December 7, 2021

SANTA CRUZ COUNTY
BEHAVIORAL HEALTH SERVICES

Mental Health Plan

# DOCUMENTATION MANUAL

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 (FQHC Psychiatry and Therapy have additional requirements).

**How can I get help?**

After reviewing this manual, if you still have questions, please contact your supervisor.

If further clarification is needed, email AskQI and CC your supervisor:
**Ask.QI@santacruzcounty.us**

This Documentation Manual reflects MHP policy and is the source for all documentation issues in addition to MHSUDS/BH 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 via email: 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.*

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

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.

All documentation shall be signed and dated with discipline, license or with job class.

All planned services shall be based on a current assessment, updated annually. All charts must contain an initial assessment, and, as indicated, a current updated assessment.

All planned services shall be based on a current Treatment Plan, updated at least annually (see Client Treatment Plan.)

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 and date progress note was completed.

## ADMISSION DATE

The Admission date is the first date of claimed outpatient services for a "new" client opened to an Avatar Episode. A " new" client is any individual admitted for outpatient services for whom there is not a current outpatient treatment Avatar 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. One Assessment can be used by multiple Avatar Episodes if all are providing services concurrently. 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. However, urgent/crisis services may be provided prior and should be coded based on the service provided. Assessment, Plan Development and *Case Management [including Intensive Case Coordination (ICC)] may be claimed before the Treatment Plan is completed to ensure necessary referral and linkage to services.

* Unpanned Case Management services related to assessment, plan development, referral/linkage to services only.

## WHEN INDIVIDUALS WHO ARE ALREADY MHP CLIENTS BEGIN TO RECEIVE A NEW SERVICE

If a new service type is added for a client, **the new service provider** needs to complete a new Treatment Plan (example: client receiving med support and case management; therapy services added).

A client who is transferred from one team to another within an Avatar Episode does not need an updated treatment plan unless a new problem, goal, objective or intervention/ service is indicated, or annual update is due.

If the new service provider updates the treatment plan, they must ensure any other providers' problems, goals, objectives and interventions continue to be represented in the new treatment plan.

## CLIENT RETURNING FOR SERVICES

When a client returns to services after the episode has been **closed**, the client must be admitted with a new intake date to the Legal Entity (LE). Within 30 days of the new intake date, an Admission Assessment must be completed, **and** an Initial 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 Legal Entity (LE), the new provider must complete a treatment plan within 60 days of opening to their Legal Entity (LE).
- Assessment updated annually.
- The Treatment Plan must be updated annually prior to the 12-month anniversary of LPHA signature date for services to continue. It must also be updated when there are changes or updates to the client's clinical need.

# TIMELINES *State DHCS requires MHP to establish and observe timelines for documentation.*

| FORM | PURPOSE | SIGNATURES | DEADLINE | UPDATES DUE |
|---|---|---|---|---|
| **INITIAL PSYCHOSOCIAL ASSESSMENT** | Documents Client's:<br>• Presenting Problem<br>• Strengths<br>• Current Resources/Living Situation Family/Relationship Issues<br>• Psychiatric & Medical history including medications /allergies<br>• Trauma history<br><br>• **Risk Assessment** if needed<br>• Substance Use history & current pattern of use<br>• Past/present victim/ perpetrator of abuse and or violence<br>• Vocational & Educational History<br>• Outside Provider Involvement<br><br>(Don't forget **Mental Status Exam** and **Diagnosis**- see below) | • Provider who gathered assessment information.<br>• Authorized clinical staff | Within 30 days of admission date | Dated and signed updates must be performed at least annually, and when clinically indicated. |
| **ANNUAL PSYCHOSOCIAL ASSESSMENT** | • Reviews previous Assessment(s)<br>• Provides current status | • Provider who gathered assessment information.<br>• Co-signature (as necessary) | Annually, and when clinically indicated. | Annually, and when clinically indicated |
| **MENTAL STATUS EXAM/ DIAGNOSIS** | Elements of the Assessment (Initial and Updates) | • Licensed/registered/ waivered professionals | Within 30 days of admission date | Annually, and when clinically indicated |
| **CANSA** | Structured assessment for identifying the client and family actionable needs and useful strengths. | • Provider who collaborated with client/family to identify needs/strengths. | Within 60 days of admission date | Every six-months, and at the end of treatment |
| **PCS-35 (Minors ages 3-18)** | Caregiver screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems. | • Provider enters information as gathered by parent/caregiver | Within 30 days of admission date | Every six-months, and at the end of treatment |
| **CLIENT TREATMENT PLAN** | • Describes goals related to problem(s)/ functional impairment(s).<br>• Has specific, observable, quantifiable (measurable) objectives with baselines.<br>• Identifies the proposed of intervention(s), consistent with the goals/objectives.<br>• Has a proposed duration & frequency of the intervention(s) to address problem.<br>• Is consistent with the diagnosis. | • Client /Legal Guardian<br>• Staff member(s) providing services/ (author)<br>• One of following if staff member providing service is not LPHA:<br>○ MD<br>○ Psychologist/waivered LCSW/registered MFT/registered LPCC/registered Nurse Practitioner | Within 60 days of admission date. | Within 12 months of the LPHA signature date. May be revised at any time which can change LPHA signatur e date. |

