County of Santa Clara
Mental Health Companion Guide
to
CalMHSA CalAIM Documentation Manual

Version 12/22/2022

Note: This guide was developed based on the information received from the Department of Health Care Services as of 12/22/2022. The guide may be updated as we receive more information moving forward.

Contents

Introduction to This Manual 3

Certified Peer Specialist Role 3

Screening Tools 3

New CSC-BHSD clients 3

Informed Consent 4

Telehealth Consent 4

Criteria for Access to Speciality Mental Health Services 5

Standardized Assessment Requirements 7

Outcome measures 9

Child and Adolescent Needs and Strengths tool (CANS) 9

Pediatric Symptom Checklist (PSC) 9

Milestones of Recovery Scale (MORS) 9

The Problem List 9

Treatment Plan 10

Care Coordination 10

Non-Reimbursable Services & Activities 10

Fraud, Waste, and Abuse 11

Lockouts 11

Authorizations 12

Progress Notes 13

Travel time 14

Documentation time 14

Discharge Planning 14

Therapeutic Behavioral Services (TBS) 14

Appendices 16

Appendix I: DHCS Priority SDOH 16

Appendix II: Documentation Manual Change Log 20

Introduction to This Manual

This manual is meant to be a companion guide to the California Mental Health Services Authority (CalMHSA) Documentation Guides that are posted on www.calmhsa.org/documentation-guides/. There are multiple guides targeted toward different types of disciplines in the mental health and substance use fields. These guides are updated by CalMHSA regularly, so we recommend NOT downloading and saving these, but rather accessing them from the website whenever possible. As such, best practice would be to refer to the CalAIM related websites[1], DHCS Information Notices, All Plan Letters, other State of California notifications[2] and CalMHSA's CalAIM documentation manuals. Please note that the documentation standards and requirements may change based on any new Information Notices, All Plan Letters and/or directives from DHCS. This guide is intended to provide as much clarity as possible based on information provided to BHSD. More information will be provided through the CalMHSA manual updates along with our BHSD clinic standards.

Certified Peer Specialist Role

The County of Santa Clara is employing Peer Support Specialists whose services must be provided under the direction of a behavioral health professional and in accordance with State guidelines and standards. Regarding Peer Support Services, on May 2, 2022 DHCS received CMS approval of SPA 22-0024, with an effective date of July 1, 2022 to broaden the definition of a Peer Support Specialist as someone who must be in recovery themselves or have lived experience with the process of recovery as a parent, caregiver, or family member. Prior to this update, Peer Support Specialists were defined solely as individuals in recovery, which excluded parents, caregivers, or family members from becoming certified as Peer Support Specialists. This update aligns the definition of Peer Support Specialist with the Medi-Cal Peer Support Specialist Certification Program requirements. BHSD has officially opted-in to Peer Support Services for SMHS and DMC-ODS effective July 1, 2022. It will still be a while before CSC is ready to bill DHCS for Peer Support Services. At this time, we are working through the Peer Support Certification grandparenting process. Further details are in process.

Peer Support Services are provided by Peer Support Specialists. A Peer Support Specialist is an individual who meets all applicable California state requirements, including ongoing education requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional. A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC, DMC-ODS, or SMHS. Although Peer Support Services must be provided under the direction of a Behavioral Health Professional, Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements.

Screening Tools

CSC-BHSD Call Center currently uses telephone screenings to determine the appropriate system of care for anyone requesting SMHS. When the statewide standardized screening forms are released, CSC-BHSD Call Center will switch to those forms. Specific information on the screening tools, scoring and thresholds for access criteria will be provided by DHCS at a later date.

New CSC-BHSD clients

Once a person is screened into the CSC-BHSD system of care, there may be additional intake paperwork that needs to be completed. These generally come from regulations about providing all clients with information about services.

[1] https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx and www.calmhsa.org
[2] www.dhcs.ca.gov

Informed Consent

When providing information about mental health services, make sure to provide all necessary information per your licensure and ethical requirements. For example, MFTs, whether licensed or not (LMFTs and AMFTs) must provide information about the limits of confidentiality (duty to report suspected child, elder, or dependent adult abuse or neglect and duty to warn under Tarasoff). If unlicensed, an AMFT must provide information that they are currently working under the license of their supervisor, who is licensed.

