THE COUNTY OF FRESNO

Department of Behavioral Health

Clinical Documentation & Billing Manual

Specialty Mental Health Services

Updated March 2021

OUR MISSION AND PURPOSE

The Department of Behavioral Health, in partnership with our diverse community, is dedicated to providing quality, culturally responsive, behavioral health services to promote wellness, recovery and resiliency for individuals and families in our community.

We are pleased to present the updated Fresno County Department of Behavioral Health *Clinical Documentation & Billing Manual for Specialty Mental Health Services.* This manual is intended to provide guidance on State Medi-Cal documentation standards, as well as Fresno County DBH documentation and compliance standards. This manual is intended to be a living document that is routinely updated as future guidance is provided by State and Federal regulations.

The Fresno County Mental Health Plan *Clinical Documentation & Billing Manual for Specialty Mental Health Services* supports the implementation of the written policies, procedures and standards of the Fresno County Mental Health Plan and is an integral part of a comprehensive compliance plan focused on adhering to Medi-Cal documentation requirements. The Fresno County Mental Health Plan refers to all Medi-Cal providers including County employees and County-contracted providers as outlined in the contractual arrangement between Fresno County and the California State Department of Health Care Services (DHCS) to provide SMHS in Fresno County.

This manual is intended to serve as a teaching, training, and documentation standards resource for specialty mental health services providers across the Child, Family, Youth and Adult/Older Adult Systems of Care and the Private Provider Network. It is a living document that is updated as regulations and policies and practices change. Always check the Managed Care website for the latest version of this Manual.

We are glad that you are a part of the Fresno County MHP provider network. We look forward to working with you to promote a culture of wellness, recovery and resiliency and compliance within our provider network. For more information, please contact:

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GUIDING PRINCIPLES OF CARE DELIVERY

The Fresno County Department of Behavioral Health *11 Principles of Care Delivery* define and guide a system that strives for excellence in the provision of behavioral health services where the values of wellness, resiliency, and recovery are central to the development of programs, services, and workforce. The principles provide the clinical framework that influences decision-making on all aspects of care delivery including program design and implementation, service delivery, training of the workforce, allocation of resources, and measurement of outcomes. Our guiding principles of care delivery include:

Principle One – Timely Access & Integrated Services

- Individuals and families are connected to services in a manner that is streamlined, effective, and seamless
- Collaborative care coordination occurs across agencies and ensures that the plan for care considers all life domains such as health, education, employment, housing, and spirituality
- Barriers to access and treatment are identified and addressed
- Excellent customer service ensures individuals and families are transitioned from one point of care to another without disruption of care

Principle Two - Strengths-based

- Positive change occurs within the context of genuine trusting relationships
- Individuals, families, and communities are resourceful and resilient in the way they solve problems
- Hope and optimism is created through identification, and focus on, the unique abilities of individuals and families

Principle Three - Person-driven and Family-driven

- Self-determination and self-direction are the foundations for recovery
- Individuals and families optimize their autonomy and independence by leading the process, including the identification of strengths, needs, and preferences
- Providers contribute clinical expertise, provide options, and support individuals and families in informed decision making, developing goals and objectives, and identifying pathways to recovery

- Individuals and families partner with their provider in determining the services and supports that would be most effective and helpful and they exercise choice in the services Inclusive of Natural Supports

Principle Four – Inclusive of Natural Supports

- The person served identifies and defines family and other natural supports to be included in care
- Individuals and families speak for themselves
- Natural support systems are vital to successful recovery and the maintaining of ongoing wellness; these supports include personal associations and relationships typically developed in the community that enhance a person's quality of life
- Providers assist individuals and families in developing and utilizing natural supports

Principle Five – Clinical Significance and Evidence Based Practices (EBPs)

- Services are effective, resulting in a noticeable change in daily life that is measurable
- Clinical practice is informed by best available research evidence, best clinical expertise, and personal values and preferences
- Other clinically significant interventions such as innovative, promising, and emerging practices are embraced

Principle Six – Culturally Responsive

- Values, traditions, and beliefs specific to an individual's or family's culture(s) are valued and referenced in the path of wellness, resilience, and recovery
- Services are culturally grounded, congruent, and personalized to reflect the unique cultural experience of each individual and family
- Providers exhibit the highest level of cultural humility and sensitivity to the self-identified culture(s) of the person or family served in striving to achieve the greatest competency in care delivery

Principle Seven – Trauma-informed and Trauma-responsive

- The widespread impacts of all types of trauma are recognized and the various potential paths for recovery from trauma are understood
- Signs and symptoms of trauma in individuals, families, staff, and others are recognized and persons receive trauma-informed responses

- Physical, psychological and emotional safety for individuals, families, and providers is emphasized

Principle Eight – Co-occurring Capable

- Services are reflective of whole-person care; providers understand the influence of bio-psycho-social factors and the interactions between physical health, mental health, and substance use disorders
- Treatment of substance use disorders and mental health disorders are integrated; a provider or team may deliver treatment for mental health and substance use disorders at the same time

Principle Nine – Stages of Change, Motivation, and Harm Reduction

- Interventions are motivation-based and adapted to the person's stage of change
- Progression through stages of change are supported through positive working relationships and alliances that are motivating
- Providers support individuals and families to develop strategies aimed at reducing negative outcomes of substance misuse through a harm reduction approach
- Each individual defines their own recovery at their own pace when provided with sufficient time and support

Principle Ten – Continuous Quality Improvement and Outcomes-driven

- Individual and program outcomes are collected and evaluated for quality and efficacy
- Strategies are implemented to achieve a system of continuous quality improvement and improved performance outcomes
- Providers participate in ongoing professional development activities needed for proficiency in practice and implementation of treatment models

Principle Eleven – Health and Wellness Promotion, Illness and Harm Prevention, and Stigma Reduction

- The rights of all people are respected
- Behavioral health is recognized as integral to individual and community well-being
- Promotion of health and wellness is interwoven throughout all aspects of DBH services

- Specific strategies to prevent illness and harm are implemented at the individual, family, program, and community levels
- Stigma is actively reduced by promoting awareness, accountability, and positive change in attitudes, beliefs, practices, and policies within all systems
- The vision of health and well-being for our community is continually addressed through collaborations between providers, individuals, families and community members

The Fresno County Department of Behavioral Health is committed to working with these guiding principles of care delivery in the ongoing service to our beneficiaries and community.

A FOCUS ON WELL-BEING

Our work enables adults to live more fulfilling and productive lives, children to be more resilient, and families to be happier and healthier.

Recovery & Resilience: we work to improve well-being in our community through a focus on recovery and resiliency across the lifespan.

Treatment Works: People can and do recover from mental illness, treatment and prevention work and well-being is something everyone deserves.

Strengthening Community: Our work is part of what makes our community strong, and healthy families grow from a foundation of mental wellness.

Our Services Save Money: Our services save the community money and make our community a better place to live.

UPDATES AND CHANGES IN THE 2021 VERSION

The COVID-19 pandemic and subsequent declaration of a public health emergency by California Governor Newsom has changed the way we are delivering specialty mental health services to the people that we serve. The 2020 version of the Fresno County DBH Documentation & Billing Manual reflects the most recent regulations and best practices for delivering services during this time. Some of the changes to this version include:

Offered guidance and clarification regarding provision of services during the COVID-19 Pandemic.

- In March 2020, DHCS issued Behavioral Health Information Notice 20-009, which encourages counties and providers "to take all appropriate and necessary measures to ensure beneficiaries can access all medically necessary services while minimizing community spread." In effect, this expands behavioral health services to be provided via telephone (audio only) and telehealth (audio and video), and to be claimable services. The standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth.
- Added links to DHCS COVID-19 Response.

Provided updates to DHCS regulations and claiming for services:

- Updated the Reasons for Recoupment to reflect FY 2020-21 DHCS information.

The Fresno County Department of Behavioral Health is dedicated to community health wellness and health promotion in Fresno County. The department works closely with the Fresno County Department of Public Health experts to provide you with up to date information on the Corona Virus (Covid-19).

Learn more about Covid-19, behavioral health resources and the Departments' services by calling the DBH Covid-19 Warm Line: 559-600-WARM (9276) Monday - Friday 8:00 a.m. to 5:00 p.m..

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REFERENCES AND LINKS

Fresno County Dept. of Behavioral Health Managed Care Contract Providers Website

DHCS COVID-19 Resources

- BHIN 20-09: Guidance for behavioral health programs regarding ensuring access to health and safety during the COVID-19 public emergency
- DHCS COVID-19 Response Website
- Infection Mitigation in Behavioral Health Facilities – COVID-19 FAQs
- California Telehealth Resource Center - CalTRC

Guidance and Regulations

- California Code of Regulations, Title 9, Chapter 11, Sections 1810 through 1840
- California Code of Regulations, Title 22, Section 81068.2(b)
- California Code of Regulations, Title 22, Section 81068.3
- Medicaid Mental Health Parity Final Rule
- MHP Boilerplate Contract, Exhibit A, Attachment 1
- DHCS Medi-Cal Billing Manual - 2019
- Caregiver's Authorization Affidavit
- Fresno County Notice of Privacy Practices
- DHCS Notice of Privacy Practices
- DHCS Privacy Forms
- DHHS Medicaid Financing of State and County Psychiatric Hospitals-2003
- State Plan, Section 3, Supplement 3 to Attachment 3.1-A (MHP Definitions of Specialty Mental Health Services - TN No. 12-025)
- EPSDT-A Guide for States
- EPSDT Intensive Services Training 2017 – Pathways to Well-Being
- CDSS Pathways to Well-Being
- Medi-Cal Manual for ICC, IHBS & TFC for Medi-Cal Beneficiaries 3rd Ed.
- The California Integrated Core Practice Model for Children, Youth and Families
- The California Integrated Training Guide (Integrated Core Practice Model)
- DHCS Mental Health Services Division Medi-Cal Billing Manual – October 2013
- DHCS Short-Term Residential Therapeutic Program (STRTP) Interim Regulations
- Fresno County Mental Health Plan Organizational Provider Manual
- Fresno County Mental Health Plan Individual/Group Provider Manual
- SAMHSA's National Registry of Evidence-based Programs and Practices site
- Columbia-Suicide Severity Rating Scale (C-SSRS)

California DHCS All County Letters and Mental Health SUDS Information Notices:

- DMH Letter 01-07 – EPSDT and TBS Notices
- DMH IN 03-03 Change in Requirements for Certification of Medi-Cal Claims
- IN 16-016 ICD-10 Included Code Sets and System Edit for SDMC II Billing
- IN 16-049: Requirements and Guidelines for Creating and Providing a Child and Family Team
- IN 16-051: Implementation of the DSM-5
- IN 16-060 California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care
- IN 17-032 Implementation of Presumptive Transfer for Foster Children Placed Out of County
- IN 17-040: Chart Documentation Requirement Clarifications
- IN 17-040 – Attachment 1: Providers of SMHS
- IN 17-055: Removal of the Lockout for ICC and IHBS for Children and Youth in Group Homes or STRTPs
- IN 17-052 –EPSDT SMHS Performance Outcomes Systems Assessment Tools for Children and Youth
- IN 17-052 – Enclosure 2 – PSC-35 Tool
- IN 17-052 – Enclosure 3 – California CANS-50 Tool
- IN 18-002 Co-Practitioner Claim Submission Requirements
- IN 18-007 Requirements for Implementing the CANS Tool within a CFT
- IN 18-010E Federal Grievance and Appeal System Requirements with Revised Beneficiary Templates
- IN 18-022 The California Children, Youth, and Families Integrated Core Practice Model and the California Integrated Training Guide
- IN 18-027 Presumptive Transfer Policy Guidance
- IN 18-029 Clarification Regarding Sharing of CANS Assessments by County placing agencies and Mental Health programs
- IN 18-048 EPSDT SMHS Performance Outcomes System Functional Assessment Tools for Children and Youth
- IN 18-054 - Annual Review Protocol for SMHS FY 2018/2019
- IN 18-054 - Annual Review Protocol for SMHS FY 2018/2019 Enclosure 1
- IN 18-054 - Annual Review Protocol for SMHS FY 2018/2019 Enclosure 2
- IN 19-013 – 2019 ICD-10 Included Code Sets & System Edit for SDMC II Billing
- IN 20-004 - Updates to optional forms relevant to involuntary treatment: DHCS 1801, 1802, 1808, and 1809
- IN 20-043 - 2020 International Classification of Diseases, Tenth Revision (ICD-10) Included Code Sets Effective October 1, 2019
    - Enclosure 1 - ICD-10 Inpatient/Outpatient Diagnosis Codes and Descriptions

Fresno County Department of Behavioral Health Policies and Procedures:

- PPG 1.1.1 – Development and Maintenance of DBH PPGs
- PPG 1.2.13 – Notice of Action – E (Lack of Timely Service)
- PPG 1.3.4 - Code of Conduct
- PPG 1.3.8C Acknowledgment of Confidentiality Mental Health Consumers
- PPG 1.3.8D Contract Provider Medical Records Review
- PPG 1.3.8E Medication Services Utilization Review
- PPG 1.3.8F Medical Record Reviews for DBH, County-Operated Mental Health Treatment Programs
- PPG 1.3.8G Electronic Signatures for Electronic Health Record Documentation
- PPG 1.3.9 Prevention, Detection, and Correction of Fraud, Waste and Abuse
- PPG 2.1.2 Abbreviations
- PPG 2.1.6 – Treatment Plan
- PPG 2.1.8 Informed Medication Consent
- PPG 2.1.9 - Assessments
- PPG 2.1.10F – Beneficiary/Family Involvement in the Development of Beneficiary Treatment Plan
- PPG 2.1.10H - Advanced Health Care Directive
- PPG 2.1.11 Definition of a Long-term Client
- PPG 2.1.19 Consent for Treatment (draft)
- PPG 4.3.5 Outpatient Medi-Cal Disallowance and Unauthorized Services
- PPG 4.3.7 Consistency Monitoring Review of TARs for IP Hospital Services
- PPG 4.4.5 EPSDT and TBS Notice
- PPG 4.4.6 Documentation Standards for Progress Notes
- Fresno County DBH LPS 5150 Re-Certification Process

Substance Use Disorder Services:

- DHCS Drug Medi-Cal Billing Manual-June 2017
- Fresno County Substance Use Disorder Provider Manual
- Fresno County Department of Behavioral Health – Drug Medi-Cal ODS Implementation Plan

CLINICAL DOCUMENTATION OVERVIEW

The principles of care delivery define a system that strives for excellence in the provision of behavioral health services where the values of wellness, recovery and resiliency, aligned with the mission of the Mental Health Services Act, are central to the development of programs, services, and staff competencies.

As service providers of Specialty Mental Health Services, we strive to provide the highest quality care to the persons we serve. Comprehensive, accurate and timely documentation of services is an important part of delivering high quality, effective care. Documentation follows a logical flow and is interconnected, ensuring comprehensive services with records that are accurate.

The course of clinical documentation begins with an initial comprehensive **Clinical Assessment**. Assessment data provide the basis for determining whether medical necessity criteria are met (or not met), and for developing the client's personalized **Treatment Plan** (also referred to as *Plan of Care* or *Client Plan*). The goals and objectives stated on the treatment plan guide the course of treatment and resultant **Progress Notes**. This clinical workflow is the "Golden Thread" of clinical documentation.

Medi-Cal services are directed by Federal and State regulations. Clinical documentation is more than just a contractual requirement. It is an important record of the person's served behavioral health journey. As State and Federal regulations are continually updated, it is best clinical practice that providers review this manual and visit the DBH website for documentation updates and resources necessary to carry out the provision of services.

The Department of Mental Health Information Notice No. 03-03 was an emergency regulation that became effective on July 1, 2003. The information notice requires MHPs to certify that the following criteria are met for every claim submitted to the State for payment:

- An assessment of the client was conducted
- The client is eligible to receive Medi-Cal at the time the service was provided
- Services claimed were actually provided
- Medical necessity was established
- A treatment plan was developed and maintained
- Authorization requirements were met for Day Treatment—Intensive and Rehabilitation, and EPSDT supplemental services

MEDI-CAL REIMBURSABLE SPECIALTY MENTAL HEALTH SERVICES (SMHS)

Specialty Mental Health Services that may be provided to beneficiaries and are Medi-Cal reimbursable include:[1]

- Mental Health Services
- Day Treatment Intensive
- Crisis Intervention
- Adult Residential Treatment
- Psychiatric Health Facility (PHF)
- Targeted Case Management
- EPSDT Supplemental SMHS
- Psychiatric Nursing Facility Services
- Medication Support Services
- Day Rehabilitation
- Crisis Stabilization
- Crisis Residential Treatment
- Psychiatric Inpatient Hospitalization
- Psychologist Services
- Therapeutic Behavioral Services (TBS)

SERVICES NOT REIMBURSABLE BY MEDI-CAL[2]

The following services are not eligible for Federal Financial Participation (FFP):

a. Academic educational services.

b. Vocational services that have as a purpose actual work or work training.

c. Recreation.

d. Socialization is not reimbursable if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.

e. Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services.

f. Medi-Cal program benefits that are excluded from coverage by the MHP as described in Section 1810.355.

[1] CCR, Title 9, Chapter 11

[2] CCR, Title 9, Chapter 11, §1840.312

g. (g) Specialty mental health services covered by this Article provided during the time a beneficiary 21 years of age through 64 years of age resides in any institution for mental diseases, unless:

   (1) The beneficiary was receiving, prior to his/her twenty-first birthday, services in an institution for mental diseases (IMD) and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier; and

   (2) The facility has been accredited in accordance with Title 42, Code of Federal Regulations, Section 440.160, and complies with Title 42, Code of Federal Regulations, 441.150 through 441.156. Facilities at which Federal Financial Participation (FFP) may be available include but are not limited to acute psychiatric hospitals and psychiatric health facilities certified by the Department as a Medi-Cal provider of inpatient hospital services.

h. Specialty mental health services covered by this Article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than an institution for mental disease that has been accredited in accordance with Title 42, Code of Federal Regulations, Sections 440.160 and 441.150 through 441.156. Facilities at which FFP may be available include acute psychiatric hospitals and psychiatric health facilities certified by the Department as Medi-Cal providers of inpatient hospital services.

i. The restrictions in Subsections (g) and (h) regarding claiming FFP for services to beneficiaries residing in institutions for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and claiming FFP is subsequently approved.

j. Specialty mental health services that are minor consent services as defined in Title 22, Section 50063.5 to the extent that they are provided to beneficiaries whose Medi-Cal eligibility pursuant to Title 22, Section 50147.1 is determined to be limited to minor consent services.

k. The MHP may not claim FFP for specialty mental health services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.

HELPFUL DOCUMENTATION TIPS

- Ensure that there is a signed note for each service billed
- Include licensure status and unique identification number, and date with the provider’s signature

- For crisis services, document risk assessments, intervention(s), the disposition and resolution of the crisis
- Be clear, accurate and concise when providing session details
- Services should be directed towards the Plan of Care goals and objectives
- Documentation needs to support that services are **medically necessary**

STRTP Only - Record Documentation and Retention Requirements

Each STRTP must ensure each child residing in the STRTP has an accurate and complete medical record. This record shall be kept confidential, and protected health information may only be disclosed under applicable federal and state laws, along with Fresno County Mental Health Plan policy. Medical records for youth residing in an STRTP must include:

1. Signed informed consent
2. Mental health assessment
3. Admission statement
4. Treatment plan
5. Mental health program progress notes
6. Child and family team meeting notes
7. Clinical review reports and transition determination
8. Physicians orders related to mental health care, medication reviews, if applicable, and written informed consent for prescribed medication
    a. The latter of these must be included regardless of whether the STRTP directly provides or makes available medication support services
9. Any and all available court documents, court orders, or judgments regarding physical or legal custody of the child, conservatorship or guardianship of the youth, as well as the child's probation, or child's juvenile court dependency or wardship
    a. Relevant legal documentation is required regardless of whether the youth is presumptively transferred
10. Documentation indicating date and name(s) of persons or groups of persons who have participated in the development of the treatment or transition plan
    a. This may include the youth/child, parent, guardian, conservator, tribal representative, child and family team members, or authorized representative
    b. This should also include mental health treatment team members, regardless of whether they are directly employed, contracted, or community partner
11. Transition determination plan that meets the latest STRTP regulatory requirements

12. In addition, DHCS and the Fresno County Mental Health Plan requires the following functional assessment tools at regulatory and policy directed intervals:

- The Child and Adolescent Needs and Strengths (CANS)
- The Pediatric Symptom Checklist (PCS-35)

Each STRTP shall retain each youth's medical record for a minimum of 10 years from the youth's transition out of the STRTP or the last audit, whichever is later. *Audit*, in this context, refers to any investigation about a complaint, unusual occurrence, chart review, or financial audit. The retention of the medical record shall be extended if the youth's treatment is subject to any due process proceeding, including administrative review and litigation, until all appeals have been exhausted.

INFORMATION TO EXCLUDE FROM DOCUMENTATION

- Information that could prove embarrassing or information that has no relevance to treatment
- Personal opinions about the client or other professionals
- Detailed, sensitive information such as sexual practices
- Do not specifically document STDs or HIV/AIDS in the chart
    - You may use language such as “chronic blood-borne condition” or “condition that requires ongoing medical attention for treatment”

Remember that the medical record may be subpoenaed at any time. Be mindful about what you are documenting!

PROVIDING SERVICES DURING A PUBLIC HEALTH EMERGENCY

- BHIN 20-009: Guidance for behavioral health programs regarding ensuring access to health and safety during the COVID-19 public emergency
- DHCS COVID-19 Response Website
- Infection Mitigation in Behavioral Health Facilities – COVID-19 FAQs
- California Telehealth Resource Center - CalTRC
- CMS COVID-19 Blanket Waivers

FREQUENTLY ASKED QUESTIONS – TELEPHONE AND TELEHEALTH DURING THE COVID-19 CRISIS[3]

The goal of Fresno County DBH is to assist practitioners as we collectively work together to ensure the persons we serve can access all medically necessary behavioral health services while minimizing the community spread of COVID-19. In accordance with State Department of Health Care Services (DHCS) Information Notice 20-009 and Fresno County Department of Behavioral Health notifications, providers should maximize the use of telephone and/or telehealth methods of delivery.

