

CLINICAL RECORD DOCUMENTATION MANUAL FOR OUTPATIENT MENTAL HEALTH SERVICES



HEALTH & HOSPITAL SYSTEM
MENTAL HEALTH DEPARTMENT

Santa Clara County
Mental Health Department

Quality Improvement Program

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Vision

The Mental Health Department (MHD) transformed mental health system is successful in helping to ensure that residents in need of public mental health services are:

- Physically and emotionally healthy, happy and thriving
- In a safe and permanent living situation
- Part of a loving and supporting social network
- Involved in meaningful school, work, and daily activities
- Free from trouble or causing harm to others
- Safe from harm from the environment or others

Mission

To assist individuals in our community affected by mental illness and serious emotional disturbance to achieve their hopes, dreams and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity.

Values

We believe without reservation that:

- All people have the right to mental health and well-being
- All people must be treated with fairness, respect, and dignity in a culturally and linguistically competent way
- With effective treatment and support, recovery from mental illness is achievable
- Consumers will actively participate in their own recovery and treatment goals
- Consumers and their families will be at the center in the development, delivery, implementation, and evaluation of their treatment
- The system of care must have a structure and process for ensuring services access to needed services for potential and current consumers
- All people must have access to the highest quality and most effective integrated services

Clinical Record Documentation Manual for Outpatient Mental Health Services

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Sources of Information

This Clinical Record Documentation Manual is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements. This manual includes information based on the following sources: the California Code of Regulations (Title 9), the State Department of Mental Health's letters/notices, the Santa Clara County Mental Health Department's policies & procedures, directives, and memos; and the Quality Improvement Program's interpretation and determination of documentation standards. In all cases, the reader should defer to California Code of Regulations, Title 9, State and Federal regulations.

Technical Assistance

The Quality Improvement Program staff is available to answer questions about this documentation manual or documentation issues in general. You can reach us at 408.793.5894.

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Record of Changes

This March 2010 Clinical Record Documentation Manual incorporates many changes when compared to the original version released in July 2004. The following is a partial list of the most significant changes:

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|---|---|
| II. Scope of Practice | |
| Page 6— Table | <ul style="list-style-type: none"> • Clarification on “Staff who can provide this activity” column. |
| III. Assessment | |
| Page 7— Introduction | <ul style="list-style-type: none"> • Assessment categories match with Standard Assessment Form categories. |
| Page 7-- Timeline | <ul style="list-style-type: none"> • Assessment shall be completed in 60 calendar days of the client’s entry into the system; • Update assessments must stand alone; • Transfer or New Program paragraph rewritten. |
| Page 8— Medical Necessity Criteria | <ul style="list-style-type: none"> • Updated to conform with Title 9 language. |
| Page 8/9— QI Tips | <ul style="list-style-type: none"> • Addition of client strength prompts; direction to follow all prompts on assessment form; direction for updated diagnosis. |
| IV. Treatment Plan | |
| Page 10— Introduction | <ul style="list-style-type: none"> • Treatment plan is required in every chart that is open beyond 60 days; • Expectation for treatment plan to be written in English and client’s preferred language; • <i>Application</i> section removed. |
| Page 11— Timeline | <ul style="list-style-type: none"> • Initial treatment plan shall be completed within 60 days of client’s entry to a program; • Treatment plan’s effective date is based on the LPHA’s signature date; • A new diagnosis may require a new Treatment Plan. |
| Page 11— Problem | <ul style="list-style-type: none"> • Problem section rewritten. |
| Page 12— Goal | <ul style="list-style-type: none"> • Goal section rewritten; • Goals must be specific, observable, and/or quantifiable. |
| Page 12— Objectives | <ul style="list-style-type: none"> • Objectives section rewritten; • Objectives must be specific, observable, and/or quantifiable. |
| Page 13— Interventions | <ul style="list-style-type: none"> • Interventions section rewritten; • Interventions must be specific, observable, and/or quantifiable; • Interventions must include duration; |

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| | <ul style="list-style-type: none"> All services must be included in the Interventions section or may be disallowed. |
| Page 14— Signatures | <ul style="list-style-type: none"> Unless the client indicates they do not want to sign the Treatment Plan and it is documented, there needs to be ongoing attempt to get a client signature on the Treatment Plan; Treatment plans without a LPHA signature or date may be disallowed. |
| Page 14— Authorization | <ul style="list-style-type: none"> A missing or late LPHA signature will cause a disallowance for the unauthorized time period. |
| Page 15— Miscellaneous | <ul style="list-style-type: none"> Miscellaneous section rewritten and clarified; Certain language on <i>Meds</i> and <i>Meds Only</i> removed. |
| V. Service Activity | |
| Page 16-36 | <ul style="list-style-type: none"> Definitions changed to conform to Title 9 language. |
| V. Service Activity: MHS--Assessment | |
| Page 16— Activities | <ul style="list-style-type: none"> Activities section rewritten. |
| Page 16— Progress Notes | <ul style="list-style-type: none"> Each assessment activity requires a matching corresponding progress note. |
| Page 17— Miscellaneous | <ul style="list-style-type: none"> Section on <i>Coding Issue</i> removed. |
| V. Service Activity: MHS—Plan Development | |
| Page 18— Activities | <ul style="list-style-type: none"> Discharge summary added to list of plan development activities |
| Page 18-- Progress Notes | <ul style="list-style-type: none"> Progress note section rewritten; Direction provided on discharge summary as an activity; Direction provided on not claiming administrative tasks. |
| Page 19— Miscellaneous | <ul style="list-style-type: none"> Direction provided on claiming plan development when client is transferred. |
| V. Service Activity: MHS—Collateral | |
| Page 20— Progress Notes | <ul style="list-style-type: none"> Progress note section rewritten; Direction provided on documenting support person significance in the client's life. |
| V. Service Activity: MHS—Rehabilitation | |
| Page 22— Activities | <ul style="list-style-type: none"> Activities section rewritten. |
| Page 23— Progress Notes | <ul style="list-style-type: none"> Progress note section rewritten; Group services calculation example format changed. |
| V. Service Activity: MHS—Therapy | |
| Page 25— Progress Notes | <ul style="list-style-type: none"> Progress note section rewritten. |