Informed consent also includes letting people know that sometimes when starting treatment, things may get worse before they get better, as discussing symptoms may trigger trauma response or starting medication may not be successful with the first attempt or dosage. If the client is discharged from a program and then later reopened, a new consent must be completed.

Telehealth Consent

If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary:

1. an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit;
2. an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future;
3. an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted;
4. and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.
5. The provider must document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received. [3]

Minor Consent

Consent is required in order to treat minors and may be signed by their parent. There are currently 2 California laws related to minor consent for mental health treatment:

Family Code §6924: A minor can consent to mental health treatment if they are 12 years of age or older; are mature enough to participate intelligently in the treatment in the opinion of the attending professional; and would be in danger of serious physical or mental harm to themselves or others without treatment; or the minor is the alleged victim of incest or child abuse.

Health and Safety Code §124260: A minor can consent to mental health treatment if they are 12 years of age or older and are mature enough to participate intelligently in the treatment in the opinion of the attending professional.

Under H&S Code §124260, parents must be involved in the minor's treatment unless the provider determines, after consulting with the minor, that the involvement would be inappropriate.

If a minor *could* consent to mental health treatment, they generally hold the privilege to their records. This means that any minor who fits this description should be the person signing any ROIs. This also means that their parent or guardian

[3] Reference DHCS IN 21-47 and DHCS IN 22-019

does NOT automatically have access to their medical record; the client must sign an authorization in order for the treating provider to disclose that information.

That being said, under H&S Code §124260, parents must be involved in the minor's treatment, unless the provider determines, after consulting with the minor, that the involvement would be inappropriate. In order to involve parents in treatment, some confidential information will need to be shared, such as appointment schedules. Again, this does not mean parents have a right to access confidential records.

Documentation from other agencies

With the CalAIM changes, beneficiaries can engage into services using the *No Wrong Door* approach.[4] The No Wrong Door for Mental Health Services policy ensures that Medi-Cal beneficiaries receive timely mental health services without delay regardless of the delivery system where they seek care, and that beneficiaries are able to maintain treatment relationships with trusted providers without interruption.

This approach allows for beneficiaries to receive concurrent services from more than one (1) agency at the same time. However, when such circumstances occur, documentation should reflect that the services are well coordinated along with being unique and unduplicated from other concurrent Medi-Cal providers. Coordination of care can include but not be limited to coordination with the beneficiary's primary care medical provider, other providers throughout the beneficiary's continuum of care from their start of treatment until their discharge. Sometimes this may include other agencies, such as hospitals, law enforcement agencies, or county social services.

Criteria for Access to Specialty Mental Health Services

Criteria for Beneficiaries to Access the Specialty Mental Health Services As of January 1, 2022 DHCS has revised the definition of Medical Necessity[5] and Access criteria, based upon the age of the beneficiary as follows:

Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System

For beneficiaries 21 years of age or older, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria, (1) and (2) below:

(1) The beneficiary has one or both of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning. AND

(2) The beneficiary's condition as described in paragraph (1) is due to either of the following:

a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

b. A suspected mental disorder that has not yet been diagnosed.

Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. OR

[4] Reference DHCS IN 22-011

[5] Reference DHCS IN 21-073

(2) The beneficiary meets both of the following requirements in a) and b), below:

a) The beneficiary has at least one of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate.

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. AND

b) The beneficiary's condition as described in subparagraph (2) above is due to one of the following:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD) and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

CSC BHSD makes use of an integrated assessment that incorporates both the assessment of mental health and substance use treatment services. At this time, the integrated assessment only applies to County operated services The timeline for providers to complete an initial assessment and subsequent assessments for SMHS is up to the clinical discretion of the provider; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice. Beneficiaries can commence treatment without a diagnosis/es already established. In such circumstances, one or more of the Z-Codes from Z55-Z65 should be used and in accordance with the scope of practice of the provider assigning one or more of these Z-Codes.