1. Can I provide telephone or telehealth services?

Yes, telephone services are encouraged. For clarification, any services that occur by telephone (no video) are referred to as "telephone services." Services that include audio and video are "telehealth." Any service, including an individual or group service, that can be provided by telephone or telehealth is reimbursable in all counties. Examples include:

- Mental health services
- Crisis intervention services
- Targeted case management
- TBS, ICC & IHBS
- Medication support services
- Components of day treatment intensive, day rehabilitation, adult residential treatment services, and crisis residential treatment services
- Mental health intake/assessments may be provided through telephone or telehealth[4]

Certain services, such as crisis stabilization, day rehabilitation, day treatment intensive, crisis residential treatment services, and adult residential treatment services require a clearly established site for services and some also include in-person contact with a beneficiary in order to be claimed. However, not all components of these services must be provided in person.[5] (An example could

[3] April 8, 2020 Memo to Fresno County DBH Providers, Amended from Santa Clara County Behavioral Health and Los Angeles County Dept. of Mental Health Guidance Documents 2020

[4] BHIN 20-009 Guidance on COVID-19 for Behavioral Health

[5] Title 9, CCR, Sections 1840.318, 1840.320, 1840.332, 1840.334 and the California's Medicaid State Plan: Supplement 1 to Attachment 3.1-A

include services via telephone for a patient quarantined in their room due to illness).

2. How can I call the people I serve without my personal phone number showing?

If you are using your personal phone, it is recommended that you dial *67 and then dial the person's phone number. This will block your phone number, thus preventing individuals you are serving from having your personal information.

3. How can I provide video-based telehealth services?

Telehealth Frequently Asked Questions

Video-based services are referred to as "telehealth services." Providers are encouraged to determine the most appropriate platform for the services they provide. Below are examples of allowable platforms which can be utilized to provide telehealth services during the COVID-19 pandemic.

- WebEx
- Zoom
- Apple FaceTime
- Skype or Skype for Business

Clinical staff who have interest in other platforms should review options with their supervisor before proceeding with any platforms not listed above. Be aware of your options which protect your personal information (phone number, email address, etc.), as this ability may be limited in some platforms.

*IMPORTANT NOTE: Due to the lack of confidentiality, all public-facing or social media platforms such as Facebook Live, Twitch, TikTok, SnapChat, Instagram, and similar applications are **not** allowed.*

4. How do I maintain confidentiality while teleworking?

When talking on the telephone or via videoconference, you must be in a room alone to preserve confidentiality. No one in your household should be able to hear the call or join the line. You should do everything possible to minimize background noise in your setting. If you have a white noise machine, you might consider utilizing it during your sessions.

The person receiving services should be encouraged to be mindful of their privacy by not have anyone in the room who isn't part of the session. If it is not possible to be alone in a room, encourage the person receiving services to wear headphones with their device, if available. The individual should be advised that if others are present nearby, they may hear them speaking and this limits

their confidentiality.

Due to the COVID-19 crisis, the U.S. Department of Health & Human Services (HSS) published a notice that under certain conditions, as long as telehealth services are provided in good faith, the Office of Civil Rights will exercise enforcement discretion to not impose penalties for noncompliance with regulatory requirements under the HIPAA Rules. As the provider, you are expected to discuss the risks/benefits related to confidentiality and telehealth services and document that this was discussed with the individual.

It is common and expected that many of us may experience anxiety and other emotions related to COVID-19. For the individuals and their families we are serving, there may be additional reactions related to the transition to telehealth. It is appropriate to ask about and address emotions and coping related to the COVID-19 pandemic, the transition of service-delivery, and related matters. Your interventions related to addressing and working through these feelings are appropriate and should be documented. It is not necessary to update the treatment plan based on these new topics unless there is a fundamental change in goals, objectives, or interventions or other relevant treatment variables.

5. What should I say regarding verbal consent and the risks, benefits, consequences and provisions of telehealth?

   Please see Appendix I – Example Script for Telephone and Telehealth Services

6. How should I prepare for potential crisis or emergency situations that may arise during a telephone or telehealth session?

   At the start of each session, ensure that you know the actual location of the person you are serving

   a. This is critical so that you can direct the individual accordingly and/or mobilize resources to them in the event of an emergency
   b. Document the location and the call back number of the person at the start of your session so that you have the information easily accessible to you

7. Identify a family member or other support person whom you can contact in case of emergency

   a. Do this at the start of treatment when describing your emergency protocols AND confirm this information at the start of each session (as the preferred or available support person may change)

b. Obtain the support person's contact information and document this in your note at the start of the session so that you have the information easily accessible to you
c. Identify in advance the local emergency resources and phone numbers and have contact information accessible during each session

- **Exodus Crisis Stabilization Center** – 24/7 facility for acute mental health crisis – 4411 E Kings Canyon Rd, Fresno 93702 - 559-453-1008 (Direct Line) or 1-800-654-3937 (Access Line)
- **National Suicide Prevention Hotline** – 24/7 availability: 1-800-273-8255
- Crisis Text Line - 24/7 availability: Send text message to 741741
- Become familiar with the location of nearest hospital emergency department capable of managing psychiatric emergencies
    a) Ensure that you know the nearest hospitals in all parts of the community you are serving
    b) In Fresno County, this includes knowing hospitals nearest to rural communities
- Review your emergency protocols with the individual you are serving at the start of services
    a) Discuss how you will evaluate a crisis or emergency
    b) Indicate the measures that you may take in the event of a crisis or emergency, including measures you will take if the crisis cannot be resolved by phone or video- based intervention and safety planning; your protocol may include contacting the identified emergency support person, calling 911, and any other interventions that are described in your emergency protocols
    c) Obtain verbal consent/agreement to the emergency protocols and document this in the individual's health record.

8. What are steps to take to further prepare the person served for this new and different way of accessing services?
9. Review your communication protocols with the individual you are serving at the beginning of services. These protocols may include expectations regarding phone, text messaging, email, or other communication channels. Recommendations for your communication protocol include addressing:

- How the individual should communicate with you for time-sensitive, urgent, or emergency situations
- How the individual should communicate with you for routine matters such as scheduling or rescheduling appointments
- How you will ensure that the person served understands what to do should a crisis or emergency occur outside of a telehealth session

10. What Specialty Mental Health Services (SMHS) may be provided over the telephone?
    - Plan Development (159)
    - Individual Therapy (126)
    - Group Therapy (82)
    - Individual Rehabilitation (158)
    - Collateral (150)
    - Collateral – Group (153)
    - Case Management (Includes Targeted Case Management) (205)
    - Case Management – Placement (206)
    - Crisis Intervention (31)
    - Medication Support Service (47)

11. What SMHS may be provided via telehealth?

- Assessment (103)
- Plan Development (159)
- Individual Therapy (126)
- Individual Rehabilitation (158)
- Collateral (150)
- Case Management (205)
- Crisis Intervention (31)
- Evaluation and Management Medication Services (190)

12. What Substance Use Disorder (SUD) services may be provided via telephone or telehealth?

Examples of SUD services allowable by telephone:

- Individual Counseling
- Case Management
- Collateral

Examples of SUD services allowable by telehealth:

- Assessment
- Individual Counseling
- Case Management
- Collateral

13. Can a provider conduct a mental health assessment over the telephone?

Yes. During the COVID-19 crisis, Fresno County DBH is allowing assessments to be completed and finalized over the telephone. The documentation should state the agreement of the person-served to receive the assessment over the telephone as well as that the service was provided via nonstandard means due to the COVID-19 crisis. Practitioners may verify the person's identity and address verbally and obtain proof of the person's identification when the individual can be seen in-person.

When certain information cannot be obtained during a telephone contact (e.g. some observational data included in the mental status exam), it should be obtained upon the first in- person encounter with the individual or at the first telehealth service. A diagnosis must be provided at the point of finalizing the assessment based on the information that has been gathered. As with any other case, a diagnosis may be subject to revision in light of additional information being obtained.

14. Can a SUD provider conduct an assessment over the telephone?

Not fully. SUD assessments may include a gathering of information by telephone; however the final determination of diagnosis and medical necessity must involve an in-person or telehealth encounter with the individual. A diagnosis must be provided at the point of finalizing the assessment based on the information that has been gathered.

15. Can group and family services be provided over the telephone or telehealth?

Yes, Fresno County DBH has expanded the use of the procedure codes for group (82) and family sessions (156) to allow for telephone and telehealth methods of delivery for mental health services. For SUD providers, group services may be delivered by telephone and telehealth using the proper Location code (refer to instructions for claiming telephone and telehealth services below, under Claiming). However, these services should be provided with caution and all individuals involved in such services must be advised of the privacy risks inherent in conducting group/family sessions over the telephone or through telehealth.

16. Previous guidance states that telehealth services should be provided to persons who are psychologically stable and non-violent, but not all individuals I'm serving meet these criteria; what guidance do you have?

During the COVID-19 response, providers are empowered to serve individuals in the manner determined to be the most reasonably safe during this national health emergency. Reaching those most at risk is a priority and exercising professional judgement is understood. All providers should have emergency contact information accessible during telehealth sessions and a plan ready should the need arise during the call or telehealth session.

17. Can we claim for telephone check-ins with individuals on our caseload during the COVID-19 crisis?

As is the case at any other time, whether a service can be claimed under Medi-Cal depends on the specific activity the provider performs, the guidance of the treatment plan, and related variables. If the service provided during a telephone check-in addresses the individual's identified mental health symptoms, behaviors, and/or impairments, the activity may be claimable as a direct treatment service such as individual rehabilitation or plan development. If the activity represents no service, such as leaving a voicemail, then a "Note to Chart" service code must be used. (SC 956)

DOCUMENTATION

18. How do I document telehealth activities?

Service documentation should be completed in the individual record in the same way as an in- person visit and the individual's verbal consent for the telehealth visit should be noted in the medical record.

19. Are there any special documentation requirements to consider during the COVID- 19 crisis?

Service documentation should be completed in the individual record in the same way as an in- person visit. If a service is delivered in a nonstandard manner (e.g. an assessment completed over the telephone or a case-management service by telehealth), this should be stated at the beginning of the progress note and that the individual agreed to the method in which the service was delivered (i.e. telephone or telehealth). In addition, the note should indicate that the service was provided during the COVID-19 crisis.

Sample progress note language:

This session was provided via [WebEx, Skype, etc. or telephone] due to recommendations from public health agencies regarding limiting face-to-face contact during the COVID-19 crisis. This individual agreed to participate in services via [telehealth or telephone] and provided verbal consent. The plan for dealing with an emergency during the session was addressed and the individual was informed that this writer will [call 911 or contact an identified emergency contact], depending on the nature of the situation. The individual is aware of and agrees to this plan.

20. How do we handle individual treatment plans if the individual is not physically present to sign, or it is not safe to pass pens and paper between the individual and practitioner?

    Individual treatment plans may be completed over the telephone or via telehealth, and verbal approval for the treatment plan may be obtained. The individual/legal representative's verbal agreement to the treatment plan should be documented on the individual treatment plan. For providers using Avatar as the electronic medical record, this is done by marking "No sign due to Telehealth" on the signature line, then documenting in the progress note that the individual agreed verbally to the plan but was not able to sign due to the COVID-19 crisis.

CLAIMING

21. How are SUD services delivered by telephone and telehealth claimed?

    No additional billing code is required. The service provided should be claimed with the appropriate procedure code. NOTE: When submitting a claim for telehealth services in Avatar, ensure that you indicate within the "Location" drop-down box one of two options:

    - Telehealth (02_P) if using video conferencing technology, or
    - Phone (02_P) if using a telephone

22. How are Mental Health services delivered by telephone and by telehealth claimed?

    Use the "T" specified service code for mental health services by telephone (Example: 126T is Individual Therapy by telephone). When the mental health service is delivered by telehealth, use the appropriate service code and indicate within the "Location" drop-down box "Telehealth."

23. How are mental health telehealth services claimed when claims are submitted by CMS 1500 claim forms?

    The GT modifier must be added to the procedure code for all telehealth services, and the place of service will be "telehealth-02".

24. How is timely access to care accounted for during the COVID-19 crisis? Do new individuals have to be assessed?

    At this time, there is no guidance from DHCS that relaxes the timeframes for access to care during the COVID-19 crisis.

STAFFING

25. Does a provider need to be certified or pre-approved for telehealth services?

    No. There is no Medi-Cal requirement that a provider be specifically certified or pre-approved for telehealth services. Licensed, license-waivered, registered and non-licensed providers may provide services through telehealth as long as the service is within their scope of practice.

    Please refer to the Fresno County Substance Use Disorders Provider Manual for Substance Use Disorder Scope of Practice standards.

26. Does someone need to be present in-person with the individual during telehealth services?

    No. For some programs that were using telehealth before the COVID-19 pandemic, there may have been a practice whereby a staff person was physically present with the individual while the person received a service from a telehealth provider. However, in order to support social distancing protocols, please note that there is no requirement for the presence of a staff person. Further, DBH supports adherence to state and local "stay at home" orders and encourages providers to allow individuals to receive their telehealth services while at home rather than in a clinic. Professional judgment is, of course, always required to determine the safest and most appropriate plan for services for every individual served.

    Fresno County DBH will continue to update providers as additional information becomes available. The COVID-19 pandemic remains a fluid situation. The federal, state, and local jurisdictions are working to address a variety of regulatory and other variables. As information becomes available that impacts the delivery of services, DBH will update guidance and communicate accordingly.

CONFIDENTIALITY & HIPAA

PPG 1.3.8B Medical Records Standards

PPG 1.3.8C Acknowledgment of Confidentiality Mental Health Consumers

Fresno County Notice of Privacy Practices

DHCS Notice of Privacy Practices

DHCS Privacy Forms

The FCMHP and contract providers strongly support the policy of client confidentiality requirements of California Welfare & Institutions Code Section 5328, and the Federal Health Insurance Portability & Accountability Act (HIPAA). We must protect client confidentiality and be aware that the medical record is a legal document that can be subpoenaed by a court.

The HIPAA Act of 1996 was developed to make it easier for people to continue with their health insurance regardless of job changes and to help the health care industry to control administrative costs. The rule went into effect in April 2003. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information
- Provides the persons we serve their rights regarding their health information

The HIPAA Privacy regulations require health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI)--when it is transferred, received, handled, or shared. This applies to all forms of PHI, including paper, oral, and electronic, etc. Furthermore, only the minimum health information necessary to conduct business is to be used or shared.

Each contracted provider, whether individual, group, or organizational provider, must develop and maintain a written Notice of Privacy Practices that is specific to their

agency, as a handout and posted at the site. Acknowledgement of receipt of Notice of Privacy Practices at the time of intake must be maintained in the client record.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Fresno County Authorization for Access, Use, and Disclosure of Protected Health Information Form (MD2910: Attachment A of directive)

Effective May 14, 2018, the FCMHP implemented an updated Release of Information form in the electronic health record (Avatar) to conform with the approved countywide form. The form is available in Avatar Search Forms field; the viewer is under *Release of Information 2018 Viewer*.[6] There are English, Spanish and Hmong versions in Avatar.

If you are not in the Avatar system and have created your own ROI form, please ensure that it includes all of the required elements as specified in *MD2910*, and is in a font size **no smaller than 12 point.**[7] Large print materials should be no smaller than 18 point font.

Important: If not done already, all active (not expired) ROI forms in Avatar signed by the beneficiary/legal guardian need to be updated and signed using the 12 point font form in order to be compliant.

RELEASE OF INFORMATION REQUESTS - TIME REQUIREMENTS

If you are asked to approve the release of records or if you are writing a summary letter, Fresno County providers shall ensure that the **copies** of medical records requested are transmitted within **fifteen (15) days** after receiving a valid written request or authorization [Health and Safety Code section 123110(b)] for copies of records.[1]

Fresno County providers may provide the individual with a **summary** of the PHI requested in lieu of providing copies of or access to the medical record(s). The summary must be made available to the consumer/beneficiary within **ten (10) working days** from the date of the consumer/beneficiary's valid written request; can be extended to no more than **thirty (30) days** from the date of receiving their valid written authorization

[6] Fresno County DBH News You Can Use #29, May 10, 2018 – *Avatar Authorization for Access, Use, and Disclosure of PHI form, also known as ROI, Updates*
[7] Civil Code Div. 1, Part 2.6 Confidentiality of Medical Information, Chapter 2, section 56.11

and/or request and the consumer/beneficiary shall be notified that the extension is needed.

UNIQUE HEALTH IDENTIFIER INFORMATION THAT MUST BE PROTECTED

Information that does not identify an individual is not considered Protected Health Information (PHI) for the purpose of disclosure. Unique health identifier information that must be protected includes:[8]

- Names
- All subdivisions smaller than a state including street address, city, county, precinct, zip code, and their equivalent geocodes All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death, and all elements of dates, including age
- Telephone numbers
- Fax numbers
- Email addresses
- Social Security numbers
- Medical Record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web URLs
- Internet protocol (IP) address numbers
- Biometric identifiers, including finger, iris, and voice prints
- Full face photographic images and any comparable images

[8] Fresno County Management Directive 2910; HIPAA Act of 1996; 45 CFR parts 160 & 164

- Any other unique identifying number, characteristic, or code

PROTECTING EMAIL CONTAINING PROTECTED HEALTH INFORMATION

All Email containing protected health information (PHI) (except for attorney-client Email, which will utilize a privileged/confidential statement) will have the following confidentiality notice placed at the beginning of each Email:[9]

> *This Email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender without using replay Email and destroy all copies of the original message.*

Staff will not include PHI in Email unless it is necessary for treatment, payment, or healthcare operations, or other reason consistent with the welfare of or services pertaining to the individual. Staff will not include PHI in the subject line of an Email for any reason.

Unique health identifier information will be restricted to first name, last initial, chart number, case number, or account number.

PROCEDURE TO SET PASSWORDS ON EMAIL ATTACHMENTS

Any Email attachment containing PHI must be password protected. Instructions are provided on how to set passwords for Microsoft Word® and Excel® documents that will be attached to Emails. Encryption is also used as an added security measure through the County network by the Information Technology Services Department (ITSD). If you have any questions, please contact ITSD or the DBH Information Systems Division.

WORD DOCUMENTS

1. Open the document
2. Click on the "File" menu
3. Select "Protect Document"
4. In the drop-down, select "Encrypt With Password"

[9] Fresno County Dept. of Behavioral Health Management Directive 2905

5. Type in the password (case sensitive)
6. Re-enter the password again, and click “OK”
7. Click “Save”

EXCEL DOCUMENTS

1. Open the document
2. Click on the “File” menu
3. Select “Protect Workbook”
4. From the drop-down menu, select “Encrypt with Password”
5. Type in the password (case sensitive)
6. Re-enter the password again, and click “OK”
7. Click “Save”

Please note: If you lose or forget a password, you cannot open or gain access to the data in a password-protected workbook.

PORTABLE DOCUMENT FORMAT (PDF)

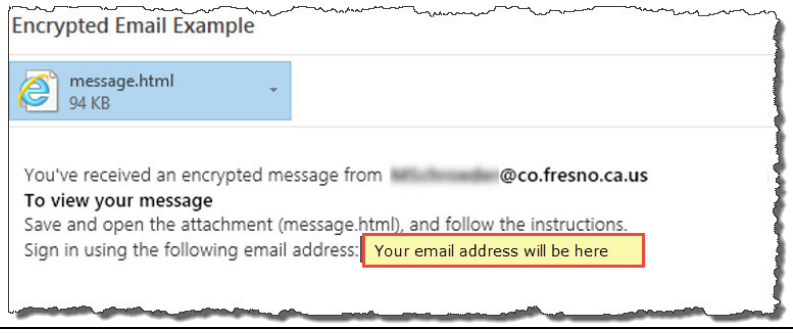
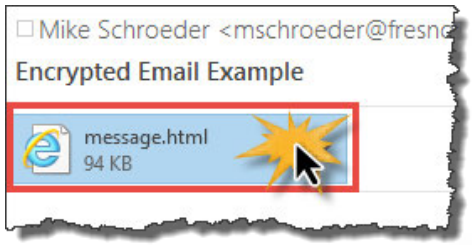
1. Open the PDF and choose File > Properties > Security
2. In the Document Security window, select “Security Method” from the drop-down menu
3. Select “Password Security”
4. Type your password (case sensitive) and click “OK”
5. Re-type your password
6. Save the document (security settings will not be applied until saved)

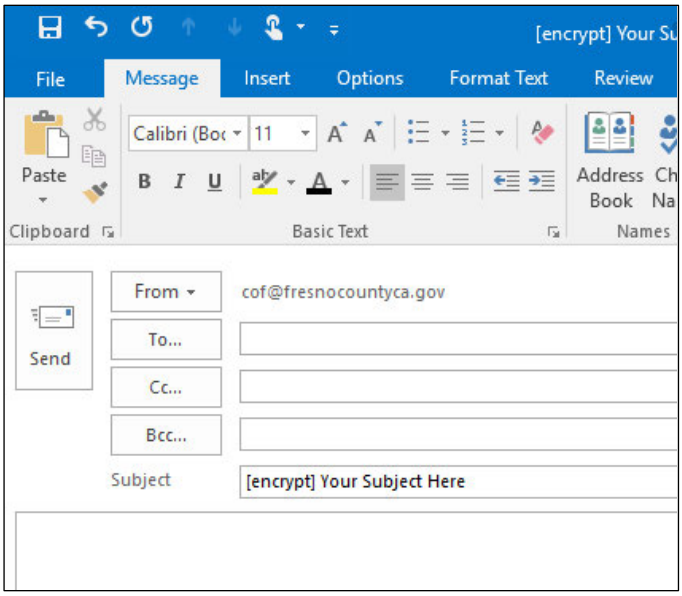
ENCRYPTING AN EMAIL

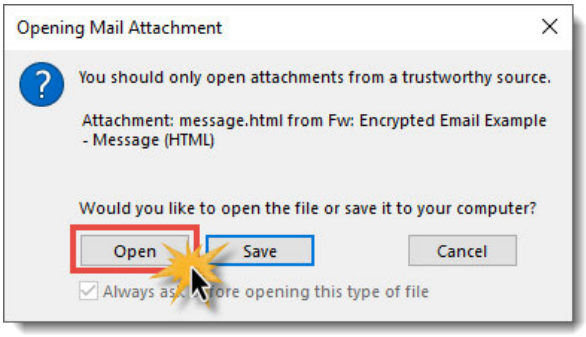
As of June 29, 2018, all Fresno County employees (in-house) will have the ability to send encrypted Emails to external Email addresses. Email encryption is an authentication mechanism that prevents the contents of an Email message from being read by an unauthorized recipient. This Emailing method functions as an added security measure for sensitive and/or confidential information. Encryption can be enabled by typing “[encrypt]” in the subject line before the title of the Email

VIEWING AN ENCRYPTED EMAIL

Please follow the instructions below to view an encrypted Email:

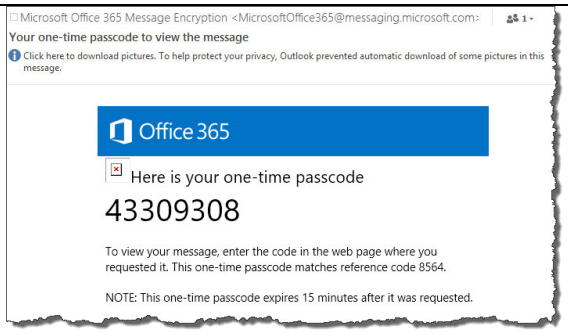
Encrypted email messages will have… Text with information on who the message is **from**, and An attachment named **messge.html**	
To read the encrypted message … Open the **message.html** attachment	

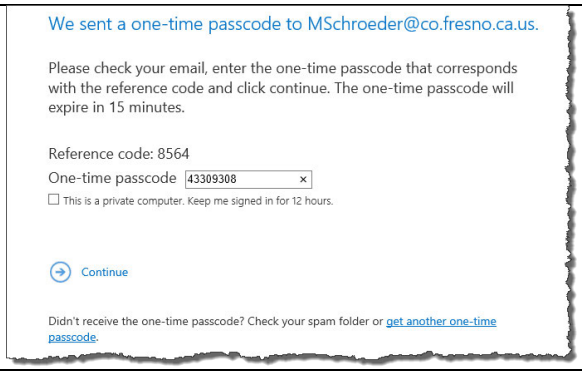
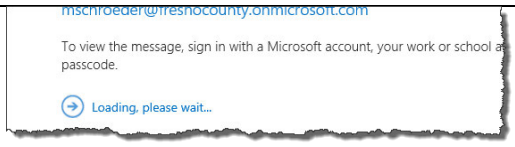


If prompted by the **Opening Mail Attachment** dialog box… Read carefully If you have received this from a trustworthy source… Click the **Open** button	
The message.htm attachment will open. Option links to view the message using a **Microsoft account** or a **one-time passcode** will display.	