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| V. Service Activity: Medication Support Services | |
| Page 31— Miscellaneous | <ul style="list-style-type: none"> • Clarification of medical staff eligible medication support services. |
| V. Service Activity: Day Rehabilitation | |
| Page 33— Progress Notes | <ul style="list-style-type: none"> • Direction provided on concurrent mental health services. |
| V. Service Activity: Day Treatment Intensive | |
| Page 34— Progress Notes | <ul style="list-style-type: none"> • Direction provided on concurrent mental health services. |
| V. Service Activity: Adult Residential Treatment | |
| Page 35— Progress Notes | <ul style="list-style-type: none"> • Daily attendance logs are required. |
| Page 35— Miscellaneous | <ul style="list-style-type: none"> • Case Management services are billed separately from AR. |
| VI. Progress Notes | |
| Page 37-38 | <ul style="list-style-type: none"> • Section rewritten; • Added: each page of documentation requires client's name and ID number; • Added: from Policy #177, the timeline to enter notes in chart; • Added: information to include when more than one clinician providing services; • Added: reference to e-signature participants; • Added: P.I.R.; • Added: references to SOAP, PIRP; • Added: procedures for correcting errors. • Added table of Accepted Credential Identifiers • Added Miscellaneous Medicare section for County staff. |
| VI. Non-Reimbursable Services | |
| Page 39 | <ul style="list-style-type: none"> • Added: After death of client, no services are billable. |
| VII. Lockouts | |
| Page 41— Crisis Stabilization | <ul style="list-style-type: none"> • Section (Crisis Stabilization) rewritten. |
| Appendix A: Medical Necessity Criteria – Diagnosis | |
| Page 42 | <ul style="list-style-type: none"> • Excluded diagnoses includes: 799.9 (deferred diagnosis) and V71.09 (no diagnosis). |
| Appendix B: Scope of Practice | |
| Page 43 | <ul style="list-style-type: none"> • Added. |
| Appendix C: Policy 177 Documentation Timeline for Outpatient SMHS | |
| Page 44 | <ul style="list-style-type: none"> • Added. |

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| Appendix D: Directive – Medicare Documentation (County Operated Programs) | |
| Page 45 | • Added. |
| Appendix E: Unicare Entry Crosswalk | |
| Page 46 | • Added. |
| Index | |
| Page 50 | • Added. |

I. Introduction

The Santa Clara County Mental Health Department's Quality Improvement Program is pleased to present this revision of the **Clinical Record Documentation Manual**, which replaces the 2004 version.

Application

This new documentation manual applies to all clients*, regardless of payor source, and is expected to be the official documentation guide for clinicians, interns, supervisors, managers, trainers, auditors, etc.

Some programs, however, may be subject to unique documentation standards. If there are any questions/concerns about which standard applies, please consult with the Quality Improvement Program staff.

Overview

- Section II is a guide on the scope of practice and answers the basic question "Who can provide what service?"
- Sections III and IV cover the assessment and treatment plan. We have included the latest information, including revised timelines and requirements, plus other useful information and helpful hints (also known as QI-Tips).
- Section V addresses all of the service activities that are reimbursable. We've provided definitions, descriptions of the activities, and other useful information.
- Section VI presents some general guidelines for writing progress notes.
- Section VII addresses all of the activities that are not reimbursable. Take note that this list has been expanding over the years.
- Finally, Section VIII simplifies the lockout rules.

*Note: A client is a person who accesses and receives outpatient mental health services; a client is also known as individual, patient, consumer, beneficiary, etc.

II. Scope of Practice

It is expected that staff will only provide services based on their credential (i.e., license, education, training, and experience). Further limitations may be due to lack of experience in the specific service category or by an agency's restrictions.
 *See Scope of Practice Crosswalk Appendix B.

| Service Activities | Staff who can provide this activity |
|---|---|
| <ul style="list-style-type: none"> ▪ Case Management¹ ▪ Assessment (except as noted below) ▪ Plan Development/ Treatment Plan * ▪ Collateral ▪ Rehabilitation (individual, group) ▪ Therapeutic Behavioral Services ▪ Crisis Intervention | <p>Physicians, psychologists, social workers, marriage & family therapists, registered nurses, licensed vocational nurses (LVN), licensed psychiatric technicians (LPT), occupational therapists registered / licensed (OTR/L), and paraprofessionals. Includes waived professionals, mental health rehabilitation specialists (MHRS), & interns/trainees. * LPHA signature required to authorize Treatment Plan</p> |
| <ul style="list-style-type: none"> ▪ Assessment: Diagnosis ▪ Therapy (individual, family, group) | <p><u>Licensed Practitioner of the Healing Arts (LPHA)</u> Physicians, licensed/waivered psychologists, licensed/waivered** clinical social workers, licensed/waivered** marriage & family therapists, licensed psychiatric nurse practitioners.</p> <p>Waivered interns. **MFT Trainees and MSW Interns when supervised by an LPHA (both need co-signatures)</p> |
| <ul style="list-style-type: none"> ▪ Assessment: Psychological Testing | <p>Licensed/waivered psychologists & psychology interns.</p> |
| <ul style="list-style-type: none"> ▪ Medication Support | <p>Physicians, registered nurses, licensed vocational nurses, psychiatric technicians and pharmacists.</p> |

Credentials and signature guidelines

- Day Rehabilitation Weekly Summary: written or co-signed by Qualified Mental Health Professional (QMHP)
- Adult Residential Weekly Summary: written or co-signed by QMHP
- Day Treatment Intensive Weekly Summary: reviewed & signed by LPHA
- Treatment Plan Authorization: reviewed & signed by LPHA

¹ Pharmacist allowed to provide case management services.

III. Assessment

Introduction

The mental health assessment serves as the foundation for the client's plan of care in the system. The assessment establishes eligibility to receive outpatient mental health services, drives the treatment planning process, and provides the basis for ongoing changes in treatment delivery and discharge planning.

- | | |
|---------|---|
| Content | <ul style="list-style-type: none">➤ The assessment includes the following categories:<ul style="list-style-type: none">▪ Presenting problem▪ Mental health history▪ Cultural factors▪ Client's strengths▪ Psychosocial history▪ Substance abuse history▪ Medical history▪ Medical necessity▪ Risk factors▪ Mental status examination▪ Five axis diagnosis |
|---------|---|

Timeline

- | | |
|-------------------------|--|
| Initial | <ul style="list-style-type: none">➤ The initial mental health assessment is required for all clients who are new to the outpatient mental health system. This assessment shall be completed within 60 calendar days of the client's entry into the system. |
| Update | <ul style="list-style-type: none">➤ An updated assessment must be completed annually.➤ Update assessments are required to be comprehensive and complete. In other words, the update assessment must stand alone. |
| Transfer or New Program | <ul style="list-style-type: none">➤ If a client transfers to a new program or is added to a new program, the clinician has the following options:<ol style="list-style-type: none">1. To complete a new assessment within 60 calendar days, or2. Accept the prior assessment, if satisfactory, as long as it was completed within the past year. This assessment must be updated within a year of the LPHA signature.3. Accept the prior assessment, but if there are sections missing or unsatisfactory the clinician must update and complete these sections within 60 calendar days either in a progress note or on an annual assessment update form. |

III. Assessment (Cont.)

Medical Necessity Criteria

Clients must meet the following medical necessity criteria as described in Title 9 (1830.205, 1830.210) in order to receive outpatient mental health services.

1. The client must have an included qualifying current Diagnostic and Statistical Manual (DSM) mental health diagnosis that is the focus of treatment. See Appendix A for a list of included and excluded diagnoses.
2. As a result of the mental health diagnosis, there must be one of the following criteria.
 - a. A significant impairment in an important area of life functioning (e.g., health, daily activities, social relationships, living arrangement).
 - b. A reasonable probability of significant deterioration in an important area of life functioning.
 - c. For a child (a person under the age of 21 years), a reasonable probability that the child will not progress developmentally as individually appropriate.
3. Must meet each of the interventions criteria listed below:
 - a. Focus of the proposed intervention must address the condition identified,
 - b. The proposed intervention will do, at least, one of the following:
 - 1) Significantly diminish the impairment
 - 2) Prevent significant deterioration in an important area of life functioning
 - 3) Allow the child to progress developmentally as individually appropriate.
 - c. The conditions would not be responsive to physical health care based treatment (Primary Care Physician).