From BHIN 22-013: California Welfare & Institutions Code § 14184.402, subd. (f) provides that coverage for, or reimbursement of, a clinically appropriate and covered mental health or substance use disorder prevention, screening, assessment, treatment, or recovery service shall not be denied on the sole basis that services were provided or rendered prior to: (1) the completion of an assessment; and/or (2) the determination of a diagnosis. In other words, appropriate claims for services provided prior to the completion of an assessment or the determination of a diagnosis are allowed. POLICY: MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:

•ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

•ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

•In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS approved ICD-10 diagnosis code list1, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code2.For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

MHPs, DMC and DMC-ODS programs and providers are required to use appropriate ICD-10 diagnosis code(s) to submit claims to receive reimbursement of Federal Financial Participation. California Welfare & Institutions Code § 14184.402,

subd. (f) provides that coverage for, or reimbursement of, a clinically appropriate and covered mental health or substance use disorder prevention, screening, assessment, treatment, or recovery service shall not be denied on the sole basis that services were provided or rendered prior to: (1) the completion of an assessment; and/or (2) the determination of a diagnosis. In other words, appropriate claims for services provided prior to the completion of an assessment or the determination of a diagnosis are allowed.

Standardized Assessment Requirements

(1) SMHS Standardized Assessment Requirements

a. The Children & Adolescent Needs and Strengths (CANS) will be completed with every beneficiary served in the Behavioral Health Services Department (BHSD) Children, Youth, and Family (CYF) System of Care for primary mental health programs that are expected to provide services for more than 90 days. CANS 5+ is used for staff that serve beneficiaries aged 6 to 18, which includes an 18+ module for TAY beneficiaries over age 18. CANS-Early Childhood (CANS:EC) is used for staff that serve beneficiaries from birth through age 5. The Pediatric Symptom Checklist-35 (PSC-35) will be completed with every beneficiary aged 3 to 18 served in the BHDS CYF System of Care for primary mental health programs. See the Children & Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35) Operational Standards on the BHSD website for more information. b. The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to the clinical discretion of the provider; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice. CANS Assessments, should adhere to State timeline standards for completion.

c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.

d. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.

e. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in their scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.

g. The Mental Health Plan (MHP) may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (Cal. Code Regs., tit. 9, § 1840.344; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3, pp. 2m-p; California State Plan Section 3, Att.3.1-B, Supp. 2, pp. 15-17)

SMHS Assessment Domain Requirements[6]

The SMHS assessment shall include the following seven (7) required domains. Providers shall document the domains in the SMHS assessment and keep the assessment in the beneficiary's medical record. Providers shall complete the assessment within a reasonable time and in accordance with generally accepted standards of practice. With the beneficiary's proper consent, the assessment should have interoperability between providers in order to reduce duplication and ensure all providers have the necessary information to best assist beneficiaries and allow beneficiaries best ease of access to specialty mental health services.

Domain 1:
- Presenting Problem(s)
- Current Mental Status
- History of Presenting Problem(s)
- Beneficiary-Identified Impairment(s)

Domain 2:
- Trauma

Domain 3:
- Behavioral Health History
- Comorbidity[7]

Domain 4:
- Medical History
- Current Medications
- Comorbidity[8] with Behavioral Health

Domain 5:
- Social and Life Circumstances
- Culture/Religion/Spirituality

Domain 6:
- Strengths, Risk Behaviors, and Safety Factors

Domain 7:
- Clinical Summary and Recommendations
- Diagnostic Impression
- Medical Necessity Determination/Level of Care/Access Criteria

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[6] Reference DHCS IN 22-019

[7] Reference DHCS IN 21-073, Page 5 and DHCS FAQs Document Attachment 1: SMHS Assessment Domain Descriptions - https://www.dhcs.ca.gov/Documents/8-8-22-V1-CalAIM-Behavioral-Health-Initiative-FAQ.pdf

[8] Reference DHCS IN 21-073, Page 5 and DHCS FAQs Document Attachment 1: SMHS Assessment Domain Descriptions - https://www.dhcs.ca.gov/Documents/8-8-22-V1-CalAIM-Behavioral-Health-Initiative-FAQ.pdf

Outcome measures

Child and Adolescent Needs and Strengths tool (CANS)

For beneficiaries served in the Children, Youth and Family (CYF) System of Care, the Child and Adolescent Needs and Strengths (CANS) assessment tool is still required and should be utilized to help inform the assessment domain requirements.[9]

IN-17-052- The Department of Health Care Services (DHCS) has selected the Pediatric Symptom Checklist (PSC-35) and the Child and Adolescents Needs and Strengths (CANS) tools to measure child and youth functioning, as intended by Welfare and Institutions Code Section 14707.5 (Enclosures 1 and 2). CANS & PSC-35 will be completed at intake, every 6 months, and at discharge.