If you do not have a Microsoft account under the email address the message was sent to, you must retrieve your message using a one-time pass code. *See those instructions below.*
If you do have a Microsoft account using the email address the message was sent to, see the instructions in next section titled *Viewing with a Microsoft Account*.

Viewing with a one-time passcode

To view the message using a one-time passcode… Click the **Use a one-time passcode** link at the bottom of the message	
You will receive an email message from **Microsoft Office 365 Message Encryption** Open this email to access your passcode **Note:** The passcode will expire in 15 minutes.	

The updated page will have a text box to enter the **One-time passcode** you received. Copy the passcode from the email and paste into the text box (or type it in) Click the **Continue** link The message will display.	
Viewing with a Microsoft Account	
To view the message using a Microsoft account… Click the **Sign in** link at the bottom of the message	
It takes a few seconds while displaying the message **Loading, please wait**	
Click the Microsoft account link and sign in using that account	

MEDICAL RECORDS RETENTION LAW FOR LMFTS

Under California law, it is unprofessional conduct to, "fail to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the

services being rendered."[10] Under California's record retention law, LMFTs are required to do the following:

1. Retain a patient's health care service record for a minimum of seven (7) years from the date therapy terminates;
2. Retain a minor patient's health care service record for a minimum of seven (7) years from the date the minor patient reaches eighteen (18) years of age; and,
3. Maintain the record in either electronic or written form.

The law applies only to the records of a patient whose therapy terminates on or after January 1, 2015.

SHARED DECISION MAKING IN MENTAL HEALTH

When talking about culture and health in shared decision making, consider the following[11]:

- Language Preferences
    - What language do you speak at home?
    - What language would you like to speak here?
    - Would you prefer to use an interpreter?
- Decision making in a person's life and family
    - How are decisions typically made in your family? In your community?
    - Are there particular family members that are consulted on important decisions?
- Beliefs about one's problem or situation
    - How do you describe or understand your situation?
    - Is there a particular name or term used in your family or community to describe what you are experiencing?
- Family or community beliefs associated with the individual's decision making

[10] California Business & Professions Code §4982(v)
[11] Source: SAMHSA

    - Are your family members aware of your situation?
    - What are their views about the decision you are weighing?
- Spiritual, religious, or family beliefs about the use of medication and other Western medicine treatments
    - How is using medication viewed within your family? Within your community?
    - How is Western medicine viewed within your family? Your faith community?
    - What alternatives are used instead of medication?
- Herbs, supplements, and other complementary or alternative medicine
    - Are there herbs, roots, or supplements that you use to promote healing?
- Customs or rituals the person is using or would like to use to promote health and healing
    - Are there customs or rituals that you use for health or healing?
    - Are these rituals rooted in religious or family traditions?
    - Are there customs, rituals, or remedies you would like to try?
- Cross-cultural understanding
    - Are there other aspects of your culture or background that are important for me to understand?
    - Are there areas of your culture or background I may have misunderstood?

CROSS-CULTURAL UNDERSTANDING

The inclusion of cultural perspectives and practices are critical components of assessments and treatment planning, to ensure perceived problems or issues are identified, and placed in the appropriate clinical context. For all **clinical assessments**, providers will document evidence of:

- A discussion of the exploration of culturally significant topics with the person served and/or significant support person(s)
- An exploration and discussion of relevant cultural issues that may pertain to the presenting mental health problem(s) and which can be used in the development of a culturally-appropriate treatment plan

- How linguistic accommodations are made, either through a bilingual certified staff or interpreter service

With such diversity among the persons we serve and treatment providers in our County, it is essential for providers to capture the impact of beliefs, norms, culture and language when considering treatment planning and service delivery. At the initial assessment, in treatment planning, and throughout ongoing treatment, providers should explore the following cultural elements in their interactions with persons served:

- Race and Ethnicity
- Linguistic factors
- Religious/spiritual factors
- Sexual orientation
- Physical abilities or challenges
- Socioeconomic factors
- Alternative or complementary healing practices
- Geography
- Work/Disability
- Art
- Sports
- Entertainment
- Technology
- Immigration

Moreover, **treatment planning** must take into account any cultural considerations and how they may influence progress towards a person's treatment plan goals. By understanding and embracing a person's cultural background, treatment providers are able to provide effective, personalized assessment and treatment strategies that elaborate on the beneficiary's natural resources and strengths.

CULTURAL AND LINGUISTIC STANDARDS[12]

The population of California is one of the most culturally and linguistically diverse in the United States. The Fresno County Mental Health Plan is committed to providing mental health services in a manner that considers the cultural and linguistic needs of the persons served.

Providers who work with beneficiaries who are limited-English proficient (LEP) or non-English speaking must use either bilingual staff members proficient in the language of the beneficiary, or interpreter services. Interpretation/Translation services shall be made available in all languages, not just the threshold languages of Fresno County.

THRESHOLD LANGUAGES

Statistical information per the California Pan-Ethnic Health Network (CPEHN) for Fresno County, languages other than English spoken at home for Fresno County in 2012 were: 76.2% Spanish, 14.8% Asian (6.5% Hmong, 1.8% Laotian, 1.8% Tagalog, 1.2% Cambodian), 7.5% Other Indo-European language, 1.5% Other languages.

Based on this information, English, Spanish and Hmong are identified as threshold languages for Fresno County. Services are to be provided to beneficiaries in their preferred language. Language interpretation/translation services should be utilized as necessary. The County of Fresno will share its' list of certified interpreters to providers upon request, but the provider will be responsible for the cost of these services. Providers may use telephone interpretation services for making appointments or getting information from beneficiaries, but will likewise be fully responsible for the cost of these services. In no case will the beneficiary be billed for the use of interpreter services.

The FCMHP strongly discourages the use of minors, family members, guardians, conservators, or friends as interpreters. If the beneficiary insists on providing his/her own interpreter, the provider will document his/her request in the beneficiary's record and have the beneficiary sign a Release of Information form to be filed in the beneficiary's record.

Providers who work with LEP or non-English speaking beneficiaries will have notices prominently posted at their practice site(s) explaining that interpreter services are available at no cost to the beneficiary.

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[12] Fresno County Mental Health Plan Organizational Provider Directory

SERVICES PROVIDED TO PERSONS WITH VISUAL OR HEARING IMPAIRMENTS

The Fresno County MHP will utilize the State TTY relay system, (7-1-1), as needed, for hearing impaired beneficiaries. The FCMHP will communicate with the local Valley agencies for the blind and hard of hearing to disseminate information about the FCMHP services offered. Beneficiary informational materials are to be made available in alternate forms (i.e., large print and online videos for the visual and hearing impaired). Agency partners for these services:

Deaf and Hard of Hearing Services, Inc.
5340 N. Fresno Street
Fresno, CA 93710
(559) 225-3323

Valley Center for the Blind
3417 W. Shaw Avenue
Fresno, CA 93710
(559) 222-4447

SCOPE OF PRACTICE REQUIREMENTS FOR SPECIALITY MENTAL HEALTH SERVICES

DHCS MHSUDS Information Notice No. 17-040

Attachment 1: Providers of Specialty Mental Health Services

The State Plan describes Specialty Mental Health Services (SMHS) and specifies the provider types for each service. Mental health professionals delivering SMHS must be working within their scope of practice. Waivered/registered mental health professionals may only direct services under the supervision/direction of a Licensed Mental Health Professional (LMHP) in accordance with applicable laws and regulations governing the registration or waiver.

If the treatment plan is written by other members of the mental health treatment team, such as a Community Mental Health Specialist (CMHS) practicing **under the direction of** a LMHP, the plan needs to be co-signed by one of the disciplines listed below.

WHO CAN DIRECT AND/OR PROVIDE SMHS

- Licensed Physicians
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Clinical Counselors
- Marriage and Family Therapists
- Registered Nurses
- Certified Nurse Specialists
- Nurse Practitioners

Direction may include, but is not limited to: being the person directly providing the service, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans.

The following types of providers must be licensed in accordance with applicable State of California licensure requirements, and must work *under the direction of* a licensed professional operating within his or her scope of practice:

- Licensed Vocational Nurses
- Licensed Psychiatric Technicians
- Physician Assistants

- Pharmacists
- Occupational Therapists

Other providers who may operate *under the direction of* a LMHP include:

Mental Health Rehabilitation Specialists (MHRS): A MHRS may provide Mental Health Services (including contributing to Assessment, but excluding Therapy), Targeted Case Management (TCM), Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential, and Crisis Residential Treatment Services.

Other Qualified Providers: The State Plan defines "other qualified provider" as "an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department." Mental Health Services (excluding Therapy), TCM, Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential and Crisis Residential Treatment.

While the State Plan specifies that treatment may be provided by any person *determined by the FCMHP* to be qualified to provide the services "under the direction of" a LMHP within their respective scope of practice, the FCMHP has not defined the criteria for "other qualified providers."

Current Fresno County Operations:

- We *do not* accept for credentialing purposes graduate student trainees (a.k.a. Masters Family Therapist Trainee; Social Work Intern I/II; PCC trainees; PhD candidates). At this time, this classification *has not* been formally recognized in the Fresno County MHP under the category of "Other Qualified Provider" for the purpose of use as clinical staff.
- We DO use graduate student trainees in DBH in-house programs. Whether or not the DBH in-house programs claim for the clinical services provided is questionable, but DBH is a practicum site.
- This practice may change in the future, especially with network adequacy needs, but for now, we do not allow practicum students to complete assessments or treatment plans that are then the basis of SMHS claims.

Pertaining to Organizational Providers Only:

The use of practicum students and trainees is dependent on the provider's contract with the FCMHP. The scope of practice of practicum students and trainees (graduate level students enrolled in an academic program but not yet eligible to be registered or

waivered) depends on the particular program in which the student or trainee is enrolled and the requirements for that particular program, including any scope, supervision, or registration requirements per regulations. Non-licensed trainees, associates and assistants must be under the immediate supervision of a LMHP who shall be responsible for ensuring that the extent, kind, and quality of the services performed are consistent with his or her training and experience and be responsible for his or her compliance with applicable state law. (Business & Professions Codes 2913; 4980.03; 4980.09; 4980.43(b); 4996.18(d); 4999.12.5).

An individual participating in a field internship/trainee placement, while enrolled in an accredited and relevant graduate program, working "under the direction of" a licensed, registered, or waivered mental health professional and determined to be qualified by the MHP, may conduct the following service activities:

- Comprehensive assessments, including mental status exams (MSE) and diagnosis
- Development of client plans
- Individual and group therapy
- Write progress notes
- Claim for any service within the scope of practice of the discipline of his/her graduate program

Pertaining to Individual and Group Providers Only:

The use of practicum students and trainees is not allowed.

QUALITY ASSURANCE AND UTILIZATION REVIEW

PPG 1.3.8D Contract Provider Medical Record Review

PPG 1.3.8E Medication Services Utilization Review

PPG 1.3.8F Medical Record Reviews for DBH, County-Operated Mental Health Treatment Programs

PPG 4.3.7 Consistency Monitoring Review of TARs for Inpatient Psychiatric Hospital Services

TIMELY ACCESS TO SPECIALTY MENTAL HEALTH SERVICES

MHSUDS Information Notice 19-020 Client Services Information (CSI) Assessment Record

PPG 1.2.12 Notice of Adverse Benefit Determination

PPG 2.1.10J Access Form: Log Initial Requests for Specialty Mental Health Services

PPG 2.1.10K Access/Referrals Access Form: Track Client Contact Attempts

DOCUMENTING INITIAL CONTACTS

Mental Health Access Form (for Providers not using the Avatar EHR)

A beneficiary may request SMHS in person, by telephone or in writing. Each service access site maintains a written Access Log and completes an Access Form. In 2019, the Department of Health Care Services issued the MH SUDS Information Notice 19-020, which specifies the requirements necessary to comply with new regulations. The State would like to capture the MHP's timeliness of access to first assessment and first mental health service appointment for all non-psychiatry Specialty Mental Health Services.

Effective February 1, 2020, every provider offering outpatient non-psychiatry Specialty Mental Health Services in Fresno County must complete the MHP Access Form for clients who are 1) new to the MHP; 2) returning to the MHP after one year of absence; or 3) had an incomplete/unsuccessful assessment process. The forms are to be completed immediately upon first contact, upon case closure, or after a successful assessment process. Individual and Group providers may access the form via this link and may complete an online or paper form. If paper forms are utilized, they must be mailed, not sent electronically. Organizational providers will enter the contact information directly into the Avatar Electronic Health Record.

Timely Access - STRTP Providers Only

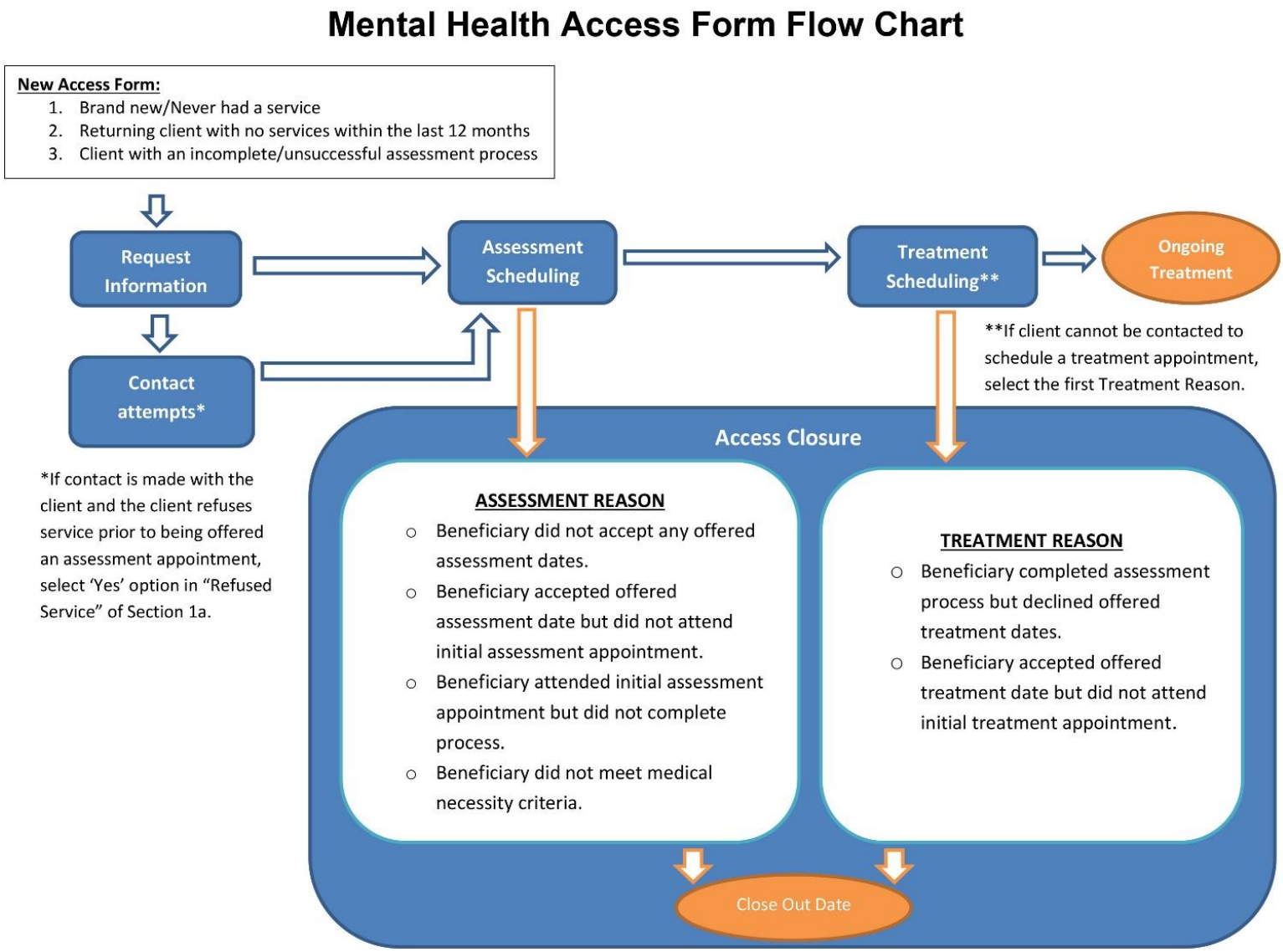
The Head of Service shall sign an admission statement ***within five calendar days*** of the child's arrival at the STRTP. In the statement, the Head of Service shall affirm that they have:

- Read the child's referral documentation and any previous mental health assessments, if available;
- Considered the needs and safety of the child;
- Considered the needs and safety of the children already admitted to the STRTP;
- Concluded that admitting the child is appropriate.

The admission statement shall affirm the following are reviewed and will ensure, if a referral for placement is made through the Interagency Placement Committee (IPC), the materials included in the IPC referral information has also reviewed:

1. The child does not require inpatient care in a licensed health facility.
2. The child has been assessed as requiring the level of services provided in a STRTP in order to maintain the safety and well-being of the child or others due to behaviors, including those resulting from traumas, that render the child or those around the child unsafe or at risk of harm, or that prevent the effective delivery of needed services and supports provided in the child's own home or in other family settings, such as with a relative, guardian, foster family, resource family, or adoptive family.
3. The child meets at least one of the following conditions:
    a. The child has been assessed as meeting the medical necessity criteria for Medi-Cal specialty mental health services, as provided for in Section 1830.205 or 1830.210 of Title 9 of the California Code of Regulations.
    b. The child has been assessed as seriously emotionally disturbed, as defined in subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.
    c. The child requires emergency placement.
    d. The child has been assessed as requiring the level of services provided by the STRTP in order to meet their behavioral or therapeutic needs.

MENTAL HEALTH ACCESS FORM FLOW CHART



DBH COUNTY-OPERATED MENTAL HEALTH MEDICAL RECORD REVIEWS

All Mental Health Divisions of the Department of Behavioral Health shall adhere to medical necessity and documentation standards set forth by DHCS and the FCMHP. Compliance of these standards shall be routinely monitored through a quality assurance review process.

All reviewers are responsible to ensure that medical necessity criteria is met and that all services are claimed appropriately. All three of the following components are required to justify medical necessity for SMHS:

1. The presence of at least one primary included ICD-10 **diagnosis**
2. Must have an **impairment** due to the mental disorder (must meet one of the following):
    a. A significant impairment in an important area of life functioning
    b. A reasonable probability of significant deterioration in an important area of life functioning
    c. A reasonable probability that a child (under age 21) will not progress developmentally as individually appropriate
3. **Intervention**-related criteria (must meet all of the following):
    a. The focus of the proposed intervention is to address the included diagnosis and impairments
    b. The expectation is that the proposed intervention(s) will significantly diminish the impairment, prevent significant deterioration in functioning and allow the child to progress as individually appropriate
    c. The condition would not be responsive to physical health care-based treatment alone

RESPONSIBILITIES OF CLINICAL SUPERVISORS AND CLINICIANS

Each Clinical Supervisor will be responsible for conducting a medical record review of each direct service staff. Such reviews will be done quarterly with adjustments to the schedule as determined necessary by the Division Manager. At the discretion of the Division Manager or Supervisor, a medical record review may exceed the minimum number of charts, review period, and/or frequency.

A minimum of one randomized chart of active persons served will be evaluated per subordinate each quarter to determine the employee's compliance-related

performance. Selection of these charts will not be randomized if the review is done for the purpose of a person-specific, staff-specific, or service-specific issue. The review will cover the three-month service period preceding the month of the review. All medical record reviews shall utilize the standardized Chart Review Tool (See PPG 1.3.8F, Attachment A).

The findings of all medical record reviews for a staff member will be reviewed with the employee. For unlicensed mental health clinicians, the findings may also be shared with their mentor.

CONTRACT PROVIDER MEDICAL RECORD REVIEWS

The Fresno County Department of Behavioral Health will perform compliance reviews of contracted providers that shall include a site visit and review of selected charts by one or more Utilization Review Specialists (URS) from the Department's Managed Care Division utilizing the *FCMHP Chart Review Documentation Checklist-OP Services*. An initial medical records review/audit will be performed within six (6) months after the provider contracts with the FCMHP and Medi-Cal reimbursable SMHS are claimed. Ongoing medical records reviews will be performed annually, or more often as needed to follow up after audits with Plans of Correction.

Reviews may be more frequent, based on compliance results as determined by the URS. Organizational provider medical records will be reviewed annually.

ASSESSMENT STANDARDS

PPG 2.1.9 - Assessments *Assessment and Re-assessment Forms*

It is the policy of the FCMHP that clinical staff shall ensure that all Fresno County persons served, adult and children, who receive outpatient Specialty Mental Health Services (SMHS) have a comprehensive assessment upon accessing services, and that appropriate updated assessments/re-assessments are completed at least every two years, in accordance with the FCMHP and DBH documentation standards.

The assessment process is a clinical evaluation of the person's *current* mental, behavioral and emotional status, and includes relevant cultural and historical information, diagnosis, and the use of testing instruments as appropriate. The golden thread of the "clinical loop" begins with the assessment and allows the clinician to develop a case formulation for the individual.

The assessment should thoroughly document the person's presenting problem(s), goals and objectives for treatment, and the strengths of the person *at a particular point in time,* and determine whether or not mental health treatment is needed based on

medical necessity. If medical necessity criteria are met, the assessing clinician, along with the person's participation and input, makes the decision to proceed to develop a treatment plan.