Q.I. Tips

An excellent initial or updated assessment includes:

- ☺ A description of the client's current symptoms and behaviors (including severity, frequency, duration, etc.) that supports the diagnosis.
- ☺ All sections must be completed (use N/A if not applicable).
- ☺ A detailed description of the client's functional impairment(s).

III. Assessment (Cont.)

- ☺ A list of the client's strengths:
 - Abilities and accomplishments
 - Interests and aspirations
 - Recovery resources and assets
 - Unique individual attributes
- ☺ A description of the client's cultural/linguistic factors.
- ☺ Follow **all the prompts** on the assessment form.
- ☺ Both the numerical code and full clinical name of the diagnoses, based on the latest DSM. For example, "Axis I: 313.81, Oppositional Defiant Disorder."
- ☺ Any updated diagnosis must be accompanied by a progress note in order to document the change. In addition those changes must be reflected on a new treatment plan. In the event of a new/updated diagnosis, a new treatment plan may be needed.

IV. Treatment Plan [†]

Introduction

Whereas the assessment serves as the foundation for the client's plan of care, the Treatment Plan is the driving force behind the delivery of care. The Treatment Plan is an agreement between the client and the clinician that establishes the mental health problem to be addressed, the specific goal, objectives, and the treatment interventions that will be delivered.

A Treatment Plan is required in every chart that is open beyond 60 days. No exceptions! The Treatment Plan shall be used for all service activities.

- There needs to be consistency between the mental health diagnosis identified in the assessment and the problem, goal, objectives, and interventions.
- A Treatment Plan is expected to be written in both the client's preferred language and English.

Timeline

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

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|--------------|---|
| Initial | ➤ The initial Treatment Plan shall be completed within 60 days of the client's entry to a program (cost center). This deadline applies both to clients who are new to the system and existing clients who enter a new program (i.e., a second provider is added or the client transfers to a new program). |
| Renewal | ➤ Each Treatment Plan can be authorized for a maximum of one year. A new Treatment Plan supersedes the previous plan. |
| Late Renewal | ☹ If the renewal period passes and the next Treatment Plan is completed late, there will be unauthorized days that should not be claimed. (i.e., the renewal date is July 1st but the Plan is completed on July 7th, then July 1st through 6th would be unauthorized for all services during that time period). |
| Q.I. Tip | A Treatment Plan's effective date is based on the LPHA's signature date. In the event of a new diagnosis, a new Treatment Plan may be needed. |

[†] Also known as Care Plan (Title 9)

IV. Treatment Plan (Cont.)

Desired Results

Use client's own words to indicate what they hope to gain from the mental health services.

Problem

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

- Example: Schizophrenia – auditory hallucinations, delusions, disorganized thinking, poor hygiene, social withdrawal, which is interfering with housing and/or family relations.
- Example: Oppositional & Defiant – arguing with adults, yelling and screaming, temper tantrums, blaming others, not taking responsibility; this behavior is interfering with school.
- In some cases, there may be two diagnoses that are the focus of treatment (e.g., Bipolar Disorder & PTSD), so there could be 2 problems identified.

Q.I.Tips

- ☺ An excellent problem section will include the client's impairment in life functioning that is related to the diagnosis, i.e., maintaining housing.
- ☺ An excellent example: Client has depressive symptoms of insomnia, isolation, social withdrawal, decreased appetite, suicidal ideation, and poor concentration, which interferes with client's daily functioning.
- ☺ Another example: Client's psychiatric symptoms of schizophrenia is evidenced by disorganized thoughts, irritability, paranoid ideations, A/VH and racing thoughts which lead to his current homelessness.
- ☺ In a Case Management/Medication Support Service (CM/Meds) Treatment Plan, the problem section will follow the same format as the mental health Treatment Plan.
- ☹ Non-compliant example: Client has symptoms of major depressive disorder (specific symptoms are missing).

IV. Treatment Plan (Cont.)

Goal

The goal needs to focus on the mental health problem, symptoms and behaviors as specified in the problem section. **The goal must be specific, observable, and/or quantifiable.** **Exception:** In a case management/meds only treatment plan the main focus is to maintain psychiatric stability, housing or employment.

- Example: Reduce auditory hallucinations from 7x to 1x per day for the next 12 months.
- Example: Reduce oppositional and defiant behavior by following adult directions from 0x/day to 3x/day; increase prosocial behaviors with friends and family from 1x/day to 7x/day for the next 12 months.
- Example: Increase attendance at school from 0 days to 3 days per week for the next 12 months.
- Example of Case Management/Meds only treatment plan goal: to “stabilize” or to “maintain” symptoms, behaviors, housing, daily activities, etc; i.e., maintain current housing for the next 12 months.

Q.I.Tips

- ☹ Avoid using percentages (%).
- ☹ Non-compliant goal: “Decrease psychiatric symptoms”. (The goal lacks numbers, frequency and duration related to specific symptoms and is too vague to measure).

Objectives

The objectives are the short-term action steps that the clients will do in order to accomplish their goals. The objective may also include, but cannot be limited to, action steps by the client’s family/support person. **The objectives must be specific, observable, and/or quantifiable.**

- Example: Take medications as prescribed; attend symptom management group 1x/week.
- Example: Attend socialization group 1x/week; participate in family therapy 1x/week.
- Example: Client will attend weekly play therapy. Parent will bring child to all scheduled clinic appointments and attend weekly parenting group.

IV. Treatment Plan (Cont.)

- Example: Child will follow parental directions at least 3x per day.
- Example of Case Management/Meds only treatment plan (Objectives focus on medication compliance): i.e., will maintain medication compliance, keep clinic appointments, report symptoms and side-effects to case manager and psychiatrist.

Interventions

Interventions are the clinician's services that are designed to assist clients in meeting their goals. Interventions must be consistent with the goals and must include duration. **All** services must be included in this section. **The interventions must be specific, observable, and/or quantifiable.**

- Example: Clinician will provide individual therapy 1x per week and will utilize cognitive behavioral techniques to assist client in stabilizing their symptoms. The clinician will also link client to psychiatric services and community resources as needed for the next 12 months.
- Example: Case manager will provide socialization group 1x/week; provide family therapy 1x/week for the next 12 months. Link client to community resources as needed for the next 12 months.
- Example for case management/meds only – Provide case management services as needed. Link client to community resources as needed for the next 12 months. Consultation with psychiatrist as needed.

Q.I. Tip

- ☹ Interventions **not included** in the treatment plan are subject to disallowance; i.e., group therapy being provided without listing it as an intervention.

IV. Treatment Plan (Cont.)

Signatures

The “signatures” section indicates the client’s participation and agreement with the Treatment Plan.