**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 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**

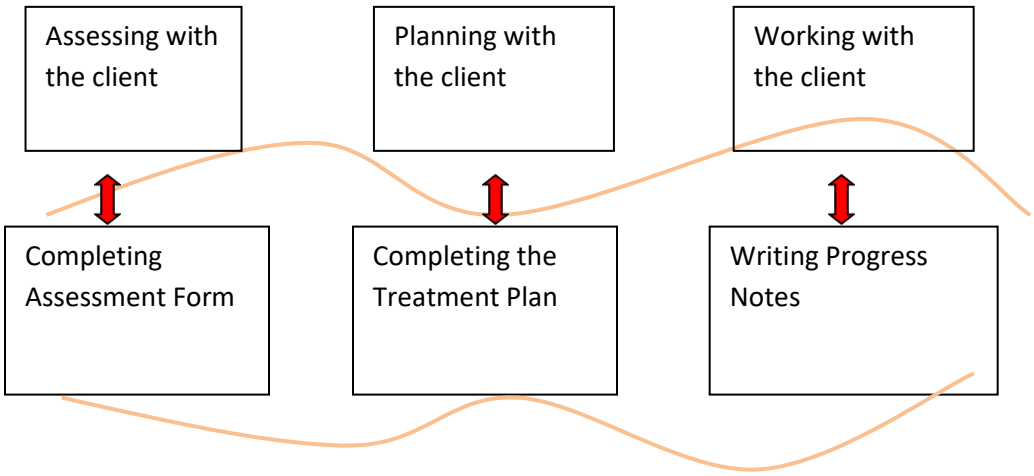
## Person Centered Services:

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?




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

# 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 most recent applicable MHSUDS/BH Information Notice listing current included diagnoses. 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.

# DIAGNOSIS & MENTAL STATUS

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 the most recent applicable MHSUD/BH Information Notice 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 updated at any time during the course of treatment and must be reviewed and updated annually along with other elements of the assessment by the above-mentioned licensed / waivered staff.

# 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:

1) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information.

2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.

3) History of trauma or exposure to trauma

4) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions.

5) Medical History, including:

   a) Relevant physical health conditions reported by the beneficiary or a significant support person.

   b) Name and address of current source of medical treatment.

   c) For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history.

6) Medications, including:

   a) Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment.

   b) Documentation of the absence or presence of allergies or adverse reactions to medications.

   c) Documentation of informed consent for medications.

7) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.

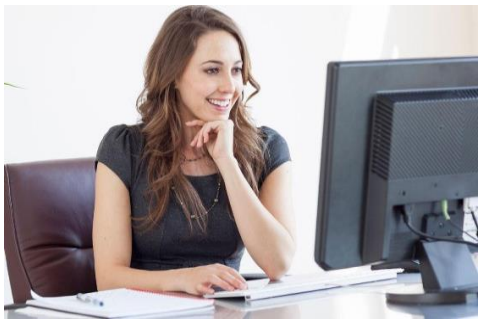
8) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).

9) Risks. Situations that present a risk to the beneficiary and others, including past or current trauma.

10) Mental Status Examination

11) A Complete Diagnosis. A diagnosis from the current ICD-code that is consistent with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis.

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 conditions that continues to meet medical necessity criteria. Only the diagnosis and MSE requires signature of LPHA who completed these tasks.

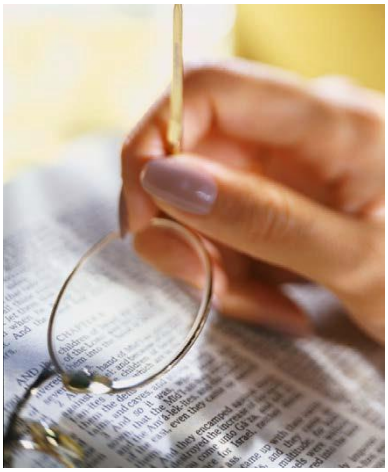
**Updates that occur at times other than during the annual renewal period do not affect the requirement for an annual update. Updates can be documented in a progress note. Annual Assessment Updates will be completed on the Psychosocial Assessment form along with updates to MSE and Diagnosis.**

# 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 Legal Entity (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 psychosocial 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

Staff should ensure a current comprehensive assessment is present in all client records annually. All assessment components are required as part of the assessment update, including a current MSE and diagnosis.

### 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 Legal Entity (LE). Annual Assessment Updates are required of contractors if client is closed to county Legal Entity (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**

# The CANSA (CANS + ANSA)

The Child and Adolescent Needs and Strengths (CANS) & Adults Needs and Strengths Assessment (ANSA) is a multiple purpose information integration tool that is designed to be the output of an assessment process.