REFER TO THE FOLLOWING DOCUMENTS:

DHCS Behavioral Health Information Notice 17-052
DHCS Behavioral Health Information Notice 18-029
Children & Adolescent Needs and Strengths (CANS) & Pediatric Symptom Checklist (PSC-35) Operational Standards

Pediatric Symptom Checklist (PSC)

The PSC-35 is required for all Medi-Cal beneficiaries ages 3 through 18 receiving SMHS. The PSC is completed by the caregiver and is required at intake/assessment, every 6-months, and at discharge, as well as whenever there is a significant change in the client's life that needs to be documented (e.g. change in caregiver). The PSC-35 should be completed in accordance with the State's timeline standards for completion.

REFER TO THE FOLLOWING DOCUMENTS:

DHCS Behavioral Health Information Notice 17-052

Children & Adolescent Needs and Strengths (CANS) & Pediatric Symptom Checklist (PSC-35) Operational Standards

Milestones of Recovery Scale (MORS)

DHCS-BH currently uses the MORS as an outcome measure for adults. Only staff trained in the MORS should complete a MORS.

The Problem List

DHCS-BH makes use of a Problem List that has largely replaced the use of treatment plans, except where federal requirements mandate a treatment plan be maintained. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list and progress note requirements identified shall support the medical necessity of each service provided.[10]

DHCS does not require the problem list to be updated within a specific time frame or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time so that it is accurate, up to date, and in accordance with generally accepted standards of practice.

Please also defer to the CalMHSA CalAIM documentation guide section related to the Problem List.

[9] Reference DHCS 22-019
[10] Reference DHCS 22-019

Treatment Plan

Treatment plans and the standards associated with them are at this time still required for ICC, IHBS, TFC, TBS, STRTP, Peer Support Services and TCM (TCM can be included in the PN).[11] Please also refer to ***BHIN 22-019, Attachment 1*** for additional information on the specific programs that continue to require a treatment plan per federal guidelines. During a chart audit, providers will need to demonstrate having the key elements of a treatment plan for programs that continue to require a treatment plan.

Treatment and Care Planning Requirements:
DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, with the exception of continued requirements specifically noted in Attachment 1. Several of these care plan requirements remain in effect due to applicable federal regulations or guidance.

A. Targeted Case Management (TCM)
Targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. See the California State Plan, Sec. 3, Att. 3.1-A, Supp. 1, pp. 8-17; 42 C.F.R. § 440.169(d)(2) and 42 C.F.R. § 441.18 for more specific guidance. The TCM care plan:

• Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary;
• Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
• Identifies a course of action to respond to the assessed needs of the beneficiary; and
• Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.
These required elements shall be provided in a narrative format in the beneficiary's progress notes. (May need to also be documented in a treatment plan *annually* but clarification is still pending from State).

Care Coordination

Make sure to get an authorization to release information (aka, ROI) if necessary. Remember that for mental health services, HIPAA allows for sharing of information without an ROI for treatment, payment, and operations. Substance use services are covered under 42 CFR part 2, which is more stringent. Review BHSD's Privacy and Security training. Please also defer to the CalMHSA CalAIM documentation guide section related to Care Coordination as well as DHCS' No Wrong Door[12] information notice.

Non-Reimbursable Services & Activities

• Academic/educational services
• Chart audits/Internal auditing (**NOTE:** this is different from Chart or Record Review for clinical purposes)
• Clerical tasks (e.g.: faxing, copying, mailing, scheduling/re-scheduling appointments, data entry, obtaining ROI, consent for treatment, etc.)
• Clinical supervision (e.g.: includes individual and group supervision)
• Cloning and cloned documents
• Completing mandatory reports and associated phone calls: CPS, APS, Tarasoff, etc.