- | | |
|----------|--|
| Client | ➤ The client signature is required in the Treatment Plan. If the client does not or cannot sign the plan, then a progress note shall document the reason for the missing signature. Ongoing efforts should be made to obtain client’s missing signature and efforts documented. Exception: If client refuses to sign, this should be documented and no further efforts are necessary. |
| Family | ➤ A family or other support person may sign the Treatment Plan for children/adolescents. |
| Staff | ➤ The cost center staff is the clinician who completes the Treatment Plan, if the cost center staff is not an LPHA, the Treatment Plan must also be co-signed by an LPHA. ➤ A treatment plan without a LPHA signature or date is subject to disallowance. |
| Q.I. Tip | ☺ An excellent progress note contains information about the client’s significant support person’s participation in the treatment planning. |

Authorization

The Treatment Plan must be authorized by an LPHA, whose signature and date of signature establishes the completion of that plan. The LPHA also reviews and authorizes the effective time period of the Treatment Plan’s Start and End date.

- | | |
|---------|---|
| Initial | ☹ A missing or late LPHA signature will result in a disallowance for the unauthorized time period. ➤ For the initial Treatment Plan, the start date is the date that the client is open to the program. The end date cannot exceed 12 months from the start date. On the initial Treatment Plan <u>only the start date</u> should be dated back to the episode opening date; for example, if the client entered the program on June 13, 2009, and the LPHA signed the Treatment Plan on August 6, 2009, the |
|---------|---|

IV. Treatment Plan (Cont.)

- authorization period can be June 13, 2009 through June 12, 2010. Subsequent treatment plans cannot be backdated.
- Renewal ➤ For the renewed Treatment Plan, the start date should be the first day after the end date of the previous plan. For example, if the previous plan ends on June 30th, then the next plan would start on July 1st. The authorization period would be from July 1st through June 30th of the following year.

Miscellaneous

- TBS ➤ For the Therapeutic Behavioral Services (TBS) treatment plan, the provider shall use the TBS treatment plan template in P&P #224.
- ⊗ TBS charts missing TBS treatment plans are subject to disallowance for the unauthorized period.
- Chapter 26.5 ➤ For Chapter 26.5 clients, the provider shall send a copy of their completed Treatment Plan to the County Representative in order to ensure alignment between the provider's mental health Treatment Plan goals and the IEP goals.

V. Service Activity

A. Mental Health Services – Assessment

Definition – “Assessment” means a service activity which may include a clinical analysis of the history and current status of a beneficiary’s mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures. (CCR Title 9 Division 1, 1810.204)

Activities

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

- Interviewing the client and/or significant support persons.
- Administering, scoring, and analyzing psychological tests.
- In some instances, gathering information from other professionals (e.g., teachers, previous providers, etc.) and reviewing/analyzing clinical documents/ other relevant documents may be justified as contributing toward the assessment.
- Observing the client in a setting such as milieu, school, etc. may be indicated for clinical purposes.

Q.I. Tip ☺ An excellent assessment will include well developed sections regarding client’s strengths, cultural factors, and psychosocial history. If using the county assessment form, please follow the prompts.

Progress Notes

- If the information for an assessment is recorded on the assessment form, then it is not required that the same information be recorded in the progress note.
- Each assessment activity requires a matching corresponding progress note.
- The final assessment progress note date should match the assessment completion date.

V. Service Activity

A. Mental Health Services – Assessment (Cont.)

Miscellaneous

Initial &
Annual

- Although an Assessment is provided during the first 60 days and annually, it can be provided at other times, as clinically appropriate.

V. Service Activity

A. Mental Health Services – Plan Development

Definition – “Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress. (CCR Title 9 Division 1, 1810.232)

Activities

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

Plan development activities can be conducted with or without client, and includes the following:

- Development of the treatment plan.
- Approval of the treatment plan.
- Updating of the treatment plan.
- Monitoring the client’s progress in relation to the treatment plan.
- Discharge summary

Progress Notes

- Plan Development progress notes are expected to refer to the treatment plan in some way (i.e., development, approval, updating, or monitoring and/or discussing updating the client’s diagnosis).
- Discharge summaries document the termination and/or transition of services and provide closure for a service episode and referrals as appropriate.
- Discharge summary may be documented in a form or progress note. (If a discharge summary form is used, it must be referenced in a progress note).

V. Service Activity

A. Mental Health Services – Plan Development (Cont.)

| | |
|-------------------------------------|---|
| Documentation for discharge summary | <ul style="list-style-type: none">➤ A discharge summary must include at a minimum the following information:<ol style="list-style-type: none">1) Initial need for treatment or presenting problem2) Summary of treatment goals3) Progress made toward treatment goals4) A clinical or administrative decision explaining the reason(s) for closing the case5) Post discharge needs/plans6) Discharge medications7) Discharge diagnosis in all five axes |
| Q.I. Tip | <ul style="list-style-type: none">☺ Evidence of the completion of Performance Outcome measures if relevant.☹ Administrative tasks such as “closing out the chart”, “copying” or “filing” cannot be claimed as billable services. |

Miscellaneous

| | |
|--------------------|---|
| When to provide PD | <ul style="list-style-type: none">➤ Plan Development is expected to be provided during the development/approval of the initial Treatment Plan and subsequent Treatment Plans. However, Plan Development can be provided at other times, as clinically indicated. For example, the client’s status changes (i.e., significant improvement or decline) and there may be a need to update the Treatment Plan. |
| Without client | <ul style="list-style-type: none">➤ Plan Development may include activities without the client’s presence, such as collaborating with other professionals in the development or updating of the Treatment Plan. |
| Chart Review | <ul style="list-style-type: none">➤ If a client is transferred to your caseload, you may claim a Plan Development activity one time, in order to review that new chart for the purpose of gaining clinical information to develop your clinical treatment formulation. |
| Multiple billing | <ul style="list-style-type: none">☹ Multiple Plan Development service activities for one event are at risk of disallowance, if inappropriately documented. For example, if several staff members are present at a team meeting in which a client’s Treatment Plan is discussed or approved, the only staff that can bill are those who are actively involved in that client’s treatment, i.e., client’s doctor and therapist. |

V. Service Activity

A. Mental Health Services – Collateral

Definition – “Collateral” means a service activity to a significant support person in a beneficiary’s life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary’s client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity. (CCR Title 9 Division 1, 1810.206).

Activities

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

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

Progress Notes

- Collateral progress notes must include the staff intervention (e.g., educating, training, etc.).
- Collateral progress notes should include the role of the significant support person (e.g., parent, teacher, guardian, etc.).

Documentation should substantiate that the support person is significant in the client’s life.

QI-Tip

- In addition to the above, an excellent collateral progress notes should document the changes that occurred as a result of educating and training the significant other, e.g., show how parents learned and demonstrated new ways of dealing with their child’s symptoms or behaviors.
- ☺ If you are billing consultation with a significant other as a collateral service, documentation **must** include how the clinician educated or trained the significant other to better understand or support the client.

V. Service Activity

A. Mental Health Services – Collateral (cont.)

- ☺ Collateral groups (i.e., parenting groups) are billable with or without the client. Refer to group calculation for billing formula located in the Rehabilitation section pages 23 and 24.
- ☹ Caution: Exchange of information with a significant support person without having an education or training component, would qualify solely as a case management service. If a case management service is billed as collateral without a teaching or training aspect, the note will be at risk for disallowance.