**Timeliness:** The CANSA is completed **during the initial assessment** period and **every six-months** after, **or when significant clinical change** necessitates an update, and **at the end of treatment**.

The purpose of the CANSA is to accurately represent the shared vision of the child/youth/adult serving system—individuals and families. As such, completion of the CANSA is accomplished in collaboration with the client/family in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANSA is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the CANSA.

**DEFINING CANSA:** Although technically the CANS and ANSA are two different tools, in the spirit of integration and the fact that the majority of the tool and its intention is the same, as a county we have decided to call our tool CANSA.

SIX KEY PRINCIPLES OF THE CANSA

1. **Items were selected because they are each relevant to service/treatment planning.** An item exists because it might lead you down a different pathway in terms of planning actions.
2. **Each item uses a 4-level rating system designed to translate immediately into action levels.** Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. **Rating should describe the client, not the client in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an "actionable" need (i.e. '2' or '3').
4. **Culture and development should be considered prior to establishing the action levels.** Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the client's developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child but would be for an older youth or adult regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the child/youth's developmental age.
5. **The ratings are generally "agnostic as to etiology".** In other words, this is a descriptive tool; it is about the "what" not the "why." While most items are purely descriptive, there are a few items that consider cause and effect; see individual item descriptions for details on when the "why" is considered in rating these items.
6. **A 30-day window is used for ratings in order to make sure assessments stay "fresh" and relevant to the client's present circumstances.** However, the action levels can be used to over-ride the 30-day rating period.

**RATING NEEDS & STRENGTHS**

Each CANSA rating suggests different pathways for service planning. There are four levels of rating for each item with specific anchored definitions. These item level definitions, however, are designed to translate into the following action levels (separate for needs and strengths):

*Basic Design for Rating Needs*

| Rating | Level of Need | Appropriate Action |
|---|---|---|
| 0 | No evidence of need | No action needed |
| 1 | Significant history or possible need that is not interfering with functioning | Watchful waiting/prevention/additional assessment |
| 2 | Need interferes with functioning | Action/intervention required |
| 3 | Need is dangerous or disabling | Immediate action/Intensive action required |

*Basic Design for Rating Strengths*

| Rating | Level of Strength | Appropriate Action |
|---|---|---|
| 0 | Centerpiece strength | Central to planning |
| 1 | Strength present | Useful in planning |
| 2 | Identified strength | Build or develop strength |
| 3 | No strength identified | Strength creation or identification may be indicated |

# PSC-35

# PSC-35

The PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

**Timeliness:** The PCS-35 is completed **during the initial assessment** period, **every six-months** after, and **at the end of treatment**.

Parents/caregivers complete the PSC-35 for their children ages 3 and youth up to age 18 and clinician enter the infarction into Avatar. The information provided by the parent/caregiver is used in conjunction with psychosocial information gathered and the CANS to provide information for assessment of client functioning.

# 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.

*Every person must have an individualized Treatment Plan within 60 days of Admission*

## 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 (interventions) that will be provided. The treatment plan must be provided in the client's/family's preferred language, in addition to English (if preferred language is not English).

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 documenting the date a copy of the plan was offered 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 client's families as full participants in their own recovery process.

## SIGNATURES

The client and/or parent/ guardian are expected to sign the plan. If a client refuses, or is unavailable to sign, the situation must be documented in the treatment plan and in a progress note. The client must 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 ongoing 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 signed/finalized by one of the following LPHA's: Licensed Psychiatrist, Licensed/ Waivered Clinical Psychologist; Licensed/Registered Clinical Social Worker, Marriage and Family Therapist, or Professional Clinical Counselor; or Nurse Practitioner.

## TIMELINES

The initial Treatment Plan is due within 60 days of Admission to the Legal Entity (LE) or program of service. Treatment Plan(s) are renewed at least every 12-months from LPHA signature date (note differing timeliness for TELOS, EDC, and STRTPs). If intervention duration is less than 12-months, the Treatment Plan must be renewed when the Interventions are expiring (e.g. 3/6/9-months).
The Treatment Plan can be revised at any time. It must have a new client/guardian signature and dated LPHA signature when updated. The Treatment Plan must be updated prior to the 12-month anniversary of LPHA signature date.

**NOTE:** Only Crisis, Assessment (including Rehab Evaluation), Case Management***** (includes ICC) and Plan Development services may be provided prior to Treatment Plan completion.

***** Unplanned Case Management services related to assessment, plan development, referral/linkage to services only.

### TRAITS OF EFFECTIVE CLIENT TREATMENT PLANS

- Both the client and provider agree on the conditions that indicate when a goal is met.
- Accessible: The Plan is provided in both English and the client/family preferred language.
- 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.