[11] Reference DHCS 22-019, page 9, and Attachment 1
[12] Reference DHCS 22-011

• Completing Social Security (SSI) reports/forms when there is no face-to-face contact
• Documents billed for, but not included in chart
• Email (sending and receiving) except for therapeutic communication with the deaf and hard-of-hearing
• Leaving or listening to phone messages
• In alignment with Medi-Cal Practice, no show's and cancelations should continue to be recorded as a non-billable activity. Reviewing a chart in preparation for a session when the client no-show's and no service is provided to the client is also non-billable.[13]
• Personal care services (e.g.: grooming, personal hygiene, assisting with medication, meal preparation, etc.)
• Preparation for a service activity such as session planning, collecting materials for a group, etc.
• Recreation (e.g.: playing basketball, going for walks, etc.)
• Services after the death of an Individual
• Socialization if it consists of generalized group activities which do not provide regular individualized feedback to the specific target behaviors of the clients involved
• Staff development (e.g.: trainings, conferences, workshops, reading literature, etc.)
• Translation/Interpretation
• Transportation
• Travel time with no face-to-face contact with the client. This includes travel time between the provider's home and between satellite/multiple provider sites that are part of the same agency or clinic
• Vocational services which have as a purpose actual work or work training

• Completing a Discharge Summary without direct client contact and no service is provided to the client

Fraud, Waste, and Abuse

Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision
(d). Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual.

Lockouts

Definition:

Services may not be reimbursable by Medi-Cal, with few exceptions, when an Individual is placed in or receiving services from certain settings as indicated below. A clinician may provide the service (e.g., case management for a client residing in an IMD), but it would not be reimbursable. This should not dissuade outpatient staff from providing services during these situations, as consistent contact is key to both engagement and supporting an Individual or Child's recovery.

Jail, Juvenile Hall (not adjudicated), IMD

- No service activities are reimbursable except for the day of admission and discharge

Psychiatric Inpatient, Psychiatric Nursing Facility

- No service activities are reimbursable except for the day of admission and discharge
- Exception: Case Management for placement related services 30 days prior to discharge

[13] Reference BHIN 22-019

Adult Residential Treatment, Youth Residential Treatment, Crisis Residential Treatment

- Medication Support Services and Case Management are reimbursable
- No other service activities are reimbursable except for the day of admission and discharge

Crisis Stabilization (EPS, etc.)

- Case management is reimbursable
- No other service activities are reimbursable except for the day of admission and discharge

Day Rehabilitation/Day Treatment Intensive

- Case Management and Medication Support Services are allowed on the same day an Individual is in Day Rehabilitation or Day Treatment Intensive.
- Mental Health Services are not reimbursable on the same day an Individual is in Day Rehabilitation or Day Treatment Intensive without a concurrent authorization from Quality Assurance.

Authorizations

BHSD does not require prior authorization for the following outpatient SMHS:

- Crisis Intervention
- Crisis Stabilization
- Mental Health Services
- Targeted Case Management (TCM)
- Medication Support Services
- Intensive Care Coordination (ICC)

BHSD does require prior authorization for the following outpatient SMHS:

- Intensive Home-Based Services (IHBS)
- Day Treatment Intensive (DTI)
- Day Rehabilitation (DR)
- Therapeutic Behavioral Services (TBS)
- Therapeutic Foster Care (TFC)
- Short Term Residential Treatment Program (STRTP)

If BHSD refers a beneficiary to any of these services, it is considered an initial authorization of those services. The point of contact for all authorizations is ***still pending within BHSD***.

Progress Notes

SMHS, DMC and DMC-ODS Progress Notes
A.

Providers shall create progress notes for the provision of all SMHS, DMC and DMC-ODS services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description. Each service activity should have a corresponding progress note to substantiate the service being provided.

B.