V. Service Activity

A. Mental Health Services – Rehabilitation

Definition – “Rehabilitation” means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and /or medication education. (CCR Title 9 Division 1, 1810.243)

Activities

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

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

- Clearly document the reason for the service as it relates to the treatment plan.

Example (Adult): Isolative schizophrenic client who needs encouragement to socialize in order to improve his support system.

The case manager may document the progress note as ...”spoke with client about ways to meet people in their self-help group and re-engage contact with his sister, with the intent of decreasing his isolation”.

V. Service Activity

A. Mental Health Services – Rehabilitation (Cont.)

Example (Child): Disruptive 12 y.o. child, lives in foster home, not following directions, needs structure to maintain placement.

The case manager may document the progress note as...“talked with client about positive ways to interact with adults and role played with client how to have respectful adult interactions which will assist him in maintaining his foster placement”.

Progress Notes

| | |
|---------------------------|--|
| Group | <p>➤ When providing Group Rehabilitation (i.e., two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:</p> <ul style="list-style-type: none">▪ Type or name of group.▪ Total group time, which is the time spent in group plus documentation time and may also include travel time.▪ Number of clients.▪ Number of clinicians and their names (if there is more than one clinician) with appropriate credentials. |
| Group Duration per Client | <p>➤ Group Rehabilitation calculation of duration is the total group time divided by the number of clients.</p> <ul style="list-style-type: none">▪ <u>Calculation #1</u>: Group A had one clinician and 6 clients.<ul style="list-style-type: none">○ The time spent in group = 120 minutes.○ The documentation time = 60 minutes. (10 minutes documentation time per client x 6 clients)○ The travel time = 0 minutes.○ The total group time = 180 minutes. ○ The total group time claimed per client = 30 minutes. (180 minutes total group time ÷ 6 clients) <p>Example of progress note: Ernest Smith, LCSW provided ADHD symptom management group to 6 children. The time spent in group = 120 minutes. Documentation time = 10 minutes per client. Travel time = 0. Client was inattentive, fidgety and had to be redirected numerous times. Client responded positively to redirections and was able to complete the group without leaving his chair.</p> |

V. Service Activity

A. Mental Health Services – Rehabilitation (Cont.)

- Calculation #2: Group B had 2 clinicians and 8 clients.
 - The time spent in group = **360 minutes.**
(both clinicians contributed 180 minutes each)
 - The documentation time = **80 minutes.**
(10 minutes documentation time per client x 8 clients)
 - The travel time = **40 minutes.**
 - The total group time = **480 minutes.**

 - The total group time claimed per client = **60 minutes.**
(480 minutes total group time ÷ 8 clients)

Example of progress note: Clinician Alice Doe, MFT and Betsy Stag, MFTI provided PTSD women's group to 8 clients. The time spent in group = 360 minutes. . Documentation time = 10 minutes per client. Travel time = 40. Client arrived to group crying. She stated she watched a T.V. episode last night which triggered her fear of being attacked again. Client reported nightmares to the group. Therapist provided unconditional positive regard and gave her coping strategies to cope with triggers. Client was able to calm down and receive support from the rest of the group.

- If the group calculation for duration includes decimals (e.g., 26.7 minutes), then round **down** to the nearest whole number which in this case is 26.
- Progress notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if the Rehabilitation activity was provided.

V. Service Activity

A. Mental Health Services – Therapy

Definition – “Therapy” means a service activity which is a therapeutic intervention that focuses primarily on symptoms reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present. (CCR Title 9 Division 1, 1810.250)

Activities

Therapy can be face-to-face, or over the telephone, with the client(s) or family, and may be provided in the office or in the community. An exception would be a pre-approved electronic communication, e.g., therapy with the hearing-impaired.

Note: Therapy can only be provided by an LPHA or a registered intern/trainee supervised by an LPHA.

- Individual Therapy
- Group Therapy (for two or more clients)
- Family Therapy at which the client is present.

Progress Notes

- | | |
|-------|--|
| Group | <ul style="list-style-type: none">➤ When providing Group Therapy (i.e., two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:<ul style="list-style-type: none">▪ Type or name of group.▪ Total group time, which is the time spent in group plus documentation time and may also include travel time.▪ Number of clients.▪ Number of clinicians and their names (if there is more than one clinician) with appropriate credentials. |
|-------|--|

For group calculations refer to pages 23 and 24.

- | | |
|----------|---|
| Q.I. Tip | <ul style="list-style-type: none">☺ For documentation of a therapy note, the interventions must focus on amelioration or reduction of mental health symptoms.☹ Progress notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if the Therapy activity was provided; i.e., each note must have the problem area/clinical focus, staff intervention and the client’s response. |
|----------|---|

V. Service Activity

A. Mental Health Services – Therapeutic Behavioral Services

Definition

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one to one, short-term, outpatient treatment intervention for clients up to age 21 with serious emotional disturbances (SED) who are experiencing a stressful transition or life crisis 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 client and can be provided in most settings. TBS-related activities can also be provided to significant support persons in collaboration with other professionals.

- One-to-one therapeutic contacts typically models/teaches, trains or supports appropriate behavioral changes.
- TBS activities may also include assessment, collateral, and plan development, which are coded as TBS.
- P&P ➤ TBS is provided only by qualified providers. (See P&P # 224 for more details).

Miscellaneous

- Q.I. Tip ☺ Reference the California Department of Mental Health's October 2009 TBS Documentation Manual for additional information.
- ☺ Contact Quality Improvement at (408) 793-5894 for technical assistance if needed.

V. Service Activity

B. Case Management

Definition – “Targeted Case Management” means services that assist a beneficiary 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 beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development. (CCR Title 9 Division 1, 1810.249)

Case Management (CM) includes a broad array of services designed to assist and support clients, including life areas that fall outside of the mental health system.

- Linkage - Assist clients to access needed services such as psychiatric, medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
- Placement - Assist clients to obtain and maintain adequate and appropriate living arrangements
- Consultation – Exchange of information with others in support of client’s services.

Activities

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

- Communicating, consulting, coordinating and corresponding with the client and/or others to establish the need for services and a plan for accessing these services.
- Establishing and making referrals.
- Monitoring the client’s access to services
- Monitoring the client’s progress once access has been established.
- Locating and securing an appropriate living arrangement, including linkage to resources; i.e., Board and Care or Section 8 Housing.

V. Service Activity

B. Case Management (Cont.)

- Arranging and conducting pre-placement visits, including negotiating housing or placement contracts.

Progress Notes

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

Miscellaneous

- FYI | ➤ CM is also known as Targeted Case Management and Case Management/Brokerage.

V. Service Activity

C. Crisis Intervention

Definition – “Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis Intervention is distinguished from Crisis Stabilization by being delivered by providers who do not meet the Crisis Stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348. (CCR Title 9 Division 1, 1810.209)

NOTE: Crisis Intervention (CI) is an immediate emergency response that is intended to help the client cope with a crisis (e.g., potential danger to self or others; potentially life altering event; severe reaction that is above the client’s normal baseline, etc.).

Activities

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

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

Progress Notes

- ☺ An excellent CI progress note contains a clear description of the “crisis,” in order to distinguish the situation from a more routine event, and the interventions used to help stabilize the client.
- ☺ All services provided (i.e., Assessment, safety plan, Collateral, Individual/Family Therapy, Case Management) shall be billed as Crisis Intervention.