# CLIENT TREATMENT PLAN PARTS

## SERVICE STRATEGIES -*Broad categories describing an underlying concept or fundamental approach by a team or program.* A ser- vice 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 ser- vices, 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 ap- propriate 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 ser- vices should promote a wellness philosophy including concepts of recovery and resiliency.

| Broad Goals | Examples of Specific Goals and Objectives |
|---|---|
| Improve problem solving | Will use behavior management skills learnt in therapy, reporting decrease in conflicts with peers to no more than 2 per month. Baseline: Has conflicts with peers 10x per month. |
| Increase socialization | Will attend one social function a week for three consecutive weeks. Baseline: Does not attend social functions |
| Increase independence | Will use motivation strategies to attend school as evidenced by getting ready for school and not being late to class for 5 consecutive days. Baseline: 2 consecutive days. |
| Improve personal hygiene | Will bathe, brush teeth daily w/out being reminded for three days/week, then gradually increase to seven days/week. Baseline 1 day per week. |
| Improve emotional regulation | Utilizing positive self-regulation skills, will decrease self-injurious behaviors, such as cutting to no more than 5X month. Baseline 13 times per month. |
| Increase activity to improve depressive behavior | Will use Behavioral Activation Activity Diary daily to track changes in activity levels by completing diary 6/7 days per week (Baseline 0/7). Will engage in one activity outside the house daily 3/7 days per week; to be tracked through Behavioral Activation Activity Diary entries. Baseline: participates in one activity outside the house 1/7 days per week. |

# 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 their 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 SNOMED Problem Codes.

**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 must be specific, observable, quantifiable with baselines and 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 <u>all</u> 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 <u>not</u> 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 and Intensive Care Coordination, must be listed on the treatment plan to avoid service disallowance. If an intervention is added in the course of treatment, the Treatment Plan must be updated.

**FREQUENCY OF INTERVENTION -** Interventions require a frequency of services included on the Treatment Plan (ex: 1x/week). The frequency must be specific and items such as "as needed", "at least", or "at a minimum of", are not allowed. Interventions not delivered in the course of treatment require documentation of explanation why service was not provided.

**DURATION OF INTERVENTION - ***Usually this will be 12 months, but may be 3, 6, or 9 months if appropriate. ***If the interventions are authorized for a duration less than 12 moths, the Treatment Plan must be renewed before the Interventions expire (i.e., 3/6/9-months).***
*Except for Telos & EDC Res and STRTPs

**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 use at least 2 actions weekly to not listen to the voices. Baseline: Uses 0 distracting actions

Will have at least one friendly talk with peers daily within 3 months and 3 times daily within 12 months. Baseline: 0

**Examples of Interventions:**

Rehabilitation counseling weekly to increase motivation while performing ADL's. (1 year)

Case Management services monthly to monitor progress in Day service program. (6 months)

Individual therapy using CBT 1X week to decrease paranoia. (9 months)

Individual Therapy with Family using Systemic Family Therapy bi-weekly. (1 year)

# 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 their 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, page 29).

## 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 (typically no more than 10-15 minutes is claimed for note writing). **Notes written after 7 calendars days are late and must be recorded as "late entry" using a non-billable code.** First day of service is counted as day one (ex: service provided on Wednesday, note due by Tuesday). All days are counted, including holidays, vacation, etc.

## 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,
- progress toward goals or objectives,
- a description of significant changes in the client's status,
- the provider's intervention(s) directed at treatment plan Goals/Objectives,
- the client's response to the intervention(s),
- a plan for subsequent service.

Interventions must be within the provider's scope of practice.

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:

Client encounters, including relevant clinical decisions and interventions.

Referrals to community resources and other agencies.

Any changes to the Treatment Plan, goals, objectives and interventions.

Plan for follow-up care or discharge summary.

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.

# TIPS FOR WRITING PROGRESS NOTES

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, GOALS, INTERVENTIONS, RESPONSES, AND PLAN.

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

**PROGRESS NOTES DESCRIBE:** The **BEHAVIOR and GOAL(S)/OBJECTIVE(S) ADDRESSED.** Include observations, the client's self-report, and report from others. Do document reports made by others involved in the client's care if important clinical information. State that any information offered by a third party, such as a parent, was reported by that individual. Any information provided by the client should be noted as such. Remember that if it is not written, it did not happen. Be aware, you may be asked to describe your treatment 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."

Progress notes should be written as if an auditor will read the document. It should describe what you did to address issues described in the Treatment Plan. Notes should reflect medical necessity.

## 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, and when authorizing a treatment plan.
- 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 them- selves 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)/Objective(s) you plan to work on with client/family in that session.
- Your plan may need to change based on client presentation, 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 Bill 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. Any time spent with the person receiving the service (client, family, support person, etc.) is recorded as face-to-face time, including if on the phone or telehealth.

**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 DIRP:

- *Data/Presentation*-objective info about client/progress toward goals;
- *Intervention- what you the clinician do*;
- *Response* to intervention- client's response;
- *Plan*-action plan between meetings e.g., client homework) is required.

