# Overview of Revisions

<table>
<thead>
<tr>
<th>Date</th>
<th>Overview</th>
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<tbody>
<tr>
<td>03/22/18</td>
<td>• Edit to Group Calculation #3 (removed statement “Provider 1 would bill 170 minutes per beneficiary and provider 2 would bill 116 minutes per beneficiary” as it is erroneous.)</td>
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<tr>
<td>03/20/18</td>
<td>• Added “Chart/Record Review” to Section XIII: Progress Notes</td>
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| 03/15/18   | • Table of Contents updated with links to assessment & care plan topics  
• Overall formatting & structural updates  
• Section I “End Users” title updated to “Adoption & Application of Practice Guidelines for End Users” and added more language from Final Rule specific to 42 CFR 438.236  
• “Primary diagnosis” throughout manual changed to “included (qualifying) diagnosis” in order to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol  
• Section IV Care Plan – changed “primary diagnosis” to “mental health diagnosis being treated.”  
• Section IV Care Plan - Presenting Problems/Obstacles, 3rd paragraph – Changed “Secondary and co-occurring diagnoses” to “Co-occurring or other mental health and substance diagnoses”  
• Section VI Care Plan - obstacles section to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol  
• Section VI Care Plan - short-term goal section to be consistent with State regs and protocols; provided clarifying sentence re: STGs being the outcome of the action steps & interventions, as well as being an improvement of functioning & cleaned up formatting (added table for goal components, as well as “tips” box  
• Section VI Care Plan - interventions section to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol; cleaned up components table  
• Section VI Care Plan - Frequency, Timing, and Documentation section to be consistent with State regs and protocols as outlined in IN 17-040, State Annual Review Protocol, and State Contract; add in QA statement re: initial care plans & audit requirements, and crisis residential plans  
• Section XIII, Progress Notes section, to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol  
• Section X, Case Management Service, to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol  
• Section IV, Assessment-frequency, timing, documentation section, to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol  
• Section IX, Group Services, to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol  
• Section X, Crisis Intervention – added statement that medical emergencies are not to be billed as crisis intervention (this is reserved for specialty MH services only)  
• Section XIII, Progress Notes - Group Calculations, to be consistent with State regs and protocols as outlined in IN 17-040 and State Annual Review Protocol; added bullet points to “all entries must include” to reference needed documentation for interventions; |
## Overview of Revisions

| Version Date | Medication Management for MDs updated (removed “E&Ms“ reference; updated med management vs consultation)  
|             | • Section IX and XIII, Group services and progress notes: created separate items for documentation time and travel time in group progress note requirements list  
|             | • Section XI: Non-Reimbursable Services, Activities, & Lock-outs - “scheduling appointments” specified as an example on non-reimbursable activities, as well as adding “youth residential treatment”  
|             | • Discharge Summary references updated in Sec VI Developing the Care Plan & Sec VIII Transition Planning to clarify best practice and reimbursement details  
|             | • Qualifying Diagnoses: updated Info Notice reference 17-004 to 17-004E, including respective attachments links  
|             | • MFTi and PCCi updated in scope & credentials to reflect associates change (AMFT and APCC)  
|             | • Removed references to chart review being a one-time only activity billed as plan development. Updated various billing descriptions to reflect record review being permitted. Glossary includes definition for chart/record review as related to IN 17-040 with link back to IN for further details. Additionally, added the following definitions to Glossary:  
|             |   - Long Term Client/Beneficiary (DHCS triennial rec)  
|             |   - Long term services & supports (DHCS triennial rec)  
|             |   - Practice Guidelines (MegaRegs/Final Rule)  
|             |   - Medical necessity & Medical necessity criteria (as related to utilization management)  
|             |   - Quality Assurance  
|             |   - Quality Improvement  
| 08/24/17    | • While not yet incorporated into the Manual, standards set in [DHCS Information Notice 17-040](#) dated 08/24/2017 are effective immediately.  
| 08/01/17    | • mental health services - updated references for assessment to reflect change of annual to every two (2) years  
|             | • added LMFT to credentials  
|             | • hyperlink updates now include reference to section or appendix title  
|             | • added "cloning" to non-reimbursable with link back to definition  
|             | • minor typos & structural/formatting updates  
|             | • short term goal verbiage re: updates  
| 06/08/17    | • updated/clarified clinical supervision recommendations  
| 06/07/17    | • scope of practice (added checks to PCCI, LPCC, and RN for co-signing)  
|             | • credential identifiers updated (including removing "Paraprofessional with BA in MH")  

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<tr>
<td>06/05/17</td>
<td>Practice Guidelines Released – Supersedes &quot;Documentation Manual March 2010 (revised Dec 2012)&quot;</td>
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- Integration of documentation requirements and recovery-oriented practice guidelines – how these areas work together and support each other.
- Guides for plan goals and interventions to focus more on improving functioning in important life areas. This is more consistent with medical necessity, the DHCS audit protocol, and recovery.
- Update of some service items, e.g.; case management includes consideration of what role the client may have in those services, day rehabilitation service clarification, travel reimbursements, and cloning risks.
- A section devoted to medical necessity and how the impairment criteria can be utilized to support a recovery process.
- Chapters on other important practices, such as Care Plan Implementation and Evaluation (progress monitoring) and Transition Planning (discharge planning and supporting transitions)