REASONS FOR RECOUPMENT FISCAL YEAR 2020-2021

MEDICAL NECESSITY/ASSESSMENT

1. The Mental Health Plan (MHP) did not submit documentation substantiating it complied with the following requirements:

A. The MHP uses the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as the clinical tool to make diagnostic determinations. *(MHP Contract, Exhibit A, Attachment 3)*

B. Once a DSM-V diagnosis is determined, the MHP shall determine the corresponding mental health diagnosis, in the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) and use the ICD-10 diagnosis code(s) to submit a claim for specialty mental health services (SMHS) to receive reimbursement of Federal Financial Participation (FFP) in accordance with the covered diagnoses for reimbursement of outpatient and inpatient SMHS.

MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations § 1830.205(b)(1) and 1830.210; and, Mental Health and Substance Use Disorder Services Information Notices

Please note: The applicable ICD-10 diagnoses are subject to change. If applicable, changes in covered ICD-10 diagnosis codes will be detailed in MHSUDS Information Notices.

2. Services, except for Crisis Intervention and/or services needed to establish medical necessity criteria, shall be provided, in accordance with the State Plan, to beneficiaries who meet medical necessity criteria, based on the beneficiary's need for services established by an Assessment. The MHP did not submit documentation substantiating the beneficiary's need for services was established by an Assessment.

   MHP Contract, Exhibit A, Attachment 2

3. The MHP did not submit documentation substantiating that, as a result of an included ICD-10 diagnosis, the beneficiary has, at least, one of the following impairments:

   a) A significant impairment in an important area of life functioning;

b) A probability of significant deterioration in an important area of life functioning;

c) A probability the child will not progress developmentally as individually appropriate; or

d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, title 9, chapter 11, section 1830.205(b)(2) (A-C); CCR, title 9, chapter 11, section 1830.210(a)(3)

TIMELINESS OF ASSESSMENTS

PPG 1.2.13 – Notice of Action – E (Lack of Timely Service)

All persons receiving outpatient SMHS shall have a comprehensive assessment completed by a designated licensed or registered/waivered staff within 30 days from the initial contact date.

- A Notice of Adverse Benefit Determination shall be sent to the client by the designated staff member if the initial comprehensive assessment is not completed within this time frame.
- When a person remains in continuous services, an update/re-assessment shall be completed *at least every two years*. The clinician may complete a comprehensive assessment instead of an update/re-assessment if it is determined to be the more appropriate clinical decision for the person served.

Assessments are time-intensive and often take more than one session to complete. If more than one assessment service is billed, clearly document in a progress note or the assessment document, the reason for each service/session. The number of assessment sessions and total time for the assessment must be reasonable and supported by what is documented in the progress notes and/or assessment. If the purpose of the contact is to gather information for an intake assessment, the service is coded as an assessment.

Example: If a clinician sees a client on Tuesday and begins the assessment and finishes the assessment on Wednesday (without the client present), the time spent on documentation may be added to Tuesday's assessment and billed as one bundled service or billed the actual day it is done. For providers with business hours of 8 hours per day, services billed may not exceed 8 hours in a 24-hour period.

Timeliness of Assessments - STRTP Providers Only

Each STRTP shall ensure that *within five (5) calendar days of the child's arrival*, the child has a completed and signed mental health assessment.

CONSENT FOR TREATMENT

PPG 2.1.19 – Consent for Treatment

DBH Guidance Regarding Consent for Behavioral Health Treatment – Appendix

Before commencing the assessment process, it is the duty of the mental health professional, or other designated person within the MHP, to inform the beneficiary or the person(s) legally authorized to act on the beneficiary's behalf, the limits of confidentiality, risks/benefits of treatment, alternative treatments, and available services to enable the beneficiary to make an educated decision prior to consenting to treatment. The written consent for treatment, as well as Informed Medication Consent forms, shall be retained in the medical record. A copy of either of these forms should be offered to the beneficiary.

CAREGIVER'S AUTHORIZATION AFFIDAVIT

There are times when parents find they need someone else, often a grandparent or other family member, to care for and make decisions for their children, but do not have legal guardianship. [13]

As an alternative to legal guardianship, caregivers can sign a Caregiver's Authorization Affidavit. A Caregiver's Authorization Affidavit is a form that is completed by a caregiver who is not the parent or legal guardian caring for a person under the age of 18. The form lets school personnel, medical/mental health providers and welfare caseworkers know who is caring for the child.[14] If possible, the parent/legal guardian must be informed by the caregiver consenting that the form was completed. If the minor stops living with the caregiver, the caregiver is required to notify any school, health care provider, or health care service plan to which the affidavit has been given.

An *affidavit* is a written statement attesting that the information on the form is true and correct to the best of their knowledge. *Legal Custody* is the legal right to make major

[13] Caring for Another's Child: Caregiver's Authorization Affidavit
[14] Instructions for Using a Caregiver's Authorization Affidavit

and long-term decisions about the raising and welfare of a child. These rights are generally shared by the parents, unless a court order is approved giving legal custody to one parent, or another person. A *custody order* is a court order that says who a child will live with and/or who should make decisions about health care, education, and other important issues affecting the welfare of the minor. A *guardian* is a person who isn't the parent, but has a court order giving them legal custody of a child. [15]

Caregiver's Authorization Affidavit-English

Caregiver's Authorization Affidavit-Spanish

Caregiver's Authorization Affidavit-Hmong

[15] California Indian Legal Services, How Do I Enroll a Child in School or Help a Child Get Medical Care if I Don't Have Legal Custody?

REQUIREMENTS FOR INFORMED MEDICATION CONSENT

PPG 2.1.8 - Informed Medication Consent

The MHP requires providers to obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication. The documentation shall include, but not be limited to: the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and, that the consent, once given, may be withdrawn at any time by the beneficiary. It is acceptable for the medication consent to include attestations, signed by both the provider and the beneficiary, that the provider discussed each of the required components of the medication consent with the beneficiary; however, this **does not** preclude the need for a signed medication consent form.

- The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the beneficiary[3]
- Judicial Council Forms (JV-217 through JV-224) are not sufficient to ensure informed medication consent
- Specifically, the court forms do not include information on the method of administration (oral or injection) or additional side effects if the child were to take the method for more than three months
- Although children under 12 years of age or older may provide legal consent to mental health treatment or counseling without the consent of their parent or legal guardian, this authority to consent *does not extend to psychotropic medications*.[16] A parent or guardian's consent is needed for a child to receive psychotropic medication[17]

[16] **Psychotropic Medications**: Medications that are administered that affect the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, psych-stimulants, and medications used for side effects caused by psychotropic medications.

[17] Family Code § 6924(f) and Health & Safety Code § 12460€

- If the medication is not a psychotropic medication and all statutory requirements are met, a child age 12 or older may be the sole signatory of a medication consent form[18]
- In the case of foster children, a court will determine who is authorized to consent to psychotropic medication on the child's behalf[19]

The prescribing psychiatrist, physician assistant (PA) or nurse practitioner (NP) must ensure the Informed Medication Consent form is completed, reviewed and signed by the adult beneficiary or parent/legal guardian of a minor child, prior to the administration of psychotropic medications.

In order to make an informed decision, the parent/legal guardian/minor is to be provided sufficient information by the treating provider prescribing such medication, which shall include the following:[20]

- Their right to accept or refuse medication (California State law requirement)
- Nature of the adult/minor person's target symptoms and/or mental condition which the proposed medication(s) have been recommended
- Reasons for taking such medication including the likelihood of improving, or not improving without such medication
- The right to withdraw previously given consent at any time by stating such intention to any member of the treating staff
- Reasonable alternative treatment, if any
- Type of medication (including the use of PRN orders)
- Range of frequency of administration
- Dosage
- Method of administration (oral or injection)
- Probable side effects

[18] MH SUDS IN 17-040, page 18
[19] Welfare & Institutions Code § 369.5(a) and 739.5(a)
[20] FCDBH Policy & Procedure 2.1.8: Informed Medication Consent

- Side effects may include persistent involuntary movements of the face, tongue or mouth and might at times include movements of the hands and feet
- Tardive Dyskinesia or other symptoms are potentially irreversible side effects that may appear even after the medications have been discontinued
- Possible additional side effects which may occur if taken longer than 3 months

Per FCMHP standards, the Medication consent form must always include:

- The date of service
- The beneficiary's name and medical record number
- The signature of the person providing the service and this person's type of professional degree, **and** licensure type or job title
- The signature of the beneficiary and/or legal guardian[21]
- If the beneficiary/legal guardian refuses to consent to medication, this shall be documented in a progress note
- If the beneficiary verbally agrees to take the medication but declines to sign the consent, this shall be documented in a progress note, and efforts should be made and documented at each subsequent visit to encourage the signature
- The date the documentation was entered into the medical record[22]

FREQUENCY OF OBTAINING INFORMED MEDICATION CONSENT FORMS

To ensure beneficiary's understanding and accuracy of medications, medication consent forms should be reviewed and signed by the person/guardian when there are any medication changes, and at least every 12 months, even if there are no changes.[23]

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[21] The Executive Order N-55-20 waives the requirement for patient signatures for psychiatric medication consents. Instead, counties shall allow a patient's verbal consent (in lieu of written consent) for receiving psychiatric medication(s), due to the difficulty of collecting signatures when services are provided via telephone or telehealth.

[22] MH SUDS IN 17-050, Enclosure 1: FY 2017-2018 Protocol, pp. 125-126
[23] FCDBH Policy and Procedure 2.1.8: Informed Medication Consent, page 3

GUIDELINES FOR THE USE OF PSYCHOTROPIC MEDICATION WITH CHILDREN AND YOUTH IN FOSTER CARE

MHSUDS IN No. 16-060 – California Guidelines for the use of Psychotropic Medication with Children and Youth in Foster Care

- Although children under 12 years of age or older may provide legal consent to mental health treatment or counseling without the consent of their parent or legal guardian, this authority to consent *does not extend to psychotropic medications*. A parent or guardian's consent is needed for a child to receive psychotropic medication[24]
- If the medication is not a psychotropic medication and all statutory requirements are met, a child age 12 or older may be the sole signatory of a medication consent form[25]
- In the case of foster children, a court will determine who is authorized to consent to psychotropic medication on the child's behalf[26]

As noted above, the JV220 or JV223 in their current form do not contain all medication consent requirements. They are currently missing two (2) elements as follows:

1. Route of administration (i.e., oral or injection) and
2. Side effects if on a medication longer than three (3) months

As such, the MHP may document these two (2) in a progress note, ideally attaching it or filing it along with the JV223 so that reviewers are able to find this information readily. You may also use the Fresno County Medication Consent form (see link below). For more detailed information on minor's consent and authorization requirements of other involved parties, please see *PPG 2.1.19 – Consent for Treatment and PPG 2.1.8 - Informed Medication Consent.*

Medication Consent Forms

[24] Family Code § 6924(f) and Health & Safety Code § 12460€
[25] MH SUDS IN 17-040, page 18
[26] Welfare & Institutions Code § 369.5(a) and 739.5(a)

CONDUCTING ASSESSMENTS

MHSUDS Information Notice No. 17-040: Chart Documentation

PPG 2.1.9 - Assessments

"Assessment" is defined as a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and, the use of testing procedures. (CCR Title 9, section 1810.204)

As best practice, a face-to-face assessment provides a more comprehensive assessment, although some may be conducted by telephone. Collateral information from previous or current treatment providers may be reviewed as part of the assessment process, as well as information gathered from family members or significant others without the person present.

REQUIRED ELEMENTS OF AN ASSESSMENT

- **Presenting Problem:** The beneficiary's chief complaint, history of the presenting problem(s), including current relevant family history and current family information. *For STRTP Providers Only*: The presenting problem must include the reason for the child's referral to the STRTP.

- **Relevant conditions and psychosocial factors** affecting the beneficiary's physical and mental health, including a history of trauma or exposure to trauma (required for STRTP assessment), living situation, daily activities, social support, and cultural and linguistic factors.

- **Mental Health History:** Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.

- **Medical History:** Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.

- **Medications:** Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. This includes prescribed, homeopathic, and over the counter medications. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications.

- **Substance Exposure/Use:** Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications, over-the-counter, and illicit drugs. Include medical marijuana and methadone treatment.

- **Person's Strengths:** Documentation of the beneficiary's strengths in achieving treatment plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

- **Risks:** Situations that present a risk to the beneficiary and/or others, including past or current trauma, danger to self (DTS) or danger to others (DTO), prior suicide attempts, history of trauma or victimization, substance use history, CPS/CWS involvement, lack of family or other support, history of self-harm behaviors, history of assaultive behaviors, physical impairments, psychological or intellectual vulnerabilities.

- **A Mental Status Exam** is documented.

- **Diagnosis:** A complete diagnosis from the most current Diagnostic and Statistical Manual, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status exam and/or other clinical data.

- **A Clinical Summary** offering additional clarifying formulation information as needed for specific target populations (0-5 years old, perinatal clients, etc.), with recommended treatment interventions.

- **Assessing clinician's dated signature,** license designation, and relevant identification number (i.e., employee number, license number). *For paper-based assessments, signature, licensure and date must be on every page of the assessment.*

Emergency Placement - STRTP Providers Only

In the case of an emergency placement pursuant to Welfare and Institutions Code section 11462.01(h)(3), a licensed mental health professional or waivered/registered professional shall make a written determination that the child requires the level of

services and supervision provided at the STRTP to meet their behavioral and mental health service needs. *The determination shall occur as soon as possible after the child arrives at the STRTP, but no later than 72 hours from the time the child arrives at the facility.*

1) The licensed mental health professional or waivered/registered professional shall consider and address, in the written determination the following information:

a) The child's presenting problem, including the history if it is available

b) Whether the STRTP meets the specific therapeutic needs of the presenting problem

c) The child's prior mental health diagnosis, if any

d) The child's current prescription and non-prescription medications, including dosages.

e) The child's current medical conditions, including any prescribed treatment and medications.

f) A risk assessment that addresses the child's likelihood of danger to self or others.

g) Commonality of need with other children at the STRTP.

h) Any other information necessary to determine whether the child requires the level of services provided at the STRTP.

A child who receives a determination pursuant to paragraph (1) shall also have a mental health assessment as required in the latest version of STRTP regulations to document the need for the STRTP level of care. *A mental health assessment that complies with the most current version of STRTP regulations, if completed within 72 hours of a child's arrival at the STRTP, shall satisfy the requirements of this section.*

Until a licensed mental health professional or waivered/registered professional determines that the child requires the level of services and supervision provided at the STRTP, the child shall have one-on-one observation at all times or be in a physically separate area from the other children in the program. During this time, the child shall receive all services and programming required in these regulations.

CLINICAL SUMMARY - SUGGESTED FORMAT

A complete, thoughtful, and comprehensive case formulation relevant to the current diagnosis is required. The clinical summary should include a thorough, concise summary of the person's presentation and recommendations for treatment. Recommended formula for your clinical summary:

Paragraph one: Review who the person is; what brought him/her to you (indicate recent crisis stabilization episodes/hospitalizations, referral or their reason for seeking treatment); Review all symptoms/problem behaviors with frequency and/or intensity (these are your **baselines** for initial and ongoing treatment planning), and how long each symptom has been present

Paragraph two: Your conceptualization – what do you believe to be the cause; from your clinical perspective, how do you understand the person's presentation?

Paragraph three: Full diagnostic string and recommendations for care

- "Based on the presentation at the time of this assessment along with collateral information provided by/through…the person currently meets criteria for the diagnosis of:…"
- Rule-Outs should be listed in the clinical summary, but not listed as a diagnosis for the basis for treatment
- Be specific as to what interventions/Evidence-based Practices should be included in recommended treatment (i.e., CBT, DBT, EMDR, etc.)

STRTP Requirements - Mental Health Assessment

The STRTP shall ensure that within five (5) calendar days of the child's arrival, the child has a completed (signed) mental health assessment.

The mental health assessment shall be completed by a licensed mental health professional or waivered/registered professional. Other STRTP mental health program staff acting within their scope of practice may assist the licensed mental health professional or waivered/registered professional in gathering information required to complete the assessment.

The mental health assessment shall include the following elements:

- Presenting problem, including the history of the presenting problem(s), family history, and current family information. The presenting problem shall include the reason(s) for the child's referral to the STRTP.
- A mental status examination.
- Mental Health History, including previous treatment, inpatient admissions, therapeutic modalities, such as medications and psychosocial treatments, and response. If available, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.
- Medical History, including physical health conditions, name and address of

current source of medical treatment, prenatal and perinatal events, developmental, and other medical information from medical records or consultation reports. The medical history shall include all present medical condition(s).

- Medications, including information about medications the child has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment, the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications. Medication information shall include all medications currently prescribed and dosage.
- Risks to the child and/or others.
- Substance Exposure/Substance Use, including past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over the counter, and illicit drugs.
- Psychosocial factors and conditions affecting the child's physical and mental health, including living situation, daily activities, social support, sexual orientation, gender identity, cultural and linguistic factors, academics, school enrollment, and employment.
- History of trauma.
- Child Strengths, including the child's strengths in achieving needs and services plan goals related to the child's mental health needs, challenges, and functional impairments as a result of the mental health diagnosis.
- A complete diagnosis shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data.
- Any additional clarifying information.

To satisfy the mental health assessment requirement as described above, the STRTP may use an existing mental health assessment that was performed within the sixty (60) day period preceding the date of the child's arrival at the STRTP, subject to all of the following requirements:

- The mental health assessment was conducted or certified by an interagency placement committee, a licensed mental health professional, or waivered/registered professional or an otherwise recognized provider of mental health services acting within their scope of practice.
- A licensed mental health professional or waivered/registered professional shall review the prior assessment within five calendar days of the child's arrival at the STRTP program and determine whether to accept the existing mental health assessment or whether conducting a new assessment is more clinically appropriate.

- As part of the review, the licensed mental health professional or waivered/registered professional shall sign and complete an addendum documenting their acceptance of the existing assessment. The addendum shall include any available information required in subdivision (c) that was missing from the existing assessment, as well as updated information regarding the child's physical and mental condition at the time of arrival, diagnosis, and reason for referral, before signing and accepting.

A mental health assessment that meets the requirements of this section shall be deemed to satisfy assessment documentation requirements for Medi-Cal beneficiaries.

In the case of an emergency placement pursuant to Welfare and Institutions Code section 11462.01(h)(3), a licensed mental health professional or waivered/registered professional shall make a written determination that the child requires the level of services and supervision provided at the STRTP to meet their behavioral and mental health service needs. The determination shall occur as soon as possible after the child arrives at the STRTP, but no later than 72 hours from the time the child arrives at the facility.

1. The licensed mental health professional or waivered/registered professional shall consider and address, in the written determination the following information:
    a. The child's presenting problem, including the history if it is available;
    b. Whether the STRTP meets the specific therapeutic needs of the presenting problem.
    c. The child's prior mental health diagnosis, if any.
    d. The child's current prescription and non-prescription medications, including dosages.
    e. The child's current medical conditions, including any prescribed treatment and medications.
    f. A risk assessment that addresses the child's likelihood of danger to self or others.
    g. Commonality of need with other children at the STRTP.
    h. Any other information necessary to determine whether the child requires the level of services provided at the STRTP.

- A child who receives a determination pursuant to paragraph (1) shall also have a mental health assessment as required and noted above, to document the need for the STRTP level of care.

- A mental health assessment that complies with subdivision (b), if completed within 72 hours of a child's arrival at the STRTP, shall satisfy the requirements of this subdivision.
- Until a licensed mental health professional or waivered/registered professional determines that the child requires the level of services and supervision provided at the STRTP, the child shall have one-on-one observation at all times or be in a physically separate area from the other children in the program. During this time, the child shall receive all services and programming required in these regulations.

DSM-5/ICD-10 DIAGNOSIS

The assessment, which includes diagnosis, is designed to evaluate the *current status* of a beneficiary's mental, emotional, and behavioral health. A diagnosis from the most current Diagnostic and Statistical Manual (DSM-5) must be documented in the assessment, consistent with presenting problems, history, mental status exam, and other assessment data. Formulation of a diagnosis requires a provider, working within his/her scope of practice, to be licensed, waivered, and/or under the direction of a LMHP in accordance with California State law.

SCOPE OF PRACTICE TO DIAGNOSE

- Physicians
- Licensed or waivered Psychologists
- Licensed or registered Clinical Social Workers
- Licensed or registered Marriage and Family Therapists
- Licensed or registered Professional Clinical Counselors
- Advanced Practice Nurses, in accordance with the Board of Registered Nursing

The following types of providers must be licensed in accordance with applicable State of California licensure requirements, and, in addition, must work "under the direction of" a licensed professional operating within his or her scope of practice:

- Licensed Vocational Nurses
- Licensed Psychiatric Technicians
- Physician Assistants
- Pharmacists

- Occupational Therapists[27]

Additional providers who may operate "under the direction of" a LMHP include:

- **Mental Health Rehabilitation Specialists (MHRS):** A MHRS shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting. A MHRS may provide Mental Health Services (including contributing to Assessment, but excluding Therapy, Targeted Case Management (TCM), Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential, and Crisis Residential Treatment services.
- **Other Qualified Providers:** The State Plan permits the provision of services by "other qualified providers," State-defined as "an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the services by the county mental health department." Mental Health Services (excluding Therapy), TCM, Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential and Crisis Residential Treatment services may be provided by any person determined by the Mental Health Plan (MHP) to be qualified to provide the service, consistent with state law. State law requires these "Other Qualified Providers" to provide services "under the direction of" a LMHP within their respective scope of practice.[28] At this time, Fresno County Mental Health Plan has not defined "other qualified providers."

DIAGNOSIS DIFFERING BETWEEN PROVIDERS

The Mental Health Plan is ultimately responsible for certifying the accuracy, truthfulness, and completeness of the diagnosis and the provision of SMHS. If there is a difference of opinion between providers (physician and non-physician LMHP) regarding

[27] State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p.
[28] State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p; CCR Title 9, §1840.344

a beneficiary's diagnosis, best practice would indicate that the providers involved would consult and collaborate to determine the most appropriate diagnosis.

- The diagnosis of a beneficiary may be used by multiple providers if the diagnosis reflects the current status of the beneficiary's mental, emotional, or behavioral health.
- "By History," "Rule Out," and "Provisional" diagnoses are not an included diagnosis (claims) and as such, they do not meet medical necessity criteria; however, a beneficiary may have a "by history," "rule out," or "provisional" diagnosis in the diagnostic string.
- A diagnosis determined during a recent inpatient stay should not replace an assessment to determine medical necessity and the person's current needs. However, the outpatient provider should review the inpatient assessment and diagnosis documentation to inform the current assessment and diagnosis.

UPDATED ASSESSMENTS/RE-ASSESSMENTS

An updated assessment/re-assessment may be required when a person has experienced a significant medical or clinical change, or where a significant amount of time has elapsed since a prior assessment and diagnosis. Determination of whether and when a re-assessment and diagnosis are necessary depends on the MHP's policies and guidelines and on the community standard of care. Fresno County in-house and contracted programs require an assessment **at least every two years**. The interventions applied by each provider must be appropriate to address the beneficiary's included diagnosis and associated functional impairments. Best practices would indicate that a re-assessment should be done when there is a significant change in the beneficiary's condition.