## 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, each clinician must write a note for the service to claim for the service. The content of the notes must indicate the specific contributions of each clinician who participated in the provision of the service. Notes must include, and may only claim for*, specific time of each provider's involvement in the service 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 Individual w/ Family Therapy
Group Services
Collateral Services
Rehabilitation Counseling
Intensive Home Based Services
Medication Support Services
Crisis Intervention
Plan Development
Case Management
Intensive Care Coordination
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.

*The full time of attendance at a CFT for a client they serve may be claimed by each clinician.

# NON-REIMBURSABLE SERVICES

All staff must understand how services are claimed and know that some services are not claimable. In other words, there may be times that you provide a necessary service that is not a reimbursable service and the service would be documented in a progress note with a non-billable code.

## 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 / sending or responding to email/text messaging**
- 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 re-schedule appointment, etc.)
- **Recreation** or general play
- **Socialization -** generalized social activities which do not provide individualized feedback and/or support the client in managing mental health symptoms.
- **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 as it pertains to improved functioning for the client.
- **Supervision:** Supervision of clinical staff or trainees **is not** reimbursable. Reviewing and amending/updating the treatment plan with a LPHA supervisor is reimbursable.
- **Utilization management, peer review, or other quality improvement activities.**
- **Interpretation/Transportation only**

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

**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 their 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 their 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 and is related to mental health needs.

# LOCKOUTS & OTHER LIMITATIONS

| | MH | Med Support * | Case Mgmt | Day Rehab | Day Tx | TBS | Adult Residential | Crisis Residential | Crisis Intervention ** | Crisis Stab *** | Psych Inpatient |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mental Health** | | | | T | T | | | A | | L | A |
| **Medication Support*** | | | | | | | | | | L | A |
| **Case Management or Intensive Care Coordination ("Katie A" services)** | | | | L | L | L | | | | | p |
| **Intensive Home Based Services ("Katie A" Services)** | | | | L | L | L | | A | | L | A |
| **Day Rehabilitation** | T | | | L | L | | | A | | L | A |
| **Day Treatment** | T | | | L | L | | | A | | L | A |
| **TBS** | | | | | | | L | A | | | A |
| **Adult Residential** | | | | | | L | L | L | | L | A |
| **Crisis Residential** | A | | | A | A | A | L | L | A | L | A |
| **Crisis Intervention**** | | | | | | | | A | | L | A |
| **Crisis Stabilization ***** | L | L | | L | T | | T | L | L | L | A |
| **Psych Inpatient** | A | A | P | A | A | A | A | A | A | A | L |

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

Note: STRTPs are not lockout locations.

# NON-BILLABLE SERVICE CODES /LOCATIONS

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. Progress notes entered into the medical record result in claims for service unless a non-billable service code is selected.

If the client is in a lock-out location, all services will be non-billable (note exceptions on prior table above).

## 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. Non-billable service codes (M001, M645,M631, etc.) must be used for non-billable services.

- 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 (such as shelter for the minor client's family)
- 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

## LOCATION LOCKOUTS

The setting in which an individual resides may make services non-reimbursable.
Providers may **not** bill for services when the individual is residing at the following locations:

- **IMD (Institute for Mental Disease)** (commonly known as locked residential care)
- **JAIL/JUVENILE HALL**
- **PSYCHIATRIC HOSPITAL** (unless Case Management for placement within 30-days of discharge)
- **LOCKED PSYCHIATRIC SNF (SKILLED NURSING FACILITY –PSYCH)**

**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 their own life, functional impairment(s), symptoms, disabilities, strengths, life conditions, cultural background, spirituality and rehabilitation readiness. Services are focused on achieving specific objectives to support the individual in accomplishing their desired goals.

Mental Health Services are individual, group, or family therapies and interventions designed to reduce mental health conditions, and/or facilitate improvement or maintenance of functioning consistent with the following: 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)**

