharge referral provided to client/family or a rehab counseling/therapy code when client is present, and you are summarizing treatment goals & discussion of aftercare plan.
- Use Discharge Form to close the LE episode.

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

- Follow first two bullets as above and do the following;
- Use code M401 (Case Management) for documenting a transfer to different LE team/program.
- Notify the new LE you are transferring client to, that their team/program needs to update the Assessment.
SERVICE CODE & ELIGIBLE PROVIDERS

CO-SIGNATURE DHCS has clarified that a 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.
- Co-signing the work of unlicensed staff before the required education or experience for independent recording of services has been acquired.

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

- Co-signing a note to a service type that is outside of the scope of provider. For example, a service delivered by rehab staff is co-signed as a therapy note.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Eligible Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>M471 - Crisis Intervention</td>
<td>All clinical staff</td>
</tr>
<tr>
<td>M431 - Assessment including MSE &amp; Diagnosis</td>
<td>All licensed, registered, waived clinical staff.</td>
</tr>
<tr>
<td>M433 - Rehab Evaluation (without MSE &amp; Diagnosis)</td>
<td>Non-licensed/registered/waivered clinical staff.</td>
</tr>
<tr>
<td>M432 - Plan Development</td>
<td>All clinical staff</td>
</tr>
<tr>
<td>M445 - Individual Rehabilitation Services</td>
<td>All clinical staff</td>
</tr>
<tr>
<td>M455 - Group Rehabilitation Service</td>
<td>All clinical staff</td>
</tr>
<tr>
<td>M448 - Individual Rehab w/ Family</td>
<td>Intensive Home Based Services(Katie A) K-numerical codes indicate eligible providers same as M-Codes or NK for Non-Katie A</td>
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<tr>
<td>M441 - Individual Therapy</td>
<td>Licensed/registered/waivered staff.</td>
</tr>
<tr>
<td>M451 - Group Therapy</td>
<td>Intensive Home Based Services (Katie A) K-numerical codes indicate eligible providers same as M-Codes or NK for Non-Katie A</td>
</tr>
<tr>
<td>M411 - Collateral w/family</td>
<td>All clinical staff</td>
</tr>
<tr>
<td>M412 - Collateral w/ non-family</td>
<td>RN/NP/LPT/LVN</td>
</tr>
<tr>
<td>M464 - Nurse Medication Support</td>
<td>RN/NP/LPT/LVN</td>
</tr>
<tr>
<td>M463 - Nurse Medication Injection</td>
<td>Licensed/registered/waivered staff.</td>
</tr>
<tr>
<td>M442 - Individual Therapy w/Family</td>
<td>All clinical staff</td>
</tr>
<tr>
<td>M401 - Case Management</td>
<td>Intensive Care Coordination (Katie A) NK402 - ICC (Non-Katie A)</td>
</tr>
<tr>
<td>58 - TBS (Therapeutic Behavioral Services)</td>
<td>All clinical staff; staff not licensed/registered/waivered must be under the direction of LPHA</td>
</tr>
</tbody>
</table>
### STAFFING QUALIFICATIONS FOR SERVICE CODE

<table>
<thead>
<tr>
<th></th>
<th>May authorize services (ACCESS)</th>
<th>May direct services by either Signature on Client Plan</th>
<th>Supervision of staff providing service</th>
<th>May provide services and be client’s care coordinator</th>
<th>Needs to have co-signature of their Weekly Summaries Day Treatment**</th>
<th>Adult Residential</th>
<th>May provide: Mental Status Examination Diagnostic Information</th>
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<td>Physician</td>
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<td>LCSW</td>
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<td>MFT</td>
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<td>ASW/AMFT/APCC (post Master’s degree and registered with BBS)</td>
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<td>Intern, Psychologist (post PhD and DHCS waiver of licensure)</td>
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<td>RN with Master’s degree in Psychiatric/Mental Health Nursing</td>
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<td>LVN/LPT</td>
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<td>MHRS- MH related MA/MS + 2 yrs experience; BA/BS + 4 years experience in Mental Health</td>
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<td>Staff NOT MHRS or BA/BS in Mental Health field</td>
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*Under LPHA supervision ** Day Treatment Only ***Must have verification of Child/Family required coursework
## SCOPE OF PRACTICE

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<tr>
<th>Assessment</th>
<th>MD</th>
<th>Lic. or Waivered Psychologist</th>
<th>LCSW/ASW MFT/AMFT LPCC/APCC</th>
<th>RN with MS-MH Nursing</th>
<th>MH-NP</th>
<th>RN no MS MH Nursing</th>
<th>LVN or Licensed Psych Tech</th>
<th>MHRS</th>
<th>Staff NOT MHRS &amp; no BA/BS</th>
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^ Must be co-signed.

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

~ Unless approved by LPHA

MHRS – Staff with MA/MS + 2 years experience in MH setting or BA/BS + 4 years experience in MH setting