Progress notes shall include:
• The type of service rendered.
• A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
• The date that the service was provided to the beneficiary.
• Duration of the service, including travel and documentation time.
• Location of the beneficiary at the time of receiving the service.
• A typed or legibly printed name, signature of the service provider and date of signature.
• For valid Medi-Cal claims, appropriate ICD-10 and HCPCS/CPT codes must appear in the clinical record, associated with each encounter and consistent with the description in the progress note.
• Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
• Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

C.
Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

D.
Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). Weekly summaries will no longer be required for day rehabilitation and day treatment intensive.

E.
When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements listed above shall also be met.

Travel time

Travel to a community location or a client's home can be included in the total service time. Travel time starts when you leave your designated workplace. Travel from one DHHS-BH clinic to another DHHS-BH clinic is not billable and should not be included. TIP: If travel time exceeds normal or reasonable limits or is more than the service time provided, it's best practice to document the reason for this in the body of the note.

Documentation time

Routine outpatient services: Documentation should be completed within three business days and within 24 hours for crisis services. If a note is submitted outside of the three business days, it is good practice to document the reason the note is delayed. Late notes should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations 31), stricter note completion timelines may be required by state regulation. Please also refer to CalMHSA's CalAIM Documentation Manual.

Discharge Planning

The discharge service provided should be appropriate to the client's needs and ensure continuity of care. Further information and guidance from the State is pending regarding statewide standards on a transition tool. When a client is closing to one program but remaining open to others, they should complete the Discharge Summary with information about closing to just that program.

Providers who work with individuals ages 5 through 20 are required to complete the CANS at discharge and a PSC for individuals who are ages 4 through 17. Please also refer to and follow any other existing BHSD policies and procedures, along with other applicable guidance related to client discharges.

When requested by the beneficiary's physician, a hospital must arrange for the development and implementation of a discharge plan for the beneficiary. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.[14]

Therapeutic Behavioral Services (TBS)

Definition:

> Therapeutic Behavioral Service (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one to one, short-term, outpatient treatment intervention for clients up to age 21 with serious emotional disturbances (SED) who are experiencing a stressful transition or life crisis and need additional short-term specific support services to accomplish outcomes specified in the written treatment plan. (EPSDT Chart Documentation Manual, September 2007, Pg. 30)

Activities:

TBS activities are usually face-to-face with the Individual and can be provided in most settings. TBS-related activities can also be provided to significant support persons in collaboration with other professionals. TBS services should be consistent with and support the Individual's recovery goal in their out-patient program.

- One-to-one therapeutic contacts typically models/teaches, trains, or supports appropriate behavioral changes
- TBS activities may also include functional analysis/behavioral assessment, collateral, and plan development, which are coded as TBS

[14] BHIN 22-019, Attachment 1

- TBS is provided only by qualified providers

For additional information, reference the CA DHCS TBS Documentation Manual:

- http://www.dhcs.ca.gov/services/MH/Documents/TBS_Documentation_Manual_10_26_09.pdf
- http://www.dhcs.ca.gov/services/MH/Documents/TBS_Coordination_of_Care_Manual__OCT2010_FINAL.pdf
- http://www.dhcs.ca.gov/services/MH/Pages/TBSManualsE-Newsletters.aspx

TBS is a service which will require its own Treatment Plan per BHIN 22-019 Attachment 1. If Case Management (CM) services are provided along with TBS, then a separate Client Plan will need to be documented in a progress note. As there will be no treatment plan per se where TBS will be identified there is no need to get a copy. However, BHSD requires that when TBS is provided, the referring agency will send the Problem List to the TBS agency denoting which problem that TBS is the identified intervention for. The referring agency will continue to provide care coordination with the TBS Provider. The TBS Provider progress notes will denote the TBS work and their collaboration with the referring agency.

TBS does not need a separate Problem List. However, when TBS is provided, the referring agency will send the Problem List to the TBS agency denoting which problem that TBS is the identified intervention for. The TBS Provider still MUST complete a TBS functional analysis/behavioral assessment which is then followed by the TBS treatment. TBS continues to follow the TBS guidelines as initially laid out by DHCS.

When a TBS provider receives the TBS referral, it should come with the current diagnosis and this is what the TBS provider should use. If this is a Z code then once the diagnosis is finalized this should be reflected in the TBS providers chart as well. Also, Per the guidelines for TBS there must be a functional analysis/behavioral assessment first which results in a TBS treatment plan and then TBS.