# COMMON SERVICES WITH CODES

| SERVICE TYPE | DESCRIPTION | EXAMPLES OF DOCUMENTATION IN NOTES |
|---|---|---|
| **ASSESSMENT-LPHA (M431)** | The evaluation and analysis of a client's historic and current mental, emotional, and/or behavioral disorders. Review of any relevant family, cultural, medical, substance use, legal or other complicating factors. Always includes MSE and diagnosis. | Administered Mini-Mental Status Examination.<br><br>Completed Annual Assessment. |
| **REHAB EVALUATION (M433)** | Evaluation by non-licensed staff based on gathering personal/family history, mental health treatment history, relevant medical, cultural, substance use, legal or other complicating issues. | Met with client and family to discuss history of mental health condition, previous treatment, social/family support system etc. |
| **PLAN DEVELOPMENT (M432)** | Development of client treatment plan<br>Approval of client treatment plan<br>Monitor the client's progress towards goal accomplishment | Met with client to formulate Treatment Plan goals.<br>Met with treatment team from group home to monitor client's progress toward goals in program. |
| **COLLATERAL (WITH FAMILY M411/NON-FAMILY M412)** | Consultation and training of the significant sup port 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 and/or mental health challenges. | Met with the father to help him understand and accept the client's condition and involved him in treatment planning and provision of care.<br>Met with teacher to ensure client had classroom placement with few distractions. |
| **REHABILITATION COUNSELING (INDIVIDUAL M445/GROUP M455)** | Working with a client to develop skills that maintain and/or restore optimal functioning. Providing education/training to assist the client to achieve their personal goals in such areas as daily living skills, socialization, mood stabilization, resource utilization. | Helped client develop strategy for dealing with difficult roommate.<br>Helped client prioritize activities to ensure completion of ADL's.<br>Used role modeling to prepare for medical appointment s/he was over- anxious about. |
| **INDIVIDUAL THERAPY M441 (GROUP THERAPY M451)** | Therapeutic interventions consistent with client's goals and which focus primarily on symptom reduction in order to improve functioning. | Reviewed homework assigned in Cognitive Behavioral Therapy with client. |
| **INDIVIDUAL THERAPY WITH FAMILY (M442)**<br><br>**INDIVIDUAL REHAB WITH FAMILY (M448)** | 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. | Met with client and parents who reported using communication strategies to resolve conflict two times since the last meeting.<br>Met with client, siblings, and parents who reported high levels of conflict in the past week. |
| **CRISIS INTERVENTION M471)** | Unplanned event that results in client's need for immediate intervention. If untreated, presents an immediate threat to client or others. | Assessed acuity of symptoms, coordinated 5150 process. Assessed intent/plan for self-harm. Client denies plan and agrees to enter Crisis Residential treatment. |
| **CASEMANAGEMENT (M401)** | Identification and pursuit of resources necessary for the client to access service and treatment. Discharge planning and Placement services. | Coordinated placement with conservator to Adult Residential Treatment facility.<br>Made a referral/called providers of needed service to determine availability & necessary qualifications for teen group. |

# 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 and psychological testing must be completed by a clinician consistent with their 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/rehab evaluation.

## PLAN DEVELOPMENT

This service code is used to document the collaborative 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 and includes **monitoring progress** to evaluate if the client treatment plan needs modification.

Monitoring progress requires a description of contact with client and/or 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. Plan Development would be utilized when the client's status changes (i.e., significant improvement or deterioration) and there is 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, as identified by the client. The significant support person can include but is not limited to, parents, legal guardian of a minor, and spouse or relatives of the client.

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 COLLATERAL PROGRESS NOTE DESCRIBES:

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

### COLLATERAL 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**

# 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 who can benefit from psychotherapy. This service is delivered when it has been determined by the appropriately licensed / waivered staff that there is a reasonable expectation that therapy will support improvement in the beneficiary's level of functioning, or will prevent regression.

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

**Therapy services can only be provided by clinicians consistent with their scope of practice**.

## 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, LMFT, and 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, via telehealth or 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** – client 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 regarding 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 they receive 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 and 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 Only for placement services within thirty (30) calendar days immediately prior to the individual's discharge from the facility.

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

## A CASE MANAGEMENT PROGRESS NOTE DESCRIBES:

Communication, coordination, referral and monitoring the service delivery to ensure client access to services and service delivery as well as the development of the plan for accessing services.

## PROGRESS NOTES DESCRIBE:

- **People involved in the services and their role**
- **Describe planning/linking & coordinating activity**
- **The client's response and the outcomes**
- **Follow Up Plan**

# 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, it must be within the group co-facilitators scope of practice 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 the number of group members and length of time for the group. Each staff must write and sign/finalize 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 psychosocial rehabilitation.
- Group Therapy: Groups focused primarily on symptom reduction in order to improve functionality and minimize impairments.

Group Therapy with Family: 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 lives of clients. Group therapy with families assists members with the development of skills that are needed to specifically address clients' mental health issues. The client must be present at the therapy session. All documentation for the group service will be in the chart of the client receiving services.

**Co-Facilitation:**

Group Facilitators and co-facilitators must both be able to provide the type of service being claimed.

Co-facilitator must each write sperate notes for claiming, indicating their unique contribution.

**Coding Examples:**

Rehabilitation Group-focus is managing 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.

**Attendance Count:**

Groups with mixed attendance are those with both Santa Cruz County clients in the Avatar EHR and those not that are not Santa Cruz County clients. The group member count must include all attendees.

## Group Documentation:

Group Progress Notes:

- Are documented using the Group Progress Note.
- Include group member count and number of facilitators.
- Include a count of the total number of attendees.
- Indicate only the clients present, not all the clients normally enrolled in the group.
- Are written by both the facilitator and co-facilitator who provided the group service; each must write their own note describing their contribution to the group service. Co-facilitators may spend unequal time with the group.
- Indicate how much total time each facilitator spent in the group and any documentation/travel time.
- Indicate the overall group focus in each note. Then document the client's participation. Address behaviors/goals, interventions, responses, and plan.