As every assessment is reflective of the beneficiary's presentation *at the current point in time*, updated assessments are to be comprehensive and complete, clearly stating why the person continues to require services (i.e., how he or she continues to meet Medical Necessity criteria). The updated assessment must contain a summary of the treatment provided in the past assessment period and the response to that treatment.

STRTP Providers Only

To satisfy the mental health assessment requirement in the latest version of STRTP regulations, the STRTP may use an existing mental health assessment that was performed within the sixty (60) day period preceding the date of the child's arrival at the STRTP, subject to all of the following requirements:

1. The mental health assessment was conducted or certified by an interagency placement committee, a licensed mental health professional, or waivered/registered professional or an otherwise recognized provider of mental health services acting within their scope of practice.
2. A licensed mental health professional or waivered/registered professional shall review the prior assessment within five calendar days of the child's arrival at the STRTP program and determine whether to accept the existing mental health assessment or whether conducting a new assessment is more clinically appropriate.
3. As part of the review referenced in paragraph (2) of this section of the STRTP Interim Protocol, the licensed mental health professional or waivered/registered professional shall sign and complete an addendum documenting their acceptance of the existing assessment. The addendum shall include any available information required in the necessary elements of an assessment that was missing from the existing assessment, as well as updated information regarding the child's physical and mental condition at the time of arrival, diagnosis, and reason for referral, before signing and accepting.

COURT-ORDERED ASSESSMENTS OR CONSERVATORSHIP INVESTIGATIONS

Medi-Cal may be billed for assessments that are completed for clinical and treatment-related purposes. Medi-Cal **cannot** be billed for assessments that are completed at the request of the court for a purpose other than determining medical necessity for specialty mental health services.

FUNCTIONAL ASSESSMENT TOOLS-ADULTS

REACHING RECOVERY TOOLS

In 2016, Fresno County Department of Behavioral Health adopted a set of wellness & recovery-based tools originally developed by the Mental Health Center of Denver. These tools are used to help determine the right level of care at the right time. At this time, these tools are used for in-house programs and contracted providers who utilize the Avatar electronic health record. The tools include:

- **Recovery Needs Level (RNL):** Completed by the provider at intake and every six months thereafter. The provider records status of observed needs across 17 dimensions.
- **Recovery Marker Inventory (RMI):** Completed by the provider initially three months after intake, then quarterly thereafter, to measure their perception

of their recovery. Components of measurement include hope, sense of safety, satisfaction with social networks, symptom management and active growth.

- **Consumer Recovery Marker (CRM**): Completed by the beneficiary initially three months after intake, then quarterly thereafter, to measure the person served on factors associated with recovery. Components of measurement include employment, education, active/growth, level of symptom management, participation in services, housing, substance abuse, and stage of change. The provider may compare the CRM data with the RMI to ensure provider & person share the same observations of recovery.

FUNCTIONAL ASSESSMENT TOOLS-CHILDREN & YOUTH

Effective July 1, 2018, FCMHP providers will be required to utilize two performance outcomes measures for children and youth. The Child and Adolescent Needs and Strengths- CA CANS-50 is completed by the provider. The Pediatric Symptom Checklist-PSC-25 is completed by the parent/guardian. In order to utilize the CA CANS-50 tool, providers must be trained and certified.

- **Child and Adolescent Needs and Strengths-CA CANS-50:** The provider completes for all children and youth age 6 through age 20. It is a structured assessment used for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes.
- **Pediatric Symptom Checklist-**PSC-35: The parent/guardian completes for all children and youth age 3 through age 18. It is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so appropriate interventions can be initiated as early as possible.

These assessment tools need to be completed at the beginning of treatment, every six months following the first administration, and at the end of treatment.

DISCHARGE AND TRANSITION SUMMARY - REQUIRED DOCUMENTATION

Fresno County Mental Health Plan Discharge Summary

When a person leaves treatment, the provider should complete a discharge summary, which outlines the course of treatment and whether discharge criteria were met per the treatment plan. The summary should include:

1. A brief summary of treatment

2. Status update on person's progress toward plan objectives
3. Referrals provided
4. Program the person is being transferred to, if applicable
5. Reason for termination or transfer of services
6. Follow-up plans
7. Other pertinent information, such as medications provided upon termination

ESTABLISHING MEDICAL NECESSITY

Medical Necessity is the principal criterion for determining the need for treatment and guides the course of treatment, and it is the principal criterion Medi-Cal uses to determine authorization and payment for new or continued services. For all planned services to be eligible for reimbursement, medical necessity for SMHS must exist before and during ongoing treatment. Medical Necessity criteria have three components: **Diagnosis, Impairment**, and **Interventions,** as outlined below:[29]

ESTABLISHING MEDICAL NECESSITY ***All three components are required to justify medical necessity for SMHS***
1. The presence of an **Included Diagnosis**. The beneficiary must have at least one primary ICD-10 included diagnoses
2. Must have an **impairment** due to the mental disorder. The beneficiary must meet at least one of the following: • A significant impairment in an important area of life functioning • A reasonable probability of significant deterioration in an important area of life functioning • A reasonable probability that a child (under age 21) will not progress developmentally as individually appropriate

[29] *Title 9, California Code of Regulations, Chapter 11 - Medi-Cal Specialty Mental Health Services, Sections 1830.205 & 1830.210; DHCS MHSUDS Information Notice 17-040*

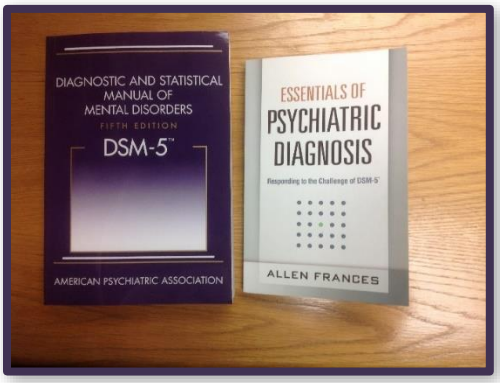
3. **Intervention-related criteria**: The beneficiary must meet all of the following:

- The focus of the proposed intervention is to address the included diagnosis and impairments
- The expectation is that the proposed intervention(s) will:
- Significantly diminish the impairment
- Prevent significant deterioration in functioning
- Allow the child/youth to progress as individually appropriate
- The condition would **not** be responsive to physical health care-based treatment alone

DIANOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS – DSM-5

The Mental Health Plan requires clinicians to use the most current DSM diagnostic criteria and to list the descriptive definition and corresponding ICD-10 code when providing the diagnosis. The DSM-5 is used for diagnostic purposes, whereas the ICD-10 Code Sets are used for billing purposes. To meet Medical Necessity criteria and be eligible for Medi-Cal SMHS, an individual must be diagnosed with *at least one of the following* disorders as outlined in the DSM-5:

- Attention Deficit/Hyperactivity Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom Disorders
- Feeding and Eating Disorders



- Elimination Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control and Conduct Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Paraphilic Disorders
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Please refer to the *MH SUDS Information Notice No. 16-051* and *CCR Title 9, sections 1830.205 or 1830.210* for more information about making diagnostic determinations regarding medical necessity criteria.

INCLUDED ICD-10 CODE SETS

Behavioral Health IN 20-043 - 2020 ICD-10 Included Code Sets Effective October 1, 2019, remaining in effect until new guidance is issued

With Behavioral Health Information Notice 20-043, DHCS added Autism Spectrum Disorder (ASD) as a ***covered*** Specialty Mental Health diagnosis. In communication with the California Behavioral Health Directors Association (CBHDA), DHCS indicated that the inclusion of this diagnosis does not mean that Mental Health Plans will now be required to provide services specifically geared toward addressing ASD, such as Behavioral Health Treatment (BHT) and Applied Behavioral Analysis (ABA). Those services will remain the responsibility of the Managed Care Plans (please see All-Plan Letter 19-014). For persons diagnosed with F84.0 - Autism Spectrum Disorder - as a diagnosis, they will need to be referred to their current Managed Care Plan provider using the existing referral process.[30]

The ASD diagnosis, per DHCS, was included to better align with the DSM-5, but not to change the responsibility for service provision. County MHPs remain responsible for the same package of specialty mental health services and will continue to cover treatment of appropriate interventions for co-occurring mental health conditions in individuals who also have autism spectrum disorders. Please proceed with no changes to your

[30] FCDBH Compliance Bulletin August 24, 2020

current practice. We will communicate further as more clarification is provided by DHCS.

INCLUDED ICD-10 CODE SETS - SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

MH SUDS Information Notice 16-016 – Enclosure 4

If a beneficiary has a dual diagnosis (such as a substance-related diagnosis) in addition to their mental health diagnosis, the mental health diagnosis must be used to qualify for SMHS claiming. It would be important and appropriate for the clinician to include the substance-related diagnosis, if appropriate, as an additional diagnosis in the diagnostic string.

EXCLUDED DIAGNOSES

The above-referenced ICD-10 code sets are *included* diagnoses that DHCS has communicated are the most current lists. It was the determination of DHCS that the conditions listed on the DHCS Outpatient Diagnostic Table were the only ones that met the criteria for SMHS.[31] Any diagnosis that is not listed on the forms is an *excluded* diagnosis and cannot be used for Medi-Cal claiming purposes.

Excluded diagnoses often reflect problems that are more organic or neurological in nature:

- Intellectual Disabilities
- Learning Disorders
- Motor Skills Disorders
- Neurocognitive Disorders
- Mental Disorders due to another medical condition
- Substance-related Disorders
- Sexual Dysfunctions

[31] Fresno County DBH News You Can Use #25, November 3, 2016 – *Services with Non-Medi-Cal Billable Diagnoses*

- Sleep-Wake Disorders
- Antisocial Personality Disorder
- Other conditions that may be a focus of clinical attention (except medication-induced movement disorders, which are included)

Additionally, except for the diagnosis given during crisis intervention or at the initial Assessment, the following codes are **not** Medi-Cal reimbursable:

- "Provisional" or "Working Diagnosis"
- "Rule-out" or "Versus"
- "By self-report"
- Diagnosis "By History"

When assessing and diagnosing a beneficiary, be mindful when choosing the diagnosis, and be as specific in the description of presenting symptoms as possible. There are several diagnoses listed in the DSM-5 that are "other" and "unspecified;" some meet medical necessity criteria while others do not (excluded diagnosis). You may claim for the assessment, even if there is an excluded diagnosis.

From the standpoint of the legal medical record and coding guidelines (which are covered under HIPAA), diagnosis codes should always reflect the beneficiary's condition and should be reported in a *sequence* that is consistent with DHCS Official Coding Guidelines. Providers should not be discouraged from reporting any and all complicating conditions and/or comorbidities that impact the treatment of the patient. Providers would still need to establish the DSM-5 diagnosis and corresponding ICD-10 Code that supports medical necessity for the services rendered.

For the purposes of supporting medical necessity for the scope of services provided, you would only need to list the diagnosis codes that are required for claims adjudication and reimbursement.

WHEN MEDICAL NECESSITY IS NOT MET

For beneficiaries who have a diagnosis that is not on the DHCS Included Diagnosis List, providers are allowed to do a re-assessment. In the justification for the re-assessment in documentation, providers should indicate the following: "Re-assessment is being

conducted to determine diagnostic clarification and potential treatment planning."[32]

- If, after the re-assessment, the person is determined to have a diagnosis that is on the included list for outpatient SMHS, treatment may continue if all other requirements are met for medical necessity
- If the person is determined to have a diagnosis that is not included on the DHCS included list, the person must be given a Notice of Adverse Benefit Determination and be referred to the appropriate services (Medi-Cal Managed Care Plan, CVRC, etc.) to address the person's diagnosis
- Existing beneficiaries receiving ongoing treatment under an excluded diagnosis, should be given an appropriate transition time to wrap up services; this is generally two sessions
- With the exception of an assessment, services provided under an excluded diagnosis (when it is primary) are not billable to Medi-Cal, therefore the MHP will not pay network providers

After the assessment or re--assessment, if medical necessity criteria for Specialty Mental Health Services for severe mental illness (SMI) are not met, complete a Notice of Adverse Benefit Determination (NOABD).

An "Adverse Benefit Determination" is defined to mean any of the following actions taken by an MCP:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.

[32] Fresno County DBH News You Can Use #25, Nov. 3, 2016 – *Services with Non-Medi-Cal Billable Diagnoses*

4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network.
7. The denial of a beneficiary's request to dispute financial liability.

Three copies of the NOABD form are needed:

1. Give one to the beneficiary within three working days of the assessment, and
2. Place one in the beneficiary's medical record, and
3. Send one to Managed Care

Include with each NOABD the following:

- "Your Rights" notification
- Language assistance taglines
- Beneficiary non-discrimination notice

CARE COORDINATION BI-DIRECTIONAL REFERRALS

As the Fresno County Mental Health Plan, we are responsible, in conjunction with the Managed Care Plans (Cal Viva and Anthem), to ensure access to care. The MHP serves people with severe impairment. If the beneficiary does not meet medical necessity criteria for SMHS through the MHP, the beneficiary should be referred for other services that meet their diagnostic needs. If the beneficiary's condition is mild to moderate, or not on the included diagnosis list, please use the ***Care Coordination Bi-directional Referral form***. There is one for Children/Youth (Appendix F) and one for Adults (Appendix G).

We screen for severity using the Fresno County (Adult or Child/Youth) Mental Health Severity Analysis & Bidirectional Referral Form. Fresno County Behavioral Health serves persons with **severe impairment.** When we screen for severity and find that medical necessity is not met for **severe impairment**, we are responsible for care coordination by facilitating linkage and ensuring the person is able to connect with a provider offering the appropriate service:

- **Mild/Moderate**: Referred to the Managed Care Health Plan (CalViva or Anthem)
- **Meds Only**: Referred to Primary Care Physician or Federally Qualified Health Clinic-FQHC

Send the form to the appropriate health plan or other agency and follow up to ensure they have connected with the beneficiary.

This bi-directional referral form is to be used **every time** we advise a person to contact and connect with their Managed Care Plan (MCP). We use the forms because the MCPs want to be able to follow up with our referral and reach out to the person.

TREATMENT PLANS

PPG 2.1.6 – Treatment Plan

PPG 2.1.10F – Beneficiary/Family Involvement in the Development of Beneficiary Treatment Plan

After the mental health assessment is completed and medical necessity for specialty mental health services (SMHS) is established, the provider works with the person to develop the **Treatment Plan**, also referred to as ***Client Plan or Plan of Care***. The treatment plan is the second step in the "golden thread" of service delivery. The treatment plan guides the delivery of SMHS and is linked to areas identified in the client's assessment. When documenting the plan development service with a progress note, be sure to indicate who was present and how the client participated.

REASONS FOR RECOUPMENT – FISCAL YEAR 2020-2021

CLIENT PLAN

Services shall be provided, in accordance with the State Plan, based on the beneficiary's need for services established by an Assessment and documented in the Client Plan. Recoupment if services were claimed:

A. Prior to the initial Client Plan being in place; or

B. During the period where there was a gap or lapse between client plans; or,

C. When the planned service intervention was not on the current client plan.

An approved client plan must be in place prior to service delivery for the following SMHS:

- Mental health services (except assessment, client plan development)
- Intensive Home-Based Services (IHBS)

- Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs
- Therapeutic Behavioral Services (TBS)
- Day treatment intensive
- Day rehabilitation
- Adult residential treatment services
- Crisis residential treatment services
- Medication Support (non-assessment/evaluation, non-plan development and non-urgent)
- Psychiatric Health Facility Services *(CCR, title 22, § 77073)*
- Psychiatric Inpatient Services *(CFR, title 42, § 456.180(a); CCR, Title 9 §§ 1820.230 (b), 1820.220 (l)(i))*

MHP Contract; State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025), page 2c; MHSUDS Information Notice 17-040

SCOPE OF PRACTICE FOR DEVELOPING TREATMENT PLANS

The treatment plan needs to be written by a Physician, qualified RN, or a licensed, waivered or registered clinician (Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist or Professional Clinical Counselor). The Treatment Plan may be written by other members of the mental health treatment team, such as a Community Mental Health Specialist (CMHS) **under the direction of a LMHP**, in which case the plan needs to be *co-signed by a LMHP*.

SIGNATURE REQUIREMENTS FOR TREATMENT PLANS

In order to be finalized and valid, a treatment plan must be signed (or electronic equivalent) **and dated** by either:

- The person providing the services
- A person representing a team or program providing services, or
- A person representing the FCMHP providing the services

In addition to a signature by one of the above, the treatment plan must be co-signed by one of the following providers listed below, if the person's treatment plan indicates that

some services will be provided by a staff member **under the direction of** one of the categories of staff listed below:

- A physician
- A licensed/waivered psychologist
- A licensed/registered/waivered social worker
- A licensed/registered/waivered marriage & family therapist
- A licensed/registered/waivered professional clinical counselor
- A registered nurse, including but not limited to, nurse practitioners and nurse specialists

A client plan is only valid/effective once it has been signed (and co-signed, if required) and <u>dated</u> by the required staff member(s).

The beneficiary's/legal representative's signature is required on the treatment plan when:

- The beneficiary is expected to be in long-term treatment as defined by the FCMHP (receiving treatment services in excess of six months from the initial assessment) and
- The treatment plan provides that the beneficiary will be receiving more than one Specialty Mental Health Service
- Note: A date next to the beneficiary's/legal representative's signature is *not* required

If a beneficiary is ***not*** expected to be in "long term treatment" as defined by the FCMP ***and*** is only receiving one SMHS ***and*** the FCMHP does NOT require a client signature, the beneficiary is not required to sign the treatment plan *(MHP Contract; CCR Title 9, section 1810.440(c (2)(A)).*

The beneficiary's participation in and understanding of their treatment plan should be documented. The beneficiary signature on the treatment plan will be used as the means of identifying the beneficiary's participation and understanding of their plan. Based on the above, if the beneficiary is not required to sign his or her treatment plan, documentation of participation in the development of and agreement with the treatment plan may include, but is not limited to:

- Reference in the treatment plan to the beneficiary's participation in the development of and agreement with their plan
- The beneficiary's signature on the treatment plan, or

- A description in the medical record (e.g., in a progress note) of the beneficiary's participation in the development of and agreement with their treatment plan (MHP Contract; CCR Title 9, section 1810.440(c)(2)

The following is an example of a progress note that would meet the requirement in the case where a client signature on the treatment plan is not required, or cannot be obtained:

> *Client participated in treatment planning sessions on (date) and (date). The client participated in developing their treatment plan goals, objectives and interventions; in particular, the goals for (state goal or goals that the beneficiary gave specific input for). The client was satisfied with their treatment plan and stated verbal agreement at the session held on (date).*

If the beneficiary refuses or is unavailable to sign their initial or updated treatment plan, the provider should include a written explanation of the refusal or unavailability. The written explanation may be on the treatment plan itself or in a progress note. Although not required, it is best practice to make additional attempts to obtain the beneficiary's signature and document the attempts in the person's record. *(MHP Contract; CCR Title 9, section 1810.440(c)(2).*

STRTP Requirements - Treatment Plan

Each child admitted to a STRTP shall have a Treatment Plan reviewed and signed by a licensed mental health professional, waivered/registered professional, or the Head of Service ***within ten (10) calendar days of the child's arrival at the STRTP***. The Treatment Plan shall include:

1. Anticipated length of stay.
2. Specific behavioral goals for the child and specific mental health treatment services the STRTP shall provide to assist the child in accomplishing these goals within a defined period of time.
3. One or more transition goals that support the rapid and successful transition of the child back to community based mental health care.
4. The child and authorized legal representative's participation and agreement. The child and the child's authorized legal representative's participation and agreement shall be documented in the client record. If the child is unable to agree or refuses to agree to the treatment plan, the child's authorized legal representative's participation and agreement shall be sufficient, but the child's inability or refusal shall be documented in the Client Record. For a child who is a Medi-Cal beneficiary, the documentation of the refusal shall be in accordance with Section 1810.440(c)(2)(B) of Title 9 of the California Code of Regulations.

5. Include participation of the child and family team, if one exists.
6. Be reviewed by a member of the STRTP mental health program staff at least every thirty (30) calendar days. The member of the STRTP mental health program staff that completes the review shall document the review in the client record and include whether it is necessary to make changes to the treatment plan.
7. A trauma-informed perspective, which includes planned services to promote the child's healing from any history of trauma.

The child's treatment plan shall be updated as the child's mental health treatment needs change.

The STRTP shall provide a copy of the treatment plan to the child's placing agency *within ten (10) calendar days of the request of the placing agency* and in compliance with all applicable privacy laws.

ADVANCED HEALTH CARE DIRECTIVE

PPG 2.1.10H – Advanced Health Care Directive

The FCMHP staff and/or contracted providers shall provide written information regarding Advanced Health Care Directive (AHCD) when the adult beneficiary is developing the Treatment Plan with their provider and annually thereafter, upon renewal or at a person's request, whichever occurs first. The FCMHP staff shall ask the beneficiary whether they have an AHCD and if they want informing materials. The beneficiary's response shall be documented on the Treatment Plan or Mental Health Assessment. If the beneficiary is incapacitated and unable to receive the information at the time of admission to mental health services, then the AHCD information may be given to family members or others involved in their care. Once the beneficiary has capacity, the Advance Directive information shall be offered to him or her.

MINIMUM AGE FOR A MINOR TO INDEPENDENTLY SIGN

There is no minimum age for a minor (under 18 years old) to independently sign a treatment plan, assuming the treatment plan is not used to obtain the minor's consent to treatment. The treatment plan is a collaborative process between the beneficiary and the provider. The beneficiary should understand what they are signing based on their participation in the process. There is currently no requirement that the beneficiary's signature on his or her treatment plan be dated.

PROVISION OF SERVICES PRIOR TO A TREATMENT PLAN BEING IN PLACE

Prior to the treatment plan being approved, the following SMHS and service activities *are* reimbursable:

- Assessment
- Plan Development
- Crisis Intervention
- Crisis Stabilization
- Medication Support Services (for assessment, evaluation, or plan development; or if there is an urgent need, which must be documented)
- Targeted Case Management (TCM) and Intensive Care Coordination (ICC) for assessment plan development, IHBS, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services)

GAPS BETWEEN TREATMENT PLANS

A "gap" between treatment plans results when a treatment plan has expired and there is an amount of time that passes before the updated treatment plan is in effect. When there is a gap between treatment plans, only those services listed above can be provided and are reimbursable. Any other services provided prior to a treatment plan being in effect are not reimbursable and will be disallowed if claimed.