Miscellaneous

- Billing
- The maximum amount claimable to Medi-Cal for CI in a 24-hour period is 8 hours (480 minutes) per client.

V. Service Activity

D. Medication Support Services

Definition – “Medication Support Services” (MSS) means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to development related to the delivery of the service and/or assessment of the beneficiary. (CCR Title 9 Division 1, 1810.225)

NOTE: These symptoms should be related to the client’s documented diagnosis.

Activities

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

- Evaluation of the need for psychiatric medication.
- Evaluation of clinical effectiveness and side effects of psychiatric medication.
- Medication education, including discussing risks, benefits and alternatives with the client or support persons.
- Ongoing monitoring of the client’s progress in relation to the psychiatric medication.
- Prescribing, dispensing and administering of psychiatric medications.

Miscellaneous

- | | |
|---------|---|
| Billing | ➤ The maximum amount claimable to Medi-Cal for medication support services in a 24-hour period is 4 hours (240 minutes) per client. |
|---------|---|

V. Service Activity

D. Medication Support Services (Cont.)

- The following services and descriptions pertain to medical staff:
 1. MD Assessment Initial/Follow-up
 - For MDs only:**
 - This service item is used when a psychiatric assessment is performed by an MD.
 2. Medication Management
 - For MDs only:**
 - Includes clinic visits, refilling Rx's, face-to-face or telephone consults with other MDs
 3. Medication Support Non-MD
 - For Medical Staff Non-MDs (RN, LVN, PT, and Pharmacist)**
 - Administering of medication per doctors orders
 - Evaluation of clinical effectiveness and side effects of psychiatric medication
 - Ongoing monitoring of the client's progress in relation to the psychiatric medication.
 - Medication education, including discussing risks, benefits and alternatives with the client or support persons
 4. Psychiatrist and all Medical Staff Non-MDs (see above) can also provide:
 - Medication Injection
 - Prep report other Physicians/Agency (Preparation of report for other physicians/agencies)
 - Review Hospital Records/Reports/Labs (Review of hospital records, reports and labs)
- Aside from MSS, all psychiatrists and most non-medical staff may also provide Plan Development, Case Management or Crisis Intervention as needed.
- For the current MHP "Medication Monitoring Guidelines" go to: www.sccmhd.org [> Staff & Contractor Information > Medical and

V. Service Activity

D. Medication Support Services (Cont.)

| Pharmacy Services]

Q.I. Tip

- ☺ If a case manager consults with a psychiatrist about a client who has new stressors in their life and the psychiatrist gives clinical advice, both the psychiatrist and the case manager should bill Case Management.
- ☺ A case manager consults with a psychiatrist about their client who is having many psychosocial problems and is also out of medication. The psychiatrist calls in bridge medication to the pharmacy. The psychiatrist should bill Medication Management. The case manager should bill Case Management.

V. Service Activity

E. Day Rehabilitation

Definition – “Day Rehabilitation”(DR) means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least 3 hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. (CCR Title 9 Division 1, 1810.212).

Activities

Service activities may include assessment, plan development, collateral, rehabilitation, and therapy.

Progress Notes

| | |
|------------------------|--|
| Weekly Summaries | <ul style="list-style-type: none">➤ DR services require weekly summaries that are reviewed and signed by a QMHP. A good weekly summary will include client’s attendance, participation, presenting problem, interventions, and any skill developments learned.➤ Daily attendance logs are required. |
| Concurrent MH Services | <ul style="list-style-type: none">➤ Concurrent mental health services are the services that are provided by non DR staff on the same day as DR services. All concurrent mental health services require payment authorizations and they must be received by the Quality Improvement program no more than 2 weeks before and no more than 2 weeks after the proposed start date. |

Miscellaneous

| | |
|---------|---|
| Billing | <ul style="list-style-type: none">➤ For Medi-Cal reimbursement, the client must be present for at least 50 percent of the scheduled hours of operation for that day.➤ Medication Support Services are billed separately from DR. |
|---------|---|

V. Service Activity

F. Day Treatment Intensive

Definition – “Day Treatment Intensive” (DTI) means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least 3 hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. (CCR Title 9 Division 1, 1810.213)

Activities

Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

Progress Notes

| | |
|------------------------|---|
| Daily | ➤ DTI services require daily progress notes. |
| Weekly Summaries | ➤ DTI services require weekly summaries that are reviewed and signed by an LPHA. |
| Concurrent MH Services | ➤ Concurrent mental health services are the services that are provided on the same day as DTI services. All concurrent mental health services require payment authorizations and they must be received by the Quality Improvement program no more than 2 weeks before and no more than 2 weeks after the proposed start date. |

Miscellaneous

| | |
|---------|--|
| Billing | ➤ For Medi-Cal reimbursement, the client must be present for at least 50 percent of the scheduled hours of operation for that day. |
| | ➤ Medication Support Services are billed separately from DTI. |

V. Service Activity

G. Adult Residential Treatment

Definition – “Adult Residential Treatment Service” (AR) means rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, 7 days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral. (CCR Title 9 Division 1, 1810.203)

Activities

Service activities may include assessment, plan development, collateral, rehabilitation, and therapy.

Progress Notes

- AR services require weekly summaries that are reviewed and signed by a QMHP.
- Daily attendance logs are required.

Miscellaneous

- | | |
|----------|--|
| Billing | <ul style="list-style-type: none">➤ Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program. AR may not be billed for days the client is not present.➤ Medication Support Services are billed separately from AR.➤ Case management services are billed separately from AR. |
| Q.I. Tip | <ul style="list-style-type: none">☺ AR is also known as Transitional Residential or Transitional Housing. |

V. Service Activity

H. Crisis Residential Treatment

Definition – “Crisis Residential Treatment Service” (CR) means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, 7 days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention. (CCR Title 9 Division 1, 1810.208)

Activities

Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

Progress Notes

- CR services require daily progress notes.

Miscellaneous

- | | |
|-----------------|---|
| Assess- ment | ➤ Clients admitted to CR must receive a mental health and medical assessment, including a screening for medical complications that may contribute to his/her disability, within 3 days prior to or after admission. |
| Billing | ➤ Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program. CR may not be billed for days the client is not present. |

VI. Progress Notes

Progress notes are a summary description of what was accomplished or attempted at the time the service activity was delivered.

- General guidelines:
 - Every service activity is expected to have a separate, corresponding note.
 - Each page of documentation requires client's name and ID number.
 - All progress notes need to include the date of service, duration in minutes, place of service, type of service activity, and provider's handwritten or approved electronic signature, plus credential.
 - All progress notes must be written or printed in black ink.
 - All progress notes must be legible.
 - Every service is expected to be documented and placed in the chart immediately after the service has been provided, but no later than 5 business days after the service event. Progress notes that are written after 5 business days of the provision of the service shall be identified as a "late entry". (See Appendix C, Policy #177 for more instruction.)
 - When there is more than one clinician providing a service to a client, the progress notes of each clinician must include information about all the participating clinicians; for example "Writer and clinician J. Doe, LCSW, met to consult regarding client's progress in treatment...."
 - MHD clinics/contractors approved for e-signature participation will operate under specific written agreements.
- At a minimum, Rehabilitation, Therapy, Collateral, Crisis Intervention, and Therapeutic Behavioral Services progress notes need to contain the following 3 elements:
 1. P: Presenting problem, how the client presents him/herself or the reason for the service activity.
 2. I: Intervention or what was attempted by the clinician.
 3. R: Response i.e., the client's response to the intervention.