# Intensive Support Services

Intensive Support Services include Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Foster Care (TFC). All beneficiaries under the age of 21 are provided clinical assessment for Intensive Support Services during the initial assessment, annually, and as clinically indicated.

Intensive Support 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.
- Meet specific eligibility criteria for the Target Population

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. These services are offered to beneficiaries who are identified as Katie A. subclass members however Katie A. subclass membership is not a prerequisite for receiving Intensive Support Services.

**ICC**

**Follows basic documentation rules for Case Management**

**IHBS**

**Follows basic documentation rules for Rehabilitation**

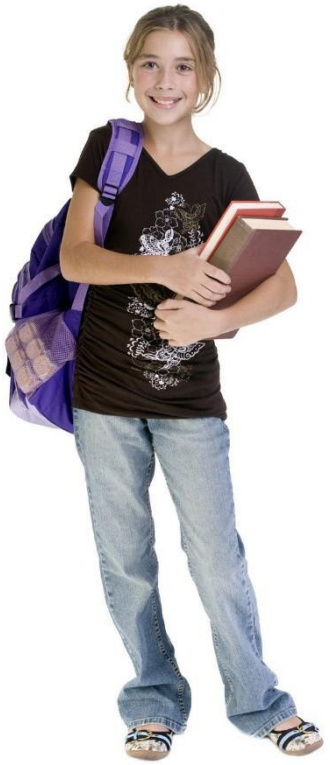
Target Population and services are described in the current DHCS/DSS Medi-Cal Manual for ICC, IHBS and TFC. Services are not stand alone.

IHBS and TFC require prior authorization before services are provide.

### INTENSIVE CARE COORDINATION (ICC)

ICC is assessment, care planning and coordination of services, including urgent services, and transition planning. It is claimed for 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 as Katie A. ICC.
- In addition, services provided to children/youth as part of the Child/ Family Team process are documented as ICC.



### INTENSIVE HOME-BASED SERVICES (IHBS)

IHBS is an intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and their 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

IHBS may not be provided at the same time as Day Treatment Rehabilitative or Day Treatment Intensive services, Group Therapy and/or Therapeutic Behavioral Services (TBS).

# THERAPEUTIC BEHAVIORAL SERVICES

**Therapeutic Behavioral Services (TBS) are one-to-one therapeutic contacts between a mental health provider and a beneficiary for a specified period of time 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**.

# DAY TREATMENT SERVICES

## AUTHORIZATION REQUIREMENTS

The DHCS/MHP contract requires mental health plans to establish payment authorization systems for Day Treatment In- tensive (DTI) and Day Rehabilitation (DR). 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.*

# DAY TREATMENT DOCUMENTATION

**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, waivered psychologist, clinical social worker, MFT, LPCC; Registered Nurse.

*Contract agencies should consult their contract and/or MHP Liaison.*

**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.

## ADULT RESIDENTIAL TREATMENT SERVICES (TRANSITIONAL)

Adult Transitional Residential Treatment Services (ARTS) are rehabilitation services provided in a non-institutional, residential setting that support clients in their efforts to restore, maintain, and apply interpersonal and in-dependent 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 ARTS shall be consistent with Section 531 of Title 9, California Code of Regulations.

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


### 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 pro-gram 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.**

CRTS and ARTS require Prior Authorization before services beginning, and Concurrent Review throughout the treatment process.

## CRISIS RESIDENTIAL TREATMENT SERVICES

Crisis Residential Treatment Services (CRTS) 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 avail- able 24 hours a day, seven days a week.

**Note:** An individual admitted to CRTS must receive a mental health and medical assessment, including a screening for medical complications which may contribute to their disability, within three days prior to or after admission.

**Service Activities** Service activities may include Assessment, Plan Development, Rehabilitation, Therapy, Group Therapy, Collateral, and/or 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**

• CRTS staffing ratios and qualifications shall be consistent with Section 531 of Title 9, California Code of Regulations.

• For staff who function both as Crisis Residential Treatment staff and in other capacities, staff time should be clearly documented & accounted for.

**Progress Notes**

CRTS 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.

# TRANSFER / DISCHARGE

**If you are discharging a client from your program, and the client is being discharge from <u>all</u> services (including psychiatry) in your Legal Entity (LE):**

a. Complete the Avatar Treatment/Discharge Summary Form.

b. Write a progress note if the final contact involves a billable services (termination session with aftercare planning) or a non-billable progress note when client is not present (e.g. client drops out of services).

c. Document Case Management for any discharge planning.

d. Use Avatar Discharge Form to close the Legal Entity (LE) episode.

**If you are discharging a client from your program, but they will start or continue to receive other services through your Legal Entity (LE) with a different team/program:**

- Follow steps a-c as above, and;
- Do not use the Discharge Form to close the Legal Entity (LE) episode.