For TCM, ICC, and Medication Support Services provided prior to a treatment plan being in place, the progress notes must clearly reflect that the service activity provided was a component of a service that is reimbursable prior to an approved treatment plan being in place, and not a component of a service that cannot be provided prior to an approved treatment plan being in place.

DISALLOWANCES FOR TREATMENT WITHOUT AN APPROVED TREATMENT PLAN

The State Plan requires SMHS to be provided based on medical necessity criteria, in accordance with an individualized treatment plan, and approved and authorized according to State of California requirements. An approved treatment plan must be in place prior to service delivery for the following *planned* SMHS:

- Mental Health Services (except assessment and treatment plan development)
- Intensive Home-Based Services (IHBS)

- Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary's treatment plan is being implemented and that it adequately addresses the beneficiary's individual needs
- Therapeutic Behavioral Services (TBS)
- Day Treatment Intensive
- Day Rehabilitation
- Adult Residential Treatment Services
- Crisis Residential Treatment Services (CCR, Title 22, § 81068.2(b) and 81068.3
- Medication Support (non-emergency)
- Psychiatric Health Facility Services (CCR, Title 22, section 77073)
- Psychiatric Inpatient Services (CCR, Title 42, section 456.180(a); CCR Title 9, sections 1820.230(b), 1820.220(l)(i))

INITIAL VS. COMPREHENSIVE TREATMENT PLANS

The provider (or MHP) may prepare a treatment plan within a short period of time of the beneficiary coming into the system or program in order to quickly begin providing services that cannot be provided without a treatment plan. However, all treatment plan requirements must be met. The treatment plan is a dynamic and living document and services can be added over time based on the individual beneficiary's needs.

For example, if a beneficiary is initially assessed to need day rehabilitation services, the MHP or provider could prepare a treatment plan that includes day rehabilitation services only, as long as the other treatment plan requirements are met. As the assessment continues and a comprehensive assessment of the beneficiary is completed, other services could be added to the treatment plan based on medical necessity and the individual person's needs. The beneficiary, parent/guardian or representative would need to sign, or the provider document their agreement with, any revisions to the plan.

REQUIRED ELEMENTS OF THE TREATMENT PLAN

The foundation of person-centered treatment plan goals are based on the symptoms and behaviors which cause impairment and are impeding the person's functioning. Accurate documentation of the frequency and intensity of symptoms and behaviors will determine whether the treatment plan will be useful and effective in treatment.

At a minimum the treatment plan, even if for just one service, must include:

- Specific observable and/or quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis
- Proposed type(s) of intervention/modality, Evidence-based Practice (CBT, PCIT, EMDR, etc.)
- Detailed description of the intervention to be provided
- Proposed frequency and duration of intervention(s)
- Interventions that focus and address the identified functional impairments as a result of the mental disorder and are consistent with the person's plan goals
- Must be consistent with the qualifying diagnoses
- Signature (or electronic equivalent) by the required staff, including job title, licensure status, and unique identifying number (i.e., license number, NPI number, employee number)
- A signature of the beneficiary/guardian (does not need to be dated)
- Evidence that a copy of the treatment plan was offered to the beneficiary and/or guardian and this is documented

If the beneficiary and/or guardian are unavailable or refuses to sign the treatment plan, a written explanation must be documented, in the plan or in a progress note. Follow-up efforts to obtain a signature and evidence of the person's participation must be regularly documented in the progress notes if the person is initially unavailable or unable to sign.

WRITING RECOVERY-FOCUSED TREATMENT PLAN GOALS & OBJECTIVES

There are two different models of treatment and perspectives on persons and their symptoms:[33]

- The **Medical Model**, which focuses on symptom reduction and views the provider as expert and beneficiary as more a passive recipient of services.

[33] Summary of DBH Training on March 16, 2016, Writing Recovery Focused Treatment Plan Goals/Objectives by Trevor Birkholz, LMFT

Examples where this works better are with short-term ailments such as many physical health ailments (fevers, infections, broken bones, etc.)

- The Person-centered **Recovery Model**, which focuses on life skills development and symptom management which works better with long-term or life-long ailments, such as developmental disorders and many chronic mental illnesses such as schizophrenia and chronic and recurring mood disorders

Medical Model	Person-centered Model
What staff see	What the person sees
Medication (or other treatment) compliance is most important	Person's growth toward personal goals is most important
Stabilization is the goal of treatment	Exploration of what makes life meaningful for the person is the goal of treatment
Maintenance, monitoring and making clients do things is focus of interventions	Questions to elicit person's interests, motivation, values, concerns and goals and encourages the person's growth is focus
Client is passive	Person is active
Staff safety and comfort are given priority	Hope, support, education and self-advocacy are given priority
Professionals direct treatment	Person directs treatment

Some of the most important components of a recovery- and person-focused treatment plan would include the following:

- What is it that the person wants? (their goals)
- What is getting in the way of what they want? (barriers to their desired outcomes)
- What is it that the person can do about it? (better manage or cope with; engage in meaningful activities)
- A change in emphasis from symptom reduction or removal to improved symptom management (decreasing self-judgment and unreasonable expectations, accepting anger as normal and improving self-control)

STRTP Providers Only

An STRTP Treatment Plan shall include:

1. Anticipated length of stay

2. Specific behavioral goals for the child and specific mental health treatment services the STRTP shall provide to assist the child in accomplishing these goals within a defined period of time
3. One or more transition goals that support the rapid and successful transition of the child back to community based mental health care
4. The child and authorized legal representative's participation and agreement. The child and the child's authorized legal representative's participation and agreement shall be documented in the client record. If the child is unable to agree or refuses to agree to the treatment plan, the child's authorized legal representative's participation and agreement shall be sufficient, but the child's inability or refusal shall be documented in the Client Record. For a child who is a Medi-Cal beneficiary, the documentation of the refusal shall be in accordance with Section 1810.440(c)(2)(B) of Title 9 of the California Code of Regulations.
5. Include participation of the Child and Family Team (CFT), if one exists.
6. Be reviewed by a member of the STRTP mental health program staff at least every thirty (30) calendar days. The member of the STRTP mental health program staff that completes the review shall document the review in the client record and include whether it is necessary to make changes to the treatment plan.
7. A trauma-informed perspective, which includes planned services to promote the child's healing from any history of trauma.

EXAMPLES OF PERSON-CENTERED GOALS

"Client will decrease staying in his room, feeling sad and sleeping throughout the day from 7 Days per week to 5 days per week within the next three months as supported by socializing with family members and neighbors, creating and following a routine sleep schedule and participating in one activity/hobby that client enjoys that can help client remain awake and increase positive mood."

"Client will decrease feeling too much worry and nervousness from 5 days per week to 3 days per week within the next three months as supported by using meditation, taking daily walks with his dog/neighbor/children. Client decided he will attempt a thought journal to help identify sensible vs. irrational thoughts."

TREATMENT PLAN TIMELINES AND EXCEPTIONS

The treatment plan *must be completed within 60 days of the assessment and at least annually,* or when the person's presentation changes and different or additional services are needed, with the following *exceptions:*

- Day Treatment Intensive – completed every three (3) months

- Day Treatment Rehabilitation – completed every six (6) months
- Crisis Residential – review weekly
- Therapeutic Behavioral Services (TBS) – every 30 days; the TBS services must also be referenced in the Plan in the "other mental health services" section

The treatment plan must be completed prior to service delivery for all *planned* services. The State Plan requires services to be provided based on medical necessity criteria, in accordance with an individualized treatment plan, and approved and authorized according to State of California requirements.

The treatment plan must be updated at least annually or when there are significant changes in the beneficiary's condition. There is no specific language in regulation or in the MHP contract defining a "significant change" in a beneficiary's condition. Examples may include a beneficiary who has never been suicidal makes a suicide attempt; or, a beneficiary who regularly participates in planned services suddenly stops coming to appointments. Major life events that might lead to a change in the beneficiary's condition include, but are not limited to: job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), or change in residence/living situation.

STRTP Providers Only

An STRTP must have a treatment plan reviewed and signed by a licensed mental health professional, waivered/registered professional, or the head of service within ten (10) calendar days of the child's arrival at the STRTP.

The STRTP shall provide a copy of the treatment plan to the child's placing agency within ten (10) calendar days of the request of the placing agency and in compliance with all applicable privacy laws.

ACTIVE TREATMENT PLANS

A person may have more than one active treatment plan. The Mental Health Plan allows providers to develop a plan that covers only the service to be delivered by that provider. An example is a plan for Therapeutic Behavioral Services (TBS), which serves as an extension of the regular treatment plan. A treatment plan is required whether a beneficiary receives only one service modality or multiple service modalities. SMHS are to be provided based on medical necessity criteria, in accordance with an individualized treatment plan.

STANDARD ELEMENTS OF THE TREATMENT PLAN

QUICK VIEW

All services except for Assessment and Crisis Services must be on the Treatment Plan in order to be billed.

AREA	DESCRIPTION	EXAMPLES
Person's Desired Outcome/Goals	**The reduction or removal of the problem**. State the person's goals using person's own words, when applicable.	*"To be able to follow directions at home and school"* *"To get along better with siblings"* *"To do better academically"*
Medical Necessity	**Must include at least one of these three areas to meet medical necessity criteria:**	• *Significant Impairment* • *Probability of Significant Deterioration* • *Probable Development Arrest*
Areas of Impairment	**Must include at least one of these areas:**	• *Living Arrangement* • *Health* • *Occupational* • *Social Support* • *Daily Activities* • *Educational* • *Other (specify)*
Person's Current Symptoms/Behaviors (with frequency & duration)	**This is a description of the behavioral health symptoms that are the focus of treatment, written in measurable terms.**	*Client does not follow directives with teacher and mother 6-9x daily* *Client fights with siblings 2-3x daily* *Client displays ADHD symptoms including distractibility and refusing directives, 20x daily*
Person's Desired Objectives (Observable, Measurable)	**What the person will do.** This is a breakdown of the goal and are specific, observable and quantifiable. **Indicate how progress will be measured** (Self-report, report by significant others, report by staff).	*Client will increase following directives from 0-1x daily to 5x daily* *Reduce client's physical aggression from 2-3x daily to 0-3x monthly* *Reduce ADHD symptoms including becoming visibly distracted, refusing directives, from 20x daily to 5-10x monthly*
Proposed Interventions (Evidence-Based Practices)	**The services that provider's staff will provide. Link the intervention with a goal.** Do not check all services to "cover your bases." **Include the frequency & duration of interventions.**	*Plan Development (always on the Plan) – at least annually and as often as appropriate (if presentation, diagnosis, and/or goals change)* *Individual Therapy 2-4x month for 12 months* *Medication Support Services 1-2x monthly for 12 months*

Other/Comments for Interventions/Techniques	**The specific Evidence-Based Practice(s) to be used.** Also note any psychological or other testing you will refer the person to.	*CBT to reduce negative thinking patterns and increase positive reframing* *EMDR to assist with processing and reducing PTSD symptoms* *PCIT to assist with better parent/child relationship*
Frequency of Interventions and Proposed Duration	**State the session frequency (how often in a week or month). Do not use "ad hoc" or "as needed."** State the plan's duration (should not exceed one year).	*Individual therapy: 2-4x monthly for 12 months* *Family therapy: 2-4x monthly for 12 months* *Plan development– at least annually and as often as appropriate (if presentation, diagnosis, and/or goals change)*
Proposed Discharge Criteria	**Working with the person served, decide how you and they will determine when treatment goals have been met.**	*Medical Necessity Criteria are no longer met* *Client no longer requires specialty mental health services for maintaining adequate functioning* *Client has derived maximum benefit from mental health treatment*
Confirmation, Signatures and Date	**Obtain the dated signatures of all participants.** If unable to obtain the person's/guardian's signature, indicate that on the progress note. If they verbally accept the plan, indicate this on a progress note. **Offer the person served a paper copy of their plan and indicate if the copy was accepted or declined.**	*Provider must sign, date, and include licensure status and a unique identifying number (i.e., license number, employee number, etc.) for the Treatment Plan to be valid*

TREATMENT PLAN PARTICIPATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

When the treatment plan is developed with a person where English is not their preferred language and an interpreter is used, the progress note must include the following:

- Inquiry into the person's language needs and preference
- That the person was made aware that services will be available in their primary language, as requested
- How service-related personal correspondence will be provided
- Description explaining the person's full participation and understanding of the treatment plan, especially when it is written in English
- For non-English-speaking persons, **each note** representing a beneficiary contact should indicate how the language barrier was addressed and if an interpreter was used during the service
- If an interpreter is used, document the interpreter's name and interpreter number

PROGRESS NOTE DOCUMENTATION STANDARDS

PPG 4.4.6 Documentation Standards for Progress Notes

Progress notes are the third step in the interrelated "golden thread" of documentation. Documentation standards, as outlined in PPG 4.4.6, provide a means of communication and demonstration of continuity of care, as evidenced by the person's progress in treatment and response to relevant clinical decisions and interventions. Progress notes should adequately document the clinical observations and interventions provided, the person's progress and response to treatment, and plan for continued care if medical necessity criteria standards continue to be met, as evidenced by reduction of impairment, restoring functioning, and/or preventing significant deterioration.

STRTP Only - Mental Health Program Progress Notes

For each child, the STRTP shall ensure that there is a minimum of one (1) written daily mental health progress note. The daily progress note shall document the following when applicable:

1. The specific service(s) provided to the child.
2. A child's participation and response to each mental health treatment service directly provided to the child.
3. Observations of a child's behavior.

4. Possible side effects of medication.
5. Date and summaries of the child's contact with the child's family, friends, natural supports, child and family team, existing mental health team, authorized legal representative, and public entities involved with the child.
6. Descriptions of the child's progress toward the goals identified in the treatment plan.

In addition to the daily mental health progress note, the STRTP mental health program staff shall write a progress note whenever there is a significant change in condition or behavior, or a significant event involving the child, including the date and time of the event and the STRTP's response to the event.

1. A significant event involving the child is any unintended or unexpected event, which could or did lead to physical or emotional harm. This includes incidents which did not cause harm but could have caused harm, or where the event should have been prevented.
2. Whenever there is a significant event involving the child, the STRTP shall consider whether the child has a history of trauma and, if so, do the following:
    A. Determine whether the child's history of trauma has precipitated the significant event.
    B. Determine whether the significant event could be used to promote healing and growth from the child's history of trauma.
    C. Determine whether the significant event has created a need for changes to the child's treatment plan.
    D. Update the child's treatment plan with any additional services that the child needs, taking into account the significant event, the child's history of trauma, and any other relevant psychosocial factors which may include the child's living situation, daily activities, social support, sexual orientation, gender identity, cultural and linguistic factors, academics, and school enrollment.

All mental health progress notes shall be completed, signed and dated (or electronic equivalent) ***within seventy-two (72) hours of the service provided.***

a. The mental health progress notes shall be maintained in the child's record.
b. If the child is a Medi-Cal beneficiary, the STRTP shall complete separate progress notes for each specialty mental health service provided.

If a progress note for a specialty mental health service is provided, this replaces the requirement for this daily mental health progress note.

REASONS FOR RECOUPMENT FISCAL YEAR 2020-2021

PROGRESS NOTES

1. The MHP did not submit documentation substantiating that the focus of the intervention is to address the beneficiary's included mental health condition.

a) A significant impairment in an important area of life functioning;

b) A probability of significant deterioration in an important area of life functioning;

c) A probability the child will not progress developmentally as individually appropriate;

d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, Title 9, chapter 11, Section 1830.205(b)(3)(A); CCR, Title 9, chapter 11, Section 1840.112(b)(4)

2. The MHP did not submit documentation substantiating the expectation that the intervention will do, at least, one of the following:

a) Significantly diminish the impairment;

b) Prevent significant deterioration in an important area of life functioning;

c) Allow the child to progress developmentally as individually appropriate; or

d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

CCR, Title 9, chapter 11, Section 1830.205(b)(3)(B); CCR, Title 9, chapter 11, Section 1810.345(c)

3. The progress note does not describe how services provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.

MHP Contract, Exhibit A, Attachment 9

4. The Provider did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:

a) No progress note submitted.

b) The progress note provided by the Provider does not match the claim submitted to DHCS for reimbursement in terms of the following:

1) Specialty Mental Health Service claimed.

2) Date of service, and/or

3) Units of time.

CCR Title 9, Sections 1840.316 - 1840.322, and 1810.440(c), CCR, Title 22, Section 51458.1(a)(3)(4); MHP Contract; CCR, Title 9, Section 1840.112(b)(3)

5. The service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation (e.g., Institution for Mental Disease [IMD], jail, and other similar settings, or in a setting subject to lockouts per CCR, Title 9, chapter 11).

Note: When a beneficiary who resides in a setting in which s/he would normally be ineligible for Medi-Cal is moved off grounds to an acute psychiatric inpatient hospital or PHF, that individual again becomes Medi-Cal eligible (unless the hospital is free-standing with more than 16 beds and is thus considered an IMD and the beneficiary is between the ages of 21-64).

CCR, Title 9, chapter 11, Section 1840.312(g-h); CCR, Title 9, chapter 11, Sections 1840.360-

1840.374; Code of Federal Regulations (CFR), Title 42, part 435, *Sections 435.1008 –*

435.1009; CFR, Title 42, Section 440.168; CCR, Title 22, Section 50273(a)(1-9); CCR, Title 22, Section 51458.1(a)(8); United States Code (USC), Title 42, chapter 7, Section 1396d

6. The service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (A dependent minor in a juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary, is Medi-Cal eligible. See CCR, Title 22, Section 50273(c)(5). A delinquent minor is only Medi-Cal eligible after adjudication for release into community. See CCR, Title 22, Section 50273(c)(1))

CFR, Title 42, Sections 435.1009 – 435.1010; CCR, Title 22, Section 50273(a)(5-8), (c)(1, 5)

7. The service provided was solely for one of the following:

a) Academic educational service

b) Vocational service that has work or work training as its actual purpose

c) Recreation

d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

e) Transportation

f) Clerical

g) Payee Related

CCR, Title 9, Sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); Title 22, chapter 3, Section 51458.1(a)(5), (7);

8. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present, and resulted in excess time claimed.

CCR, Title 9, Section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, Section 7.5.5.; MHSUDS Information Notice 17-040

9. For service activities involving one (1) or more providers, progress notes, or other relevant documentation in the medical record, did not clearly include the following:

a) The total number of providers and their specific involvement in the context of the mental health needs of the beneficiary; **or**

b) The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable; ***or***

c) The total number of beneficiaries participating in the service activity.

CCR, Title 9, Section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, Section 7.5.5.; MHSUDS Information Notice 17-040

10. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

MHP Contract; MHSUDS Information Notice 17-040

11. The Provider did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:

a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a "no show'), or

b) Service provided did not meet the applicable definition of a SMHS.

CCR, Title 9, Section 1840.112(b)(3); Title 22, Section 51470(a); MHSUDS Information Notice 17-040; MHP Contract, Exhibit E, Attachment 1

12. The service provided was not within the scope of practice of the person delivering the service.

CCR, Title 9, Section 1840.314(d); MHSUDS Information Notice 17-040

CLINICAL DOCUMENTATION-TIMELINESS

All clinical documentation of SMHS must be completed, signed and filed in the clinical record, either paper chart or Electronic Health Record (EHR) **within five (5) business days** following the delivery of service unless specific exception is made by the clinical supervisor or their designee. All clinical correspondence and correspondence received from outside sources related to the person served must be submitted to Medical Records and scanned into his/her clinical record **within five (5) business days** of receipt, and must minimally contain the beneficiary's full name.

For STRTP Providers Only

All mental health progress notes shall be completed, signed and dated (or electronic equivalent) within seventy-two (72) hours of the service provided.

LATE ENTRIES

Best practice is to write and sign progress notes immediately after the provision of services. If the progress note is not completed within five (5) business days, it is considered a late progress note. In these cases, include an indication at the beginning of the note "Late entry progress note for services provided on (date)."

PROGRESS NOTE REQUIRED ELEMENTS

Documentation requirements are that progress notes describe how services provided reduced the impairment(s), restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the treatment plan. Items that shall be contained in the record related to the beneficiary's progress in treatment include:

- Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
- Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

- Interventions applied, beneficiary's response to the interventions, and the location of the interventions;
- The date the services were provided;
- Documentation of referrals to community resources and other agencies, when appropriate;
- Documentation of follow-up care, or as appropriate, a discharge summary;
- The amount of time taken to provide services;
- The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title, and relevant identification number.

If an interpreter was used, include the interpreter name, interpreter number, and language used. If multiple providers are treating the person served, documentation of collaboration between providers, and what services were provided by each provider, should be included in the progress note.

STRTP Providers Only

For each child, the STRTP shall ensure that there is a minimum of one (1) written daily mental health progress note. The daily progress note shall document the following when applicable;

1. The specific service(s) provided to the child
2. A child's participation and response to each mental health treatment service directly provided to the child
3. Observations of a child's behavior
4. Possible side effects of medication
5. Date and summaries of the child's contact with the child's family, friends, natural supports, child and family team, exist mental health team, authorized legal representative, and public entities involved with the child
6. Descriptions of the child's progress toward the goals identified in the treatment plan.

If the child is a Medi-Cal beneficiary, the STRTP shall complete separate progress notes for each specialty mental health service provided. *If a progress note for a specialty mental health service is provided, this replaces the requirement for a daily mental health progress note.*

PROGRESS NOTE FORMATS

A progress note can be written in any format, ensuring all the standard elements of good progress notes are clearly documented. Some examples of good documentation formats include:

- SOAP – Subjective, Objective, Assessment, Plan
- BIRP – Behavior, Intervention, Response, Plan
- BIOP – Behavior, Intervention, Outcome, Plan
- DAP – Data, Assessment, Plan

PIRP – Problem, Intervention, Response, Plan

PROGRESS NOTE EXAMPLES

Example 1:

S: Client reported having a depressed mood for two days this past week. Reported that he felt hopeless, stayed in the house during these days, ate very little, and had trouble sleeping. Client mentioned that the other five days, he was able to shower, visit family members, met a couple that moved in next door, and felt more motivated and energetic. Client reports that he feels this is an improvement from having depressive symptoms daily upon entering treatment five months ago.

O: Therapist assessed client safety and determined no safety plan was needed. Therapist reviewed client's wellness plan and advocated for client to utilize the identified strategies and resources from the plan. Therapist used Consumer Recovery Measure (CRM) results to facilitate discussion about client's progress toward his wellness goals and the impact on depressive symptoms. Explored changes in perceived hope, socializations and symptoms indicated on the CRM.

A: Client was receptive to utilizing his established wellness plan daily. Upon discussion, client indicated that their change to a new neighborhood and stable home had contributed to increased feelings of hopefulness about 5 days per week on average, as well as feeling safe in the new neighborhood. Client mentioned that he had been able to socialize with a couple of his neighbors which led to less isolation in the past few weeks. Client indicated that utilizing his wellness plan mainly following the daily schedule has contributed to his perceived improvements and decrease in overall depressed mood.