VI. Progress Notes (Cont.)

- Q.I. Tip** ☺ Other clinical documentation formats such as SOAP or PIRP are also acceptable as long as they contain the above listed elements.
- Errors**
- Correcting handwritten notes: If the writer realizes that part of a client's chart needs correction/amending due to an entry made in error, the writer will strike through what needs to be corrected and will initial/date it and amend any entry.
 - Correcting electronic notes: If the writer realizes that a note contains erroneous or incomplete information, a second note should be entered into the medical record clarifying the errors or adding new information. No other method of correcting an error, or adding additional information should be employed. Do not re-write notes and do not alter the content of notes.
- Late Entry** ☹ Progress notes documented after five business days shall be identified as a "late entry." In the date column, write the date the service was provided and underneath the date write "late entry." In the body of the progress note, write "late entry written on [date progress note is written]," then proceed with the rest of the note.

| | | | | | |
|--|--|--|---|--|---|
| Accepted Creden- tial Identifiers | ASW – associate social worker | LCSW – licensed social worker | LPT – licensed psychiatric technician | LVN – licensed vocational nurse | MD – medical doctor |
| | MFT – marriage & family therapist | MFTI – marriage & family therapist intern | MFTT – marriage & family therapist trainee | MHRS – mh rehabilitation specialist | MSW Intern – masters social work intern |
| | OTR/L - occupational therapist registered / licensed | Parapro- fessional >2yrs | Parapro- fessional <2yrs | Parapro- fessional w/BA in MH | PhD / Psychology |
| | RN – registered nurse | RPh – registered pharmacist | For others not listed, please check with the QI Program. | | |

Miscellaneous

| | |
|----------|--|
| Medicare | ➤ See Appendix D for Medicare and Medi-Medi documentation guidelines for county staff. |
|----------|--|

VII. Non-Reimbursable Services

For Medi-Cal, some services are not eligible for reimbursement, even though they may be provided on behalf (and to the benefit) of the client. These non-reimbursable services include, but are not limited to, the following:

- Academic educational services.
- Vocational services which have as a purpose actual work or work training.
- Recreation.
- Personal care services provided to clients (e.g., grooming, personal hygiene, assisting with medication, preparation of meals, etc.).
- Socialization if it consists of generalized group activities which do not provide systematic individualized feedback to the specific target behaviors of the clients involved.
- Transportation of a client.
- Translation/interpretation services.
- Missed appointments, including documenting in the chart that a client missed an appointment.
- Travel time when no face-to-face contact with the client or significant support person was provided, including leaving a note on the door for the client.
- Leaving and/or listening to telephone messages
- Communication via e-mail unless clinically appropriate (e.g., therapeutic communication for deaf and hard-of-hearing clients).
- Completing mandatory reports: CPS, APS, Tarasoff, etc., including making associated phone calls.
- Completing Social Security reports, if there is no face-to-face contact with the client or significant support person.
- Clerical tasks: faxing, copying, mailing, etc.
- After the death of a client, no services are billable.

VII. Non-Reimbursable Services (Cont.)

- Supervision in which the primary purpose is for the benefit of the clinician, which includes trainees and student interns. Regularly scheduled supervision time would not be reimbursable, even though the client's care may be discussed.
- Staff development activities, including conferences, workshops, trainings, reading literature, Internet searches, etc.
- Preparation for a service activity, such as collecting materials for a group session.



VII. Lockouts

A “lockout” means that a service activity is not reimbursable through Medi-Cal because the client resides in and/or receives mental health services in one of the settings listed below. A clinician may provide the service (e.g., CM for a client residing in an IMD), but it would not be reimbursable.

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

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

- ❖ Psychiatric Inpatient
- ❖ Psychiatric Nursing Facility

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

Exception: Case Management for placement-related services provided 30 days prior to discharge is reimbursable

- ❖ Adult Residential Treatment
- ❖ Crisis Residential Treatment

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

Exception: MSS and CM are reimbursable

- ❖ Crisis Stabilization (EPS)

No other service activities are reimbursable during the same time period that the client is at EPS.
(Except for the day of admission and discharge)

Exception: Case Management is reimbursable while client is at EPS

- ❖ Day Rehabilitation
- ❖ Day Treatment Intensive

MHS are not reimbursable if provided by the DR/DTI staff during the same time period that DR/DTI is open.

Appendix A: Medical Necessity Criteria - Diagnoses

INCLUDED DIAGNOSES

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

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

EXCLUDED DIAGNOSES

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

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

Appendix B: Scope of Practice

Santa Clara County Mental Health Department

| | Physician (MD) | Psychologist (PhD) #1, #2 | LCSW or ASW | MFT or MFTI | MFTT or MSW Intern #5 | RN | LVN | Lic. Psych. Tech. (LPT) | Pharmacist (RPh) | Occup. Therapist (OTR/L) | MHRS #3 | Paraprofessional w/ BA in MH | Paraprofessional > 2Yrs. | Paraprofessional < 2Yrs. |
|--|---|------------------------------|-------------|-------------|--------------------------|------|-----|----------------------------|------------------|-----------------------------|---------|---------------------------------|-----------------------------|-----------------------------|
| = Licensed Practitioner of the Healing Arts (LPHA) | | | | | | | | | | | | | | |
| Assessment | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Case management | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Collateral | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Crisis Intervention | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Diagnosis, Five Axis | X | X | X | X | X | X #6 | | | | | | | | |
| Evaluation | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Medication Support Services | X | | | | | X | X | X | X | | | | | |
| Plan Development | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Psychological Testing | | X | | | | | | | | | | | | |
| Rehabilitation—Group | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Rehabilitation—Individual | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Therapy--Group | X | X | X | X | X | | | | | | | | | |
| Therapy--Individual | X | X | X | X | X | | | | | | | | | |
| Treatment Plan | X | X | X | X | X | X | X | X | | X | X | X | X | X |
| Treatment Plan Requires LPHA Signature | X | X | X | X | | | | | | | | | | |
| Progress Notes w/o co-sign. | X | X | X | X | | X | X | X | X | X | X | X | X | |
| Progress Notes w/ co-sign. | | | | | X | | | | | | | | | X |
| May Co-sign O/P Prog. Notes | X | X | X | X | | X | X | X | | X #4 | X | | | |
| May Co-sign D/TX Daily Notes | X | X | X | X | | X | X | X | | X #4 | X | | | |
| May Co-sign D/TX Wkly. Notes | X | X | X | X | | X | | | | | | | | |
| May Co-sign D/R Wkly. Summ. | X | X | X | X | | X | X | X | | X #4 | X | | | |
| May Co-sign Adult Res. Notes | X | X | X | X | | X | X | X | | X #4 | X | | | |
| May Co-sign Crisis Res. Notes | X | X | X | X | | X | X | X | | X #4 | X | | | |
| #1 Clinical Psychology | #5 Must be co-signed by LPHA | | | | | | | | | | | | | |
| #2 Licensed or Waivered | #6 Must be Licensed Psychiatric Nurse Practitioner (LPNP) | | | | | | | | | | | | | |
| #3 County Certified MHRS | *Volunteers remain subject to scope of practice | | | | | | | | | | | | | |
| #4 Must Also Be County Certified MHRS | | | | | | | | | | | | | | |