TBS will continue to have its own regulatory process as defined in early BHIN’s as a result of the Emily Q lawsuit. TBS will continue to need a functional analysis/behavioral assessment which is separate from the CalAIM 7 Domain Assessment. As such, TBS will continue to need a treatment plan developed based on the functional analysis/behavioral assessment. TBS will continue to need initial authorization and reauthorization every 3 months for ongoing services. TBS progress notes can be completed in a manner that is consistent with CalAIM progress note documentation standards.

Appendices

Appendix I: DHCS Priority SDOH

The Appendix in the CalMHSA Documentation Guide is an abridged list that focuses on specific SDOH. The full list of Social Determinants of Health (SDOC) are ICD-10 codes Z55-Z65, which can be found on this website: https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65.

A screenshot of the categories of SDOH can be found below.

Persons with potential health hazards related to socioeconomic and psychosocial circumstances Z55-Z65

Codes

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

Codes

- Z59 Problems related to housing and economic circumstances
  - Z59.0 Homelessness
    - Z59.00 ...... unspecified
    - Z59.01 Sheltered homelessness
    - Z59.02 Unsheltered homelessness
  - Z59.1 Inadequate housing
  - Z59.2 Discord with neighbors, lodgers and landlord
  - Z59.3 Problems related to living in residential institution
  - Z59.4 Lack of adequate food
    - Z59.41 Food insecurity
    - Z59.48 Other specified lack of adequate food
  - Z59.5 Extreme poverty
  - Z59.6 Low income
  - Z59.7 Insufficient social insurance and welfare support
  - Z59.8 Other problems related to housing and economic circumstances
    - Z59.81 Housing instability, housed
      - Z59.811 ...... with risk of homelessness
      - Z59.812 ...... homelessness in past 12 months
      - Z59.819 ...... unspecified
    - Z59.89 Other problems related to housing and economic circumstances
  - Z59.9 Problem related to housing and economic circumstances, unspecified

- Z55 Problems related to education and literacy
  - Z55.0 Illiteracy and low-level literacy
  - Z55.1 Schooling unavailable and unattainable
  - Z55.2 Failed school examinations
  - Z55.3 Underachievement in school
  - Z55.4 Educational maladjustment and discord with teachers and classmates
  - Z55.5 Less than a high school diploma
  - Z55.8 Other problems related to education and literacy
  - Z55.9 Problems related to education and literacy, unspecified
- Z56 Problems related to employment and unemployment
  - Z56.0 Unemployment, unspecified
  - Z56.1 Change of job
  - Z56.2 Threat of job loss
  - Z56.3 Stressful work schedule
  - Z56.4 Discord with boss and workmates
  - Z56.5 Uncongenial work environment
  - Z56.6 Other physical and mental strain related to work
  - Z56.8 Other problems related to employment
    - Z56.81 Sexual harassment on the job
    - Z56.82 Military deployment status
    - Z56.89 Other problems related to employment
  - Z56.9 Unspecified problems related to employment
- Z57 Occupational exposure to risk factors