P: Will meet with client in one week. Client and therapist to update treatment plan goals next session due to client wanting to focus more on increase socialization and looking

for jobs. Plan to assist client with developing an updated treatment plan and wellness goals.

Example 2:

B: Case manager met with client at his home following discharge from psychiatric hospital 3 days ago. Since being discharged, client reported he feels mildly depressed the past 3 days for most of the day and has a poor appetite but has no thoughts of harming himself. Client reported he was able to fall asleep and stay asleep throughout the night for about 8 hours since discharge. Client reported he was able to stick to his daily routine since discharge and left the house this morning for 1 hour, walking to the park.

I: Case manager monitored client's current symptoms and reviewed client's safety plan and reviewed client's daily schedule to advocate for use and make modifications if necessary. Case manager highlighted client's ability to stick to daily walking routine despite feeling depressed. Case manager used Consumer Recovery Measure (CRM) results related to activity growth and safety to discuss client's progress in these areas despite recent hospitalization.

O: Client was able to identify feeling happier following walks and more energetic due to getting more sleep. Client reported moving homes last month. He feels this has contributed to feeling safer and comfortable with leaving his home more. Client indicated he will plan on sticking to his daily schedule, will use self-talk techniques that his clinician recommended when having depressive symptoms. Client reported his appetite may be poor due to recent changes in medication and upset stomach side effects. Client reports he will eat small snacks instead of larger meals.

P: Will assist client with adding 1 more item to daily routine to facilitate wellness if client remains stable through next visit in 1 week.

PERSON CENTERED RECOVERY TREATMENT LANGUAGE SUGGESTIONS

Instead of:	**Use:**
He/she is mentally ill	Person is living with…
Defining the person by their diagnosis/struggles/distress	Person is experiencing…
Using condescending, intimidating, or clinical language	Language that conveys hope and optimism
Sensationalizing a mental illness (i.e., "suffers from," "victim of," etc.	Language that supports wellness and recovery

PROGRESS NOTE PRACTICES TO AVOID

A finalized progress note is a legal document that ensures transparency. The following are chart documentation practices to avoid:

- Putting other people's names in the chart (use "mother," "son," "friend," etc.)
- Pre-writing notes
- Using white-out or white-out tape
- Using noticeably different pens to write the note
- Cutting and pasting from other notes
- Use of scotch tape
- Use of "post-it" notes in the chart

DOCUMENTING MEDICAL NECESSITY

Components of medical necessity that must be documented in the progress note include the specific intervention that was provided, how the intervention provided reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the treatment plan, and the beneficiary's response to the intervention.

While not all components of medical necessity must be documented in a progress note, the progress notes must clearly link the intervention to the identified functional impairment(s), as a result of the beneficiary's identified mental health diagnosis.

The interventions should be described in such a way that a reviewer reading the note would be able to determine whether the interventions were clinically appropriate to the impairments and whether there was a reasonable likelihood that the interventions would reduce impairments, restore functioning, prevent deterioration, or allow developmental progress.

The use of check boxes may be used for capturing routine information. The use of check boxes, however, would not be adequate or descriptive enough to capture specific individualized information regarding how the intervention reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the treatment plan, and the beneficiary's response to the intervention.

- An example of how a check box might be used in a progress note would be to indicate whether services were provided in the beneficiary's preferred language
- An example of how a check box might be used on the treatment plan is to indicate that a copy of the plan was offered to the beneficiary

DOCUMENTING SPECIFIC INTERVENTIONS

Progress notes should document the use of specific interventions and Evidence-based Practices used, such as motivational interviewing; CBT using techniques such as identifying automatic negative thoughts, and reframing. Documentation should describe how the technique/intervention assisted to reduce impairment, restore functioning, allow developmental progress as appropriate, or prevent significant deterioration in an important area of life functioning outlined in the treatment plan, and the beneficiary's response to the intervention.

Fresno County Department of Behavioral Health encourages and supports the use of Evidence-based Practices (EBPs), as well as Promising Emerging Practices (PEPs) to support wellness, recovery and resiliency. Through research and practice, EBPs have demonstrated effectiveness in treating various types of mental health and SUD issues. Evidence-based Practices demonstrate the integration of:

- The best available research
- Clinical expertise
- The context of beneficiary's characteristics, culture, and preferences

The National Registry of Evidence-based Programs and Practices (NREPP) is an evidence-based repository and review system designed to provide the public with reliable information on mental health and substance use interventions. All interventions in the registry have met NREPP's minimum requirements for review. The programs' effects on individual outcomes have been independently assessed and rated by certified NREPP reviewers.

The purpose of NREPP is to help people learn more about available evidence-based programs and practices and determine which of these may best meet their needs. NREPP is one way SAMHSA is working to improve access to information on evaluated

interventions and reduce the lag time between creation of scientific knowledge and its practical application in the field.

Please visit SAMHSA's National Registry of Evidence-based Programs and Practices site for more information on Evidence-based Practices.

INDIVIDUALIZED PROGRESS NOTES OF GROUP ACTIVITIES

Medi-Cal does allow for some services to be provided in the group format. These services include rehabilitation, psychotherapy, collateral and medication education. In order to accurately account for each person in the group, use the following group formula:

Service Time (time group in session) + Total Documentation Time + Travel Time, divided by the number of persons participating in the group.

4. If more than one facilitator is present, each facilitator will write their own individualized progress notes including their NPI number. The description of interventions applied must include a description of each facilitator's role during the group activity
5. The allocation of service time must be adjusted for late arrival and/or early departure of persons to the group activity.

MULTIPLE PROVIDER CLAIM SUBMISSION REQUIREMENTS

MHSUDS IN 18-002 – Co-Practitioner Claim Submission Requirements

When services are being provided "by two or more persons at one point in time, each person's involvement shall be documented in the context of the mental health needs of the beneficiary." *CCR Title 9, section 1840.314(c).*

The Department of Health Care Services requires MHPs to submit a separate claim for each rendering provider using each rendering provider's assigned National Provider Identifier (NPI) number.

CASE CONFERENCES

The term "case conference" is not specifically defined in the State Plan, MHP contract, or regulations. It may refer to a discussion between direct service providers and other significant support persons or entities involved in the care of the beneficiary, and may be comparable to a multi-disciplinary team meeting. If the case conference concerns placement for a beneficiary, the conference could be claimed as Case Management-

Placement. If it concerns the assessment of a beneficiary, the conference could be claimed as Assessment.

Individual participants claiming for their participation in these services must describe their role and involvement in the service. Any participation time claimed, which may include active listening time, must be supported by documentation showing what information was shared and how it can/will impact the person served.

PROGRESS NOTE CORRECTIONS – PAPER CHARTS

When correcting a finalized progress note entry in a paper chart, always correct by making a single line through the entry (ex: ~~"Mary went to the market")~~, write "error," and put your initials and make the correction. At the top of the documentation, you should write "Amended for (reason)," and sign and date.

PROGRESS NOTE CORRECTIONS – ELECTRONIC HEALTH RECORDS

The FCMHP in-house programs and some contracted providers utilize the Avatar Electronic Health Record (EHR) for clinical documentation. Avatar EHR Progress Notes are corrected by completing a Service Correction/Adjustment Request Form (SCARF). Refer to the link for training and questions *How to File a SCARF*. Complete an *Append Progress Note form*, if applicable. For providers using another Electronic Health Record, complete an amendment, a note to chart, or an authorization to edit. Be sure the date of the initial entry and date of correction are clear.

DOCUMENTING SPECIALTY MENTAL HEALTH SERVICES

MHP Definitions of SMHS-Supplement 3 to Attachment 3.1-A (TN No. 12-025)

Rehabilitative Mental Health Services are provided as part of a comprehensive SMHS program available to Medi-Cal beneficiaries that meet medical necessity criteria established by the State, based on the beneficiary's need for Rehabilitative Mental Health Services as established by an assessment, and documented in the person's treatment plan. Claimed services that do not meet the definitions as defined are reasons for recoupment. *Note: all SMHS definitions included in the following pages in italics are taken directly from the State Plan document TN No. 12-025.*

STRTP Providers Only

The STRTP shall provide structured mental health treatment services in the day and evening, seven (7) days per week, according to the child's individual needs as indicated in the child's treatment plan. The STRTP shall be able to directly provide the following mental health treatment services onsite:

1. Crisis Intervention as defined in Section 1810.209 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.
2. Mental Health Services as defined in Section 1810.227 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.
3. Targeted Case Management as defined in Section 1810.249 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

The STRTP shall make available the following mental health treatment services according to the child's treatment plan:

1. Day treatment intensive as defined in Section 1810.213 of Title 9 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.
2. Day rehabilitation as defined in Section 1810.212 of Title 9 for Medi-Cal beneficiaries equivalent services for children who are not Medi-Cal beneficiaries.
3. Medication Support Services as defined in Section 1810.225 of Title 9 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.
4. EPSDT services as defined in Section 1810.215 of Title 9 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

5. Psychiatric nursing services, which shall include, but not be limited to, nursing assessments, taking vital signs, monitoring vital signs, coordinating medical care, administering, dispensing, and furnishing medication, and other services described in the Business & Professions Code Section 2725. The psychiatric nursing services shall be provided by a registered nurse, licensed, or vocational nurse, licensed psychiatric technician, or another licensed professional acting within the scope of their practice.

For purposes of this section of the STRTP protocol, "make available" means that the STRTP mental health program either directly provides the services or provides access to services provided by other providers. A child may receive services provided offsite by other providers to meet the child's needs as set forth in the child's treatment plan.

If a child is a Medi-Cal beneficiary and the STRTP is not certified to provide a specialty mental health service that is medically necessary for that child, the STRTP shall arrange for the child to receive the service through the mental health plan with responsibility for providing or arranging for specialty mental health services for that child.

ASSESSMENT

"Assessment" is defined as a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures. CCR Title 9, sec. 1810.204.

Staffing Requirements: Assessments may be conducted by licensed, waivered, registered staff (Physician, Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist, Professional Clinical Counselor, RN) or other qualified providers as designated by the FCMHP. The diagnosis, mental status exam, medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a licensed or waivered provider, operating in his/her scope of practice under California State law. The original assessment must be signed and dated by the clinician, and must be kept in the beneficiary's chart.

The FCMHP 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. *CCR, Title 9, sec. 1840.344.*

Service Location: Assessment services may be provided at the program site or in the field.

Billing Lockouts: Staff cannot bill for Assessment services when the person served is in an acute inpatient hospital, psychiatric health facility (PHF), crisis stabilization unit, day treatment program during program hours, Jail or Juvenile Hall unless the services were provided prior to admission, or if the juvenile has been adjudicated (does not apply to adults).

Staffing Requirements: Assessments may be conducted by licensed, waivered, registered staff (Physician, Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist, Professional Clinical Counselor, RN) or other qualified providers as designated by the FCMHP. The diagnosis, mental status exam, medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a licensed or waivered provider, operating in his/her scope of practice under California State law. The original assessment must be signed and dated by the clinician, and must be kept in the beneficiary's chart.

The FCMHP 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. *CCR, Title 9, sec. 1840.344.*

Service Location: Assessment services may be provided at the program site or in the field.

Billing Lockouts: Staff cannot bill for Assessment services when the person served is in an acute inpatient hospital, psychiatric health facility (PHF), crisis stabilization unit, day treatment program during program hours, Jail or Juvenile Hall unless the services were provided prior to admission, or if the juvenile has been adjudicated (does not apply to adults).

PLAN DEVELOPMENT

"Plan Development" means a service activity that consists of one or more of the following: development of client plans, approval of client plans and/or monitoring of a beneficiary's progress. "Client Plan" means a documented plan for the provision of services to a beneficiary who meets medical necessity criteria; it contains specific observable and/or quantifiable goals and treatment objectives, proposed type(s) of intervention(s), and the proposed duration of the intervention(s). A Client Plan is consistent with the beneficiary's diagnosis or diagnoses. A Client Plan is signed by the person providing the service(s), or a person representing a team or program providing

services, and must include documentation of the beneficiary's participation in, and agreement with, the Client Plan.

Staffing Requirements: Plan Development services can be provided by licensed, waivered, registered staff (Physician, Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist, Professional Clinical Counselor, RN, NP, CNS) or Mental Health Case Managers.

Service Location: Plan Development services can be provided at the program site or in the field.

Billing Lockouts: Staff cannot bill for Plan Development services when the person served is in an acute inpatient hospital, PHF, crisis stabilization unit, day treatment program during program hours, Jail or Juvenile Hall unless the services were provided prior to admission or if the juvenile has been adjudicated (does not apply to adults).

When the person we serve has Limited English Proficiency, the progress note needs to document how the language barrier will be addressed. The documentation needs to include:

- Inquiry into the person's language needs and preference
- That the person was made aware of service availability in their preferred language
- How service-related personal correspondence will be provided
- If an interpreter will be used and when
- Description explaining person's full participation and understanding of the plan of care/treatment plan, especially when the Plan is written in English.

CHARTING TIPS FOR PLAN DEVELOPMENT

- ❖ Indicate the individuals present that participated in the development of the plan
- ❖ If the client and/or guardian is unavailable or refuses to sign the treatment plan, a written explanation in the progress notes why the signature could not be obtained is necessary (this should also be documented on the treatment plan)
- ❖ Document ongoing efforts to obtain a signature if the client is initially unavailable to sign
- ❖ Evidence of client participation must be regularly documented in the progress notes
- ❖ "Plan Development" must be indicated on the Plan of Care

THERAPY

"Therapy" means a service activity focusing primarily on symptom reduction and restoration of functioning. Therapy improves coping and adaptation, and reduces functional impairments. Therapeutic interventions include the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development,

wellness, adjustment to impairment, and recovery and resiliency, to assist a beneficiary in acquiring greater personal, interpersonal and community functioning.

Therapeutic interventions are used to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

Staffing Requirements: Therapy services can be provided to individuals or groups by licensed, waivered, or registered staff (Physician, Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist, Professional Clinical Counselor, Nurse Practitioner, Certified Nurse Specialist).

Service Location: Therapy services can be provided at the program site or in the field. Therapy can be provided individually, with a family, or in groups. *The person served must be present for the service.*

Billing Lockouts: Staff cannot bill for therapeutic services when the person served is in an acute inpatient hospital, PHF, crisis stabilization unit, day treatment program during program hours, Jail or Juvenile Hall unless the services were provided prior to admission or if the juvenile has been adjudicated (does not apply to adults).

EXAMPLE: INDIVIDUAL THERAPY PROGRESS NOTE

B: Client presents for session today to address irritability and hopelessness, states that she is improving in her ability to utilize mindfulness practices in her daily life, and that it is still a struggle for her. She states that she is "getting a lot better at noticing things," than she had been in the past and states that she feels that she has spent her entire life "trying not to notice things." She states that she feels strongly that there is "something wrong" with her due to this fact, and that she is "still really confused about why" she has the symptoms that she has. She notes that her ability to notice her own emotional experience has resulted in positive strides in her relationship with her son, and that she has enjoyed that. She notes that she is getting better at noticing her emotional experience, but that she is frustrated because it doesn't seem to change much other than her being aware of her emotional responses to stimuli. She denies any crisis criteria currently, but states that she is "doing a little better" regarding her affective state but still feels that she "has a long way to go" before she feels that she has achieve her treatment goals.

I: Continued with mindfulness skills, continued focus on positive affect, reviewed psychoeducation re: biopsychosocial model and normalized progress. Began educating on emotional regulation skills.

O: Client responded moderately to interventions. She is improving in her struggle with mindfulness, and remains committed to improving. She had forgotten entirely about the goal of observing without interacting with her emotional responses, and finds a reminder and practice of same in session to be helpful. She states that it is "really uncomfortable" for her to practice experiencing emotions without interacting with them, and she does understand this this is an important part of the mindfulness practice in order to notice her feelings and experience them without judging them or ignore them or want to get rid of them. She does remember the value of practicing noticing without acting, on a minute-by-minute basis with wanting to check her phone or drink her coffee; states that she will try and utilize these practices this week, which she did not do the past week. She responds well to psychoeducation, does appear to be able to reframe her struggle from one of failure and brokenness to one of "learning a new language" and being in the early phases of doing the same.

P: Client's next session is scheduled for therapy 12/15 @ 0900 to continue treatment to address irritability and hopelessness. Homework of practicing mindfulness.

CHARTING TIPS FOR THERAPY SERVICES

- ❖ Tie the interventions to the identified symptoms/goals on the Plan of Care
- ❖ Include specific interventions used
- ❖ Focus documentation on how interventions resulted in symptom reduction, prevention of deterioration of functioning or developmental arrest
- ❖ Document the client's response to the interventions and his/her general progress, or lack of progress
- ❖ Document your plan for continued services or complete a discharge summary

CASE MANAGEMENT

"Case Management" is defined as activities that assist a beneficiary to access needed vocational, rehabilitative, or other needed community services. Case Management service activities are divided into two categories:

1. **Linkage and Consultation:** Assisting with identification and pursuit of resources, ensuring access to needed services and monitoring the progress of the person we serve. Activities include, but are not limited to:
    - Consultation, communication, coordination (both within the agency and with other parties)

- Creating and monitoring referrals
- Monitoring service delivery to ensure access and reduce barriers to access
- Monitoring progress in treatment

2. **Placement:** Providing supportive assistance to the person served in the assessment, determination of need and securing of adequate and appropriate living arrangements. Activities include, but are not limited to:

- Assisting the person in securing housing
- Engaging in activities that help the person to negotiate the housing process and housing systems
- Accessing services necessary to secure placement

Staffing Requirements: Case Management services can be provided by licensed, waivered, or registered staff: Physicians, Clinical Psychologists, Clinical Social Workers, Marriage and Family Therapists, Professional Clinical Counselors, Pharmacists, RNs, NPs, CNSs, LVNs, LPTs, Mental Health Case Managers, Mental Health Rehab Specialists, Physician Assistants, Occupational Therapists, or Other Qualified Providers.

Service Location: Case Management services can be provided at the program site, in the field, or over the telephone.

Billing Lockouts: Lockouts include acute inpatient psychiatric hospitalization and PHF episodes except for placement activities 30 days prior to discharge (Case Management-Placement-206 services only); or when the person is in Jail or Juvenile Hall, unless the services were provided prior to admission or if the juvenile has been adjudicated (does not apply to adults).

CHARTING TIPS FOR CASE MANAGEMENT

- Tie service into the identified symptoms on the treatment plan
- Use a verb that describes the case management activity (see below)
- Comment on the individual's functioning in one of the following spheres: living arrangement, social support, health, daily activities
- Document plan for future services and explain how information from the case management session will impact future plans for the individual's care

CASE MANAGEMENT VS. REHABILITATION SERVICES

Case Management: Assists with access to services. It can be done with another provider or support person. The person served does not need to be present. Case Management

involves linkages, monitoring progress, advocating, brokering or ensuring access with or on behalf of the person served.

Rehabilitation: Addresses learning to deal with mental health symptoms and reinforcing activities of daily living (ADLs). Rehab activities are done WITH the client present to educate, teach, coach, or assist with a skill needed by the client to manage mental health symptoms.

EXAMPLE: CASE MANAGEMENT LINKAGE/CONSULTATION PROGRESS NOTE

Current Behavioral Goals as Stated in the POC: Reduce withdrawn, depressed, angry irritable mood and poor impulse control from daily to 1x/week. Reduce suicidal thoughts from 2x/week to 0x/week.

Therapeutic Interventions: Travelled to client's home to monitor his mood. Mother stated that client continues to withdraw daily but has not attempted to harm him/herself or others this week. Client was sitting alone in his room when I arrived. Client stated that he would like to have friends but does not know how to make them. Discussed options available in the community with mother and client. Linked to Boys and Girls Club in an attempt to decrease isolating behaviors.

Progress in Treatment: Client appears willing to attempt planned social interactions.

Plan: Mother will take client to medication appointment this week and to Boys and Girls Club twice this week. Will consult with supervising clinician to convey information gathered and seek direction for future interventions.

EXAMPLE: CASE MANAGEMENT – PLACEMENT PROGRESS NOTE

S: Met with the client and his care provider at his Board and Care home. The care provider stated that due to a death in her family, she needs to move back to New York to care for her invalid mother. She states she needs to close the Board and Care home as soon as possible and regrets her residents will have to move quickly. Client stated he didn't want to move "because the people in the white car would follow and hurt him, but that the radio told him he was bad and deserved to be kicked out."

O: This writer explained that he was not being kicked out. Care provider also assured him that he had been very welcome, but that she had to move, and would miss him. Client asked if her birds would be going, too. Care provider said she didn't think so, and that she would have to find them a good home. Consumer stated he would give them a good home. Care provider stated if his new Board and Care home would allow birds, that client could take them there.

A: Client continues to talk about his fears of the people in the white car and the voice on the radio. Client may be able to adjust to the move better if he is able to have something from his current home. As he has expressed an interest in the current Board and Care parakeets, this will be explored.

P: Schedule an appointment for next Monday for visits to possible Board and Care placements. Explore Board and Care's willingness to accept small pets (parakeets).

CASE MANAGEMENT IS *NOT*:

- Skills Development
- Assistance in Daily Living
- Training a Beneficiary to Access Services

CASE MANAGEMENT—KEY PHRASES:

- Linked, Assisted To…, For…,With…
- Monitored…
- Brokered For…, In Regards To…, Concerning…
- Advocated For…, In Regards To…, On Behalf Of…

REHABILITATION SERVICES

"Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

Rehabilitation may include any or all of the following. Assistance in restoring or maintaining a client's:

- Functional Skills
- Daily Living Skills
- Social Skills
- Grooming Skills
- Personal Hygiene Skills
- Teaching, coaching, practicing, role playing, planning and organizing

- Support Services
- Providing the actual services of training/assisting the client in techniques to address his/her mental health symptoms and behaviors which prevent optimal functioning

Staffing Requirements: MD/DO, licensed or waivered psychologists, licensed or registered clinical social workers, licensed or registered marriage and family therapists, RNs, NPs, CNSs, LVNs, LPTs, Recreational Therapists, Mental Health Case Managers.

Service Location: Rehabilitation services can be provided at the program site or in the field. Rehabilitation can be provided individually, or in groups.

Billing Lockouts: Staff cannot bill for rehabilitation services when the client is in an acute inpatient hospital, PHF, crisis stabilization unit, day treatment program during program hours, Jail or Juvenile Hall, unless the services were provided prior to admission or if the juvenile has been adjudicated (does not apply to adults).

EXAMPLE: INDIVIDUAL REHABILITATION PROGRESS NOTE

S: Client was brought to the clinic by foster mother, who stated that he continues to not follow through with his chores 5-7 days of the week. During session, client interrupts constantly to report that the chores are "dumb," and that "he can't do them." When asked what chores he is able to complete, he said, "helping to feed the dog and cat," and "sorting my laundry." When asked what chores he is not able to complete, he said, "making my bed" and "when it is my turn to set the table." When asked what is happening with school, both client and foster mother said completing homework continues to be a problem, as is staying seated in class. Foster mother stated that client has an appointment with the psychiatrist in two weeks for a medication evaluation.