**If you are discharging a client from your program <u>and</u> Legal Entity (LE) WHILE at the same time transferring the client to a different Legal Entity (LE) team/program:**

- Follow steps a-d as above, and;
- Notify the new Legal Entity (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 their 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 cannot be co-signed as a therapy note.

| Service Code | Eligible Providers |
|---|---|
| M471-Crisis Intervention | All clinical staff<br>*Non-MHRS see Scope of Practice table pg. 40 |
| M431-Assessment (including MSE & Diagnosis)<br><br>M433-Rehab Evaluation (without MSE & Diagnosis). | All licensed, registered, waivered clinical staff<br><br>Non-licensed/registered/waivered clinical staff |
| M432-Plan Development | All clinical staff |
| M445-Individual Rehabilitation Counseling<br>M455-Group Rehabilitation Counseling<br>M448 Individual Rehab Counseling w/ Family | All clinical staff |
| M441-Individual Therapy<br>M442- Individual Therapy w/Family<br>M451-Group Therapy | Licensed/registered/waivered staff |
| M411-Collateral w/family<br>M412-Collateral w/ non-family | All clinical staff |
| M464-Nurse Medication Support | RN/NP/LPT/LVN |
| M401- Case Management<br>K402-Intensive Care Coordination (Katie A)<br>NK402-ICC (Non-Katie A) | All clinical staff |
| NK-414 Intensive Home Based Services (IHBS) Non-licensed service<br>NK-415 Intensive Home Based Services (IHBS) Licensed service<br>(Katie A- use service code that corresponds to treatment provided during IHBS, ex. K455, K441, K411) | All clinical staff<br><br>Licensed/registered/waivered staff |
| M447- Therapeutic Behavioral Services (TBS) | All clinical staff in TBS program; staff not licensed/ registered/waivered must be under the direction of LPHA |

* Katie A Codes start with the modifier "K" in place of "M"

# STAFFING QUALIFICATIONS FOR SERVICECODE

| | May authorize services<br><br>(ACCESS) | May direct services by either<br><br>Signature on Client Plan<br><br>Supervision of staff providing service | May provide services and be client's care coordinator | Needs to have co-signature of their:<br><br>Weekly Summaries<br><br>Day Treatment**<br><br>Adult Residential | May provide:<br><br>Mental Status Examination<br><br>Diagnostic Information |
|---|---|---|---|---|---|
| **Physician** | **Yes** | **Yes** | **Yes** | **No** | **Yes** |
| **Psychologist** | **Yes** | **Yes** | **Yes** | **No** | **Yes** |
| **LCSW** | **Yes** | **Yes** | **Yes** | **No** | **Yes** |
| **MFT** | **Yes** | **Yes** | **Yes** | **No** | **Yes** |
| **LPCC*** ** | **Yes** | **Yes** | **Yes** | **No** | **Yes** |
| **ASW/ AMFT/APCC (post Master's degree and registered with BBS)**<br><br>**Intern, Psycholo-gist (post PhD and DHCS waiver of licensure)** | **Yes** | **Yes** | **Yes** | **No** | **Yes** |
| **RN with Master's degree in Psychiatric/ Mental Health Nursing** | **Yes** | **Yes** | **Yes** | **No** | **Yes** |
| **RN** | **No** | **Yes** | **Yes** | **No** | **No** |
| **LVN/LPT** | **No** | **No** | **Yes** | **Yes** ** | **No** |
| **MHRS- MH related MA/MS + 2 yrs experience; BA/BS + 4 years experience in Mental Health** | **No** | **No** | **Yes** | **Yes** ** | **No** |
| **Staff NOT MHRS or BA/BS in Mental Health field** | **No** | **No** | **Yes** * | **Yes** | **No** |

*Under LPHA supervision ** Day Treatment Only ***Must have verification of Child/Family required coursework

# SCOPE OF PRACTICE

| | MD | Lic. or Waivered Psychologist | LCSW ASW MFT/AMFT LPCC/APCC | RN with MS-MH Nursing | MH-NP | RN no MS MH Nursing | LVN or Licensed Psych Tech | MHRS | Staff NOT MHRS & no BA/BS |
|---|---|---|---|---|---|---|---|---|---|
| **Assessment** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| **MSE** | Yes | Yes | Yes | Yes | Yes | No | No | No | No |
| **Dx** | Yes | Yes | Yes | Yes | Yes | No | No | No | No |
| **Approve Treatment Plan** | Yes | Yes | Yes | Yes | Yes | No | No | No | No |
| **Crisis Intervention** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No~ |
| **Medication Administra-tion** | Yes | No | No | Yes | Yes | Yes | Yes | No | No |
| **Medication Prescribing** | Yes | No | No | No | Yes | No | No | No | No |
| **Medication Sup** | Yes | No | No | Yes | Yes | Yes | Yes | No | No |
| **Psych Testing** | No^ | Yes | No^ | No | No | No | No | No | No |
| **Therapy** | Yes | Yes | Yes | Yes | Yes | No | No | No | No |
| **Rehab** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes+ |
| **Case Mgmt** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes+ |
| **TBS** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |

**+ 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**
**BA/BS + 4 years experience**
**AA/AS + 6 years experience**