    - Z57.0 Occupational exposure to noise
    - Z57.1 Occupational exposure to radiation
    - Z57.2 Occupational exposure to dust
    - Z57.3 Occupational exposure to other air contaminants
        - Z57.31 Occupational exposure to environmental tobacco smoke
        - Z57.39 Occupational exposure to other air contaminants
    - Z57.4 Occupational exposure to toxic agents in agriculture
    - Z57.5 Occupational exposure to toxic agents in other industries
    - Z57.6 Occupational exposure to extreme temperature
    - Z57.7 Occupational exposure to vibration
    - Z57.8 Occupational exposure to other risk factors
    - Z57.9 Occupational exposure to unspecified risk factor
- Z58 Problems related to physical environment
    - Z58.6 Inadequate drinking-water supply
- Z59 Problems related to housing and economic circumstances
    - Z59.0 Homelessness
        - Z59.00 Homelessness, unspecified
        - Z59.01 Sheltered homelessness
        - Z59.02 Unsheltered homelessness
    - Z59.1 Inadequate housing
    - Z59.2 Discord with neighbors, lodgers, and landlord
    - Z59.3 Problems related to living in residential institution
    - Z59.4 Lack of adequate food
        - Z59.41 Food insecurity
        - Z59.48 Other specified lack of adequate food
    - Z59.5 Extreme poverty
    - Z59.6 Low income
    - Z59.7 Insufficient social insurance and welfare support
    - Z59.8 Other problems related to housing and economic circumstances
        - Z59.81 Housing instability, housed
            - Z59.811 Housing instability, housed with risk of homelessness
            - Z59.812 Housing instability, homelessness in past 12 months
            - Z59.819 Housing instability, unspecified
        - Z59.89 Other problems related to housing and economic circumstances
    - Z59.9 Problem related to housing and economic circumstances, unspecified
- Z60 Problems related to social environment
    - Z60.0 Problems of adjustment to life-cycle transitions
    - Z60.2 Problems related to living alone
    - Z60.3 Acculturation difficulty
    - Z60.4 Social exclusion and rejection
    - Z60.5 Target of (perceived) adverse discrimination and persecution
    - Z60.8 Other problems related to social environment
    - Z60.9 Problem related to social environment, unspecified
- Z62 Problems related to upbringing
    - Z62.0 Inadequate parental supervision and control
    - Z62.1 Parental overprotection
    - Z62.2 Upbringing away from parents
        - Z62.21 Child in welfare custody
        - Z62.22 Institutional upbringing
        - Z62.29 Other upbringing away from parents
    - Z62.3 Hostility towards and scapegoating of child
    - Z62.6 Inappropriate (excessive) parental pressure

- Z62.8 Other specified problems related to upbringing
  - Z62.81 Personal history of abuse in childhood
    - Z62.810 Personal history of physical and sexual abuse in childhood
    - Z62.811 Personal history of psychological abuse in childhood
    - Z62.812 Personal history of neglect in childhood
    - Z62.813 Personal history of forced labor or sexual exploitation in childhood
    - Z62.819 Personal history of unspecified abuse in childhood
  - Z62.82 Parent-child conflict
    - Z62.820 Parent-biological child conflict
    - Z62.821 Parent-adopted child conflict
    - Z62.822 Parent-foster child conflict
  - Z62.89 Other specified problems related to upbringing
    - Z62.890 Parent-child estrangement NEC
    - Z62.891 Sibling rivalry
    - Z62.898 Other specified problems related to upbringing
- Z62.9 Problem related to upbringing, unspecified

- Z63 Other problems related to primary support group, including family circumstances
  - Z63.0 Problems in relationship with spouse or partner
  - Z63.1 Problems in relationship with in-laws
  - Z63.3 Absence of family member…
    - Z63.31 Absence of family member due to military deployment
    - Z63.32 Other absence of family member
  - Z63.4 Disappearance and death of family member
  - Z63.5 Disruption of family by separation and divorce
  - Z63.6 Dependent relative needing care at home
  - Z63.7 Other stressful life events affecting family and household
    - Z63.71 Stress on family due to return of family member from military deployment
    - Z63.72 Alcoholism and drug addiction in family
    - Z63.79 Other stressful life events affecting family and household
  - Z63.8 Other specified problems related to primary support group
  - Z63.9 Problem related to primary support group, unspecified
- Z64 Problems related to certain psychosocial circumstances
  - Z64.0 Problems related to unwanted pregnancy
  - Z64.1 Problems related to multiparity
  - Z64.4 Discord with counselors
- Z65 Problems related to other psychosocial circumstances
  - Z65.0 Conviction in civil and criminal proceedings without imprisonment
  - Z65.1 Imprisonment and other incarceration
  - Z65.2 Problems related to release from prison
  - Z65.3 Problems related to other legal circumstances
  - Z65.4 Victim of crime and terrorism
  - Z65.5 Exposure to disaster, war, and other hostilities
  - Z65.8 Other specified problems related to psychosocial circumstances
  - Z65.9 Problem related to unspecified psychosocial circumstances

Appendix II: Documentation Manual Change Log

Section	Change Description	Revision Date