Appendix D: Directive—Medicare Documentation

*dedicated to the Health
of the Whole Community*



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MENTAL HEALTH DIRECTIVE NO.: 2007-03

Date: June 12, 2007
To: County Operated Programs
Subject: Medicare Documentation

The purpose of this directive is to ensure that services billed to Medicare meet the documentation requirements as set forth by the Centers for Medicare & Medicaid Services. **This directive applies to physicians, licensed psychologists, and licensed clinical social workers.**

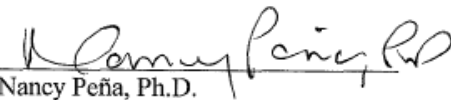
Note: This directive does not apply to licensed Marriage & Family Therapists, all waived staff, rehabilitation counselors, psychiatric technicians, community workers, and interns because their services are not reimbursable by Medicare.

For all existing and new consumers at county-operated clinics who have Medicare insurance (whether or not they also have another payor, such as Medi-Cal), the clerical support staff will place a Medicare label on the consumer's clinical record(s).

When documenting services for Medicare consumers, physicians, licensed psychologists and licensed clinical social workers should follow the current Quality Improvement documentation standards, except for the following:

- For assessment, medication management, individual therapy, and group psychotherapy services, the corresponding progress note must include the **face-to-face start and stop times** in the body of the progress note. For example, if the office visit starts at 10:00 AM and the consumer leaves the office at 10:30 AM, then the progress note should indicate "consumer was seen from 10:00–10:30 AM in the office" or "face-to-face start time = 10:00 AM, stop time = 10:30 AM."
- For individual therapy and group psychotherapy services, no more than 10 minutes of documentation time can be added to the total time billed.

If you have any questions, please contact the Quality Improvement Program at 408-793-5894.


Nancy Peña, Ph.D.
Mental Health Director

6/12/07
Date

The Department of Mental Health is a division of the Santa Clara Valley Health & Hospital System. Owned and operated by the County of Santa Clara.



Appendix E: Unicare Entry Crosswalk
APPENDIX E

DOCUMENTATION MANUAL - UNICARE ENTRY CROSSWALK
August 2009

| DOCUMENTATION MANUAL TERM | UNICARE ENTRY TERM | SERVICE STATUS |
|------------------------------|--|---|
| Adult Residential Treatment | Adult Trans Residential | |
| Assessment | | |
| Initial | Assessment Initial/Follow Up | Initial |
| Update | Assessment Initial/Follow Up | Follow-up |
| Case Management | Case Mgmt/Brokerage | |
| | Prep Rpt Oth Phys/Agency Review Hosp Rec/Rpts/Lab | |
| Collateral | Collateral | Family w/client (Family with client) |
| | | Family w/out client (Family without client) |
| | | Sig Support/not fam (Significant support person not family) |
| | | Multi-Family Group |
| Crisis Intervention | MH Crisis Intervention | |
| Crisis Residential Treatment | Crisis Residential | |
| Day Rehabilitation | | |
| Full day | Day Treatment Rehab Full | |
| Half day | Day Treatment Rehab Half Day | |
| Day Treatment Intensive | | |
| Full day | Day Treatment Intensive Full | |
| Half day | Day Treatment Intensive Half Day | |
| Evaluation | Evaluation | |
| | Psychological Testing | |

Appendix E (Cont.)

| DOCUMENTATION MANUAL TERM | UNICARE ENTRY TERM | SERVICE STATUS |
|-----------------------------|--|----------------------|
| Medication Support Services | MD Assessment Initial/Follow Up | Initial |
| | Brief Medication Visit MD | Follow-up |
| | Medication Management MD | |
| | Medication Support - non MD | |
| | Medication Visit MD | |
| | Medication Injection | |
| Medication Injections | Medication Inject Fluphenazine (12.5 mg) | |
| | Medication Inject Fluphenazine (25 mg) | |
| | Medication Inject Haloperidol (50 mg) | |
| | Medication Inject Risperdal Consta (25 mg) | |
| | Medication Inject Risperdal Consta (37.5 mg) | |
| | Medication Inject Risperdal Consta (50 mg) | |
| | Medication Other Drugs | |
| Non-reimbursable Service | Activity | |
| | Institutions and IMD | |
| Plan Development | Treatment Planning/Plan Development | |
| Rehabilitation | Rehabilitation (for individual) | |
| | Group Rehabilitation | |
| TBS | Therapeutic Behavioral Services | |
| Therapy | Individual | Individual Treatment |
| | Family | Individual Treatment |
| | Group | Group Treatment |

Glossary

Cost Center

A Uni/Care term that refers to a specific program. Also known as the reporting unit.

Emergency Psychiatric Services(EPS)

Santa Clara County's program that provides crisis stabilization services.

Institute for Mental Disease (IMD)

A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental illnesses.

Interns/Trainees

Undergraduate, graduate, and post-graduate students who are gaining experience, credit, or hours in conjunction with their academic program and discipline. They may provide the same service activities as their supervisor, but subject to the limitations of their discipline and academic program's requirements.

Licensed Practitioner of the Healing Arts (LPHA)

Includes physicians, licensed/waivered psychologists, licensed/waivered clinical social workers, licensed/waivered marriage & family therapists, and licensed psychiatric nurse practitioner.

Mental Health Rehabilitation Specialist (MHR)

A credential issued by the Quality Improvement Program for paraprofessionals who have a bachelor's degree plus four years of experience in a mental health setting. A master's degree in a mental health related field may substitute for two years of experience. A two-year college degree plus six years of experience would also meet the minimum qualifications.

Paraprofessional

An individual who provides mental health service activities but does not have a license/waiver/registration as a physician, psychologist, social worker, marriage & family therapist, registered nurse, licensed psychiatric technician, or occupational therapist registered / licensed. If the individual does not have a bachelor's degree in a mental health field and does not have at least two years of mental health experience, then all progress notes must be co-signed.

Psychiatric Nursing Facility

A skilled nursing facility that includes special treatment program services for mentally disordered persons.

Qualified Mental Health Professional (QMHP)

Includes physicians, licensed/waivered psychologists, licensed/waivered clinical social workers, licensed/waivered marriage & family therapists, registered nurses, licensed vocational nurses, psychiatric technicians, and mental health rehabilitation specialists.

Significant Support Person

In the opinion of the client or the staff providing services, a person who has or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of the client who is a minor, the legal representative of the client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client.

Waivered Professional

A credential issued by the Quality Improvement Program for social workers and marriage & family therapists and by the State Department of Mental Health for psychologists, which means that the person may perform the same service activities and other services as a licensed professional in their discipline.

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