O: Client continues to blurt out answers before questions are finished. He does not sit still throughout the session, he moves about and fidgets in his seat. Discussed with client and foster mother the possibility of changing chores. Foster mother agreed to change chore of taking a turn to set the table. Making the bed was agreed, at this time, to be client's best effort, with the understanding that client will work to improve skills for this task with guidance from foster mother.

A: Client presented as restless, with much fidgeting and moving about the office, consistent with previous sessions. Problems with difficulty completing chores at home and school continue to prevent the client from progressing developmentally and socially. Client is presenting with several symptoms consistent with his diagnosis of ADHD.

P: Will continue to work with client and foster mother to provide praise and reinforcement for desired behaviors and increased planned ignoring for undesired behaviors at foster home and school. Teach and model ways client can stay more on-task. Consult with the psychiatrist to share this writer's observations during the last several sessions to aid in the medication evaluation and treatment planning.

EXAMPLE: GROUP REHABILITATION PROGRESS NOTE

S: Client was on time for group today, and participated well in the session. She reported she continues to feel sad, but made herself come to group today because she knows once she gets here, she feels better. She states she saw the physician last week, and was given new medication. She indicated she doesn't like it as much as the old medication, as it makes her feel "out of it." She stated she continues to have restless sleep at night and never feels rested. She stated her son didn't come by last week as she had hoped, but that he called, and they had a good conversation. In sharing with the group what she likes best about herself, she said, "I wish I would have been a better mother when my kids were young," but feels she "did the best she could at the time."

O: Client was dressed in casual clothes, she appeared clean and her hair was combed. She did not make eye contact with the other members of the group. She sat slumped over most of the time and spoke very softly. Client was given much positive support from the group members for being at group today, and for maintaining a good relationship with her son. Client was encouraged to talk to the physician about her experience with the new medication.

A: Client appears to be maintaining about the same level of functioning as when she started attending group. She does appear to have made good connections with group members as support system.

P: Continue attending group once a week. This writer will continue to give positive support, encouragement, and model effective communication skills.

The goal of all mental health services, including Rehabilitation, is to improve the beneficiary's quality of life and functioning in the community.

REHABILITATION SERVICES—KEY PHRASES:

- Offered Assistance With…, To…, For…, On Behalf Of…
- Offered Training to Consumer In Regards to…
- Counseled Consumer In Regards to…
- Offered Support For…, In Regards to…
- Offered Encouragement To…, For…, In Regards to…

COLLATERAL SERVICES

"Collateral" means a service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client treatment plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity. Remember that appropriate Releases of Information forms must be completed prior to releasing or exchanging information.

"Significant Support Person" means persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to a parent, legal guardian, other family member, or other unrelated individual of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary.

Collateral services may include any or all of the following:

- Training of a significant support person to increase understanding of the client's mental illness
- Training a significant support person in assisting the client in managing her/his mental health symptoms or training the significant support person in managing the symptoms and behaviors
- The service must show how the collateral intervention helped the significant support person improve, maintain, or better understand the mental health of the client

Staffing Requirements: Collateral services can be provided by licensed, waivered, or registered staff (MD, Psychologist, Clinical Social Worker, MFT, PCC, RN, NP, CNS, LVN, LPT) or by Mental Health Case Managers.

Service Location: Collateral services can be provided at the program site, in the field, or by phone (not collateral group). Collateral can be provided individually or in groups.

Billing Lockouts: Staff cannot bill for collateral services when the client is in an acute inpatient hospital, PHF, crisis stabilization unit, day treatment program during program

hours, Jail or Juvenile Hall unless the services were provided prior to admission, or if the juvenile has been adjudicated (does not apply to adults).

COLLATERAL VS. CASE MANAGEMENT SERVICES

- Collateral is a service where the practitioner educates, informs, trains a significant support person. Collateral is not monitoring. When providing a collateral service, the provider educates the support person on how to intervene on the treatment plan goals or better understand the mental health condition.
- Case Management is a service that monitors symptoms or progress toward treatment goals. A service that involves consultation or coordination with other treatment providers for the purpose of coordinating care or linking to needed service. Case management usually involves monitoring, coordinating, linking and consulting.

EXAMPLE: COLLATERAL PROGRESS NOTE

S: Met with client's biological mother in their home today for a collateral session. Mother reported that the client is using verbal aggression daily with his teacher, and at home. She explained that his new medication is making him tired.

O: Mother appeared upset about the perceived lack of progress. She became teary-eyed as she discussed the meeting she had with the school teacher recently. This writer provided her with information on behavioral management techniques. Worked on a behavioral chart with mother to increase consistency and follow-through of discipline for the verbal aggression. Mother participated in the creation of the behavioral chart and provided feedback on what has worked in the past, and what has not worked. Mother appeared anxious to implement the behavioral chart.

A: The client continues to struggle with verbal aggression when he gets frustrated or loses patience. He appears better able to control his verbal aggression when he is closely monitored and held accountable for his actions.

P: Continue to work with client and mother on consistency and implementation of the behavioral chart.

CHARTING TIPS FOR COLLATERAL SERVICES

- ❖ Tie the service into the identified behaviors or symptoms noted on the individual's treatment plan. Do not focus on the significant support person's behavioral issues.
- ❖ Describe how the interventions help a significant support person improve, maintain, or better understand the mental health status of the *person served* (i.e., putting together a behavioral chart with a parent, teaching how to better reinforce appropriate behaviors, discussing the mental health disorder with the care provider)
- ❖ Explain how the interventions are designed to help the significant support person assist the person served with learned interventions
- ❖ Document the significant support person's response to the intervention(s)
- ❖ Document the plan for future services
- ❖ Document the plan for continued services

MEDICATION SUPPORT SERVICES

MH SUDS IN 17-040: Chart Documentation Requirement Clarifications

"Medication Support Services" include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. The maximum number of hours claimable for medication support services in a 24-hour period is 4 hours. This service includes one or more of the following service components:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- The obtaining of Informed Medication Consent (see forms)
- An Informed Medication Consent must be completed fully whenever there is a new medication prescribed, a change in medication, route or dosage unless a range is clearly indicated on the form
- Medication education including instruction in the use, risks and benefits of and alternatives for medication
- Collateral

- Plan Development
- Medication support services for Caregiver's Affidavit (PPG 2.1.8 section IV)
- Medication support services for minors: The use of the JV 220 series (PPG 2.1.8 section V)

When using the JV 220 A or 220 B, the requesting prescriber *must complete the document fully*. The JV 220 court forms do not currently include all of the required components for informed consent for medications; specifically, they do not include information on the method of administration (oral or injection) or additional side effects if the child were to take the medication for more than three months. Therefore, the prescriber must also complete the Informed Medication Consent form and obtain the client's/parent's signature in addition to completing the JV 220.

The Informed Medication Consent process must be repeated in the following circumstances:

- The client previously refused to accept the medication but subsequently agrees to accept the medication
- There is a change in dosage (a "dosage range" is acceptable)
- The medication has been discontinued and subsequently restarted after an interval of one (1) year
- New information about the medication, such as side effects, risks, indications, or other significant information is recognized

STRTP Providers Only

Medication Assistance, Control, and Monitoring

A nurse practitioner, physician's assistant or registered, licensed or vocational nurse acting within their scope of practice may perform the functions in the following three paragraphs, under the direction of a psychiatrist; however, each child shall be examined by a psychiatrist at least one time during the child's stay at the STRTP.

A physician or psychiatrist shall examine each child prior to prescribing any psychotropic medication. The examination shall include a screening to determine whether there are potential medical complications from the medication that could impact the child's mental health condition. The examination shall be noted in the client record.

A physician or a psychiatrist, shall sign a written medication review for each child prescribed psychotropic medication. This review shall be completed as often as clinically appropriate, but at least every forty-five (45) days. This review may be prepared by a

STRTP mental health program staff member acting within the scope of their practice and shall be included in the client record. The medication review shall include:

1. Observations of any side effects and review of any side effects reported by the child or noted in the client record.
2. The child's response to each psychotropic medication currently prescribed and the child's perspective on the effectiveness of these medications.
3. The child's compliance with taking psychotropic medication prescribed.
4. Justification for continuing to prescribe psychotropic medication and/or changing the child's medication plan.
5. A statement that the physician, psychiatrist has considered the goals and objectives of the child as listed in the child's needs and services plan and the treatment plan, and that the psychotropic medication prescribed is consistent with those goals and objectives.

A psychiatrist shall review the course of treatment for all children who are not on psychotropic medication to treat mental health conditions as clinically appropriate, but at least every ninety (90) days and include the results of this review in a progress note signed by the psychiatrist at the time the review is completed.

Psychotropic medications for a child residing in a STRTP shall be administered and dispensed in accordance with state and federal laws for pharmaceuticals, which include but are not limited to, laws related to authorization, administering and dispensing medication, psychotropic medication, storage and disposal, informed consent, and documentation of informed consent.

The STRTP shall ensure the following is documented in the client record: the date and time a prescription or non-prescription medication was taken, the dosage taken or refused, and the child's response to medication.

CLIENTS RECEIVING ONLY MEDICATION SUPPORT SERVICES

Mental health assessments are required to be completed every two years. For those clients who are receiving **only** Medication Support Services, in lieu of completing an entire assessment, the provider must complete an updated mental status exam and document that they have reviewed the prior mental health assessment (including all 12 elements of the assessment). This will be considered sufficient to stand as an update to required assessment which should be done every two years.

"Telemedicine" means providing a service via the use of information exchanged from one site to another via electronic communications to improve a beneficiary's mental

health condition. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the beneficiary, and the service provider at the distant site. (PPG 3.1.1)

The patient needs to provide written consent to the provider initiating the use of telehealth/telemedicine prior to the initial use of telehealth/telemedicine. The provider needs to document consent in the patient's medical record. If a client wants to stop/withdraw from taking medication(s), they may do so verbally, but the provider should document this in the chart.

Staffing Requirements: In person Medication Support Services may be provided within their scope of practice by an MD/DO, RN, CNS, LVN, PT, PA, NP, or Pharmacist. Only MDs/DOs and NPs can utilize Telemedicine technology.

Service Location: Medication Support Services can be provided at the program site, in the field, through telemedicine technology or via the telephone. Medication education can be provided individually or in groups. Telemedicine is generally used when a local provider is unavailable, the wait time for a local provider is unacceptable, or a local provider is unable to address the bilingual or cultural needs of the client. *Telemedicine requires completion of a specific consent form separate from the general consent form utilized for psychiatric services (See PPG 3.1.1, Attachment A).*

Billing Lockouts: Staff cannot bill for medication support services when the client is in an acute inpatient hospital, PHF, crisis stabilization unit, day treatment program during program hours, Jail or Juvenile Hall unless the services were provided prior to admission, or if the juvenile has been adjudicated (does not apply to adults).

CRISIS INTERVENTION

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)NIMH Ask Suicide Screening Questions (ASQ) Toolkit

NIMH ASQ (Ask Suicide Screening Questions) Suicide Risk Screening Tool

"Crisis Intervention" is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

Crisis intervention may be provided face-to-face, by telephone or by telemedicine with the beneficiary and/or significant support persons and may be provided in a clinic setting or anywhere in the community. This service includes one or more of the following:

- Assessment
- Collateral
- Therapy
- Referral

Crisis intervention is a service lasting less than 24 hours. It is distinguished from crisis stabilization in that crisis stabilization is a bundled service that has specific staffing and physical site requirements. Only sites certified to provide crisis stabilization can bill Medi-Cal for crisis stabilization. Crisis intervention services bill at a higher rate than standard Medi-Cal mental health service codes. Therefore, practitioners can only bill crisis intervention for the time needed to de-escalate the client so that she/he is no longer in imminent danger. Once the client is de-escalated, the practitioner can continue to bill Medi-Cal, but not for crisis intervention. Other mental health service codes, such as individual therapy or collateral, must be used at this time since the client is no longer "in crisis."

Please note that the identified crisis must be the client's crisis. Although a significant support person (i.e., parent, spouse) may be experiencing a crisis, it must be the client who is experiencing a mental health crisis to bill Medi-Cal for Crisis Intervention.

CLAIMING FOR CRISIS INTERVENTION

Crisis intervention is an unplanned, expedited service which may occur at any phase of engagement, any time during the course of treatment or before a Mental Health Assessment or Treatment Plan have been completed.

As an example, If the provider is seeing a client who is currently open for services and they have a current assessment and diagnosis of record, the provider would use that diagnosis when claiming for crisis intervention.

CLAIMING FOR CRISIS INTERVENTION

If a crisis is presented to a responding staff via the Crisis Intervention Team, telephone, field work, or clinic walk-in, and the staff member determines the situation not to be a crisis upon initial evaluation, the service may still be claimed as Crisis Intervention if the crisis described in the originating encounter is so documented.

If there is no clear diagnosis at the time of the service (i.e., insufficient current or historical information to make an accurate diagnosis at the time of the service, or no assessment was conducted to determine a diagnosis), for claiming purposes, it is most appropriate to use the ICD-10 diagnostic code *Z03.89 – Encounter for observation for other suspected diseases and conditions ruled out.*

Per the MHP Contract, Crisis Intervention services are billable without a completed mental health assessment, provided that the following elements are met *and documented*:

- The date(s) services were provided
- The location where the service was provided
- The amount of time (per minute unit) taken to provide the service
- Client's symptoms present at time of crisis
- The intervention(s) provided and beneficiary's response
- Any referrals, follow-up care, and relevant clinical decisions
- An included ICD-10 diagnostic code with defining nomenclature*
- The provider's signature, including the provider's type of professional degree, licensure or job title

CRISIS INTERVENTION FOLLOW-UP PROCEDURES

Once the event has de-escalated, it is very important to ensure the client is linked back to DBH or their current provider for appropriate follow up and ongoing treatment. Persons without a current provider should be encouraged to walk into the Fresno County DBH Urgent Care Wellness Center the following day to be linked to ongoing services.

CHARTING TIPS FOR CRISIS INTERVENTION

- Identify the crisis, being clear about the real immediacy and if there is an imminent threat to the individual or others
- Describe the interventions used to de-escalate the individual and the individual's response
- Document other emergency personnel involved in the intervention (police, EMS, security guard, etc.)
- Clearly document the specific resolution

- Identify and provide additional resources & referrals
- Document the plan for provider's follow-up—specific date, time, with whom

INVOLUNTARY HOLDS

Detention of Mentally Disordered Persons for Evaluation and Treatment [5150 - 5155]

When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, the professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment.[34]

INITIATING A WIC 5150

The following forms may be used when placing a person on an involuntary hold. DHCS has indicated that these forms may be incorporated into the provider's electronic health records and/or modified to suit the needs of your particular agency.

DHCS WIC 1801 Form-Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment

DHCS WIC 1802 Form-Involuntary Patient Advisement

MHSUDS IN 20-004: Updates to optional forms relevant to involuntary treatment: DHCS 1801, 1802, 1808, and 1809

The person making the determination for the involuntary hold shall not be limited to consideration of the danger of imminent harm. Historical mental health history is to be considered. Previous law also required the *original* 5150 document be presented to the accepting facility. AB 2099,[35] which became effective September 5, 2018, allows for *a copy of that application to be treated as the original.*

The Director of Behavioral Health determines who may be authorized to write a 5150. Writers must be certified by the County to write them, for **each** of the locations the provider works. The Managed Care Division provides the training and certification,

[34] WIC 5150(a)
[35] AB 2099, Gloria. Mental Health: detention and evaluation. An act to amend § 5150(e) of the W & I Code.

which is effective for one year. To be re-certified, you may attend a live class, or do self-study through the use of this presentation: *LPS Re-Certification Process.*

Staffing Requirements: Crisis Intervention services may be provided by an MD/DO, PhD, PsyD, LMFT, LCSW, RN, CNS, LVN, PT, PA, NP, OT, MHRS, a Pharmacist, and other qualified provider.

Service Location: Services can be provided at a program site, in the field, or by phone.

Billing Lockouts: Crisis Intervention is not reimbursable on days when crisis residential treatment services, psychiatric health facility services, or psychiatric inpatient hospital services are reimbursed, except for the day of admission to those services. The maximum amount claimable for crisis intervention in a 24-hour period is 8 hours (480 minutes).

EXAMPLE: CRISIS INTERVENTION PROGRESS NOTE

S: Client's spouse called to state that the client has stopped eating, has had trouble sleeping and has been verbalizing an imminent desire to end his life again.

O: Traveled to client's home. Mr. X was observed to be sitting in the corner of his room, rocking back and forth. He acknowledged that he had not bathed in four days and had not eaten anything for the past two days. He said that he stopped taking his medication because "there is no point, I want it to end anyhow." Assessed for suicidal ideations, intent, means and plan. He acknowledged an intent and a plan to overdose on his pain killers. When asked when he planned to do this, he said that he planned to do it as soon as this therapist left the house. Attempted to explore his feelings and contract for safety. Mr. X was unable to contract for safety.

A: This therapist responded to a call from the spouse of Mr. X due to recent problems with sleep, appetite, mood and suicidal ideations. He has been unable to work on his goals and is not taking medications, which has resulted in psychiatric decompensation. Client did have an intent to harm himself, and a feasible plan. The danger to himself was determined to be imminent as he had not eaten or slept in the past few days, and he had a plan and the means to end his life. This clinician called the crisis team for an assessment for danger to self and grave disability.

P: This clinician will continue to follow up with client and his wife. Will work collaboratively with crisis assessment team to provide additional information. Will provide support for the client's spouse. Will advise team and physician of the escalation of symptoms and today's intervention. Will consult with treatment team and supervisor on continued client support.

CRISIS STABILIZATION

"Crisis Stabilization" is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the beneficiary or others, or substantially increase the risk of the beneficiary becoming gravely disabled.

Crisis stabilization is an all-inclusive program, and no other Rehabilitative Mental Health Services are reimbursable during the same time period this service is reimbursed. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this available.

Crisis Stabilization includes one or more of the following service components:

- Assessment
- Collateral
- Therapy
- Target Case Management
- Crisis Intervention
- Medication Support Services
- Referral

Staffing Requirements: A physician must be on call at all times for the provision of crisis stabilization services that must be provided by a physician. There shall be a minimum of one registered nurse, psychiatric technician, or licensed vocational nurse on site at all times beneficiaries are present. At a minimum, there shall be a ratio of at least one licensed mental health or waivered/registered professional on site for each four beneficiaries or other clients receiving crisis stabilization services at the same time. If a beneficiary is evaluated as needing service activities that may only be provided by a specific type of licensed professional, such a person must be available. Other persons may be utilized by the program according to need.

Service Location: Crisis stabilization must be provided on-site at a licensed 24-hour health care facility, at a hospital-based outpatient program (services in a hospital-

based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Mental Health or MHP to perform crisis stabilization.

Billing Lockouts: Crisis stabilization is not reimbursable on days when psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed, except on the day of admission to those services (CCR Title 9, Section 1840.368).

CHARTING TIPS FOR CRISIS STABILIZATION

- Every person served must have a physical and mental health assessment
- The documentation must clearly state the reasons for admission and justification for further psychiatric stabilization, and disposition at discharge
- The maximum number of hours claimable in a 24 hour period is 20 hours

CRISIS RESIDENTIAL TREATMENT

"Crisis Residential Treatment services are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term-03 months or less) 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, improve, and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. The timing, frequency, and duration of the various types of services provided to each beneficiary receiving Crisis Residential Treatment services will depend on the acuity and individual needs of each beneficiary.

For example, a beneficiary newly admitted to a CRT program would be more likely to receive crisis intervention or psychotherapy than the development of community support systems, which would be more appropriate as the beneficiary prepares for discharge from the program.

Crisis Residential Treatment services must have a clearly established site for services, although all services need not be delivered at that site. Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service. In a crisis residential treatment facility, structured day and evening services are available seven days a week." Services include:

- Individual and group counseling
- Crisis intervention such as counseling focusing on immediate problem solving in response to a critical emotional incident to augment the individual's usual coping mechanisms
- Planned activities that develop and enhance skills directed towards achieving client plan coals
- Family counseling with significant support persons directed at client's treatment/rehabilitation plan
- The development of community support systems for beneficiaries to maximize their utilization of non-mental health community resources
- Counseling focused on reducing mental health symptoms and functional impairments to assist beneficiaries to maximize their ability to obtain and retain pre-vocational or vocational employment
- Assisting beneficiaries to develop self-advocacy skills through observation, coaching, and modeling
- An activity program that encourages socialization within the program and general community, and which links the beneficiary to resources which are available after leaving the program
- Use of the residential environment to assist beneficiaries in the acquisition, testing, and/or refinement of community living and interpersonal skills.

Crisis Residential Treatment includes one or more of the following service components:

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral
- Crisis Intervention

Staffing Requirements: Crisis residential treatment services may be provided within their scope of practice by a Physician, a Psychologist, a waivered Psychologist, a Licensed Clinical Social Worker, a waivered/registered Clinical Social Worker, a Licensed Professional Clinical Counselor, a waivered/registered Professional Clinical Counselor, A Marriage and Family Therapist, a waivered/registered Marriage and

Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and Other Qualified Provider.

Service Location: Crisis residential treatment services must have a clearly established site for services, although all services need not be delivered at that site. Crisis residential treatment services are not provided in an institution for mental diseases as defined in SSA Sec. 1905(i) and 42 CFR 435.1010.

Billing Lockouts: Crisis residential treatment services are not reimbursable on days when the following services are reimbursed, except for day of admission to crisis residential treatment services: mental health services, day treatment intensive, day rehabilitation, adult residential treatment services, crisis intervention, crisis stabilization, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services.

CHARTING TIPS FOR CRISIS RESIDENTIAL TREATMENT SERVICES

- Medical necessity must establish that the beneficiary's mental health condition is creating barriers to the beneficiary's successfully living and functioning independently
- Medical necessity must be established daily and documented in the chart
- Treatment planning is done weekly and documentation must establish that the beneficiary participated in the treatment planning

THERAPEUTIC BEHAVIORAL SERVICES

PPG 4.4.5 – EPSDT and TBS Notice

Therapeutic Behavioral Services (TBS) are supplemental Specialty Mental Health Services under EPSDT. It is an intensive, individualized, one-to-one, short-term outpatient treatment intervention for clients who qualify for the services. TBS services are designed to supplement, not supplant, other SMHS the client is already receiving. What makes these services unique is the individualized, on-site nature of the services. The TBS practitioner is immediately available to intervene on the behaviors for a specified period of time. For the clients who qualify for TBS, it is an entitlement program.

Entitlement Criteria: The consumers must:

- Be age 21 or under

- Have full scope Medi-Cal
- Meet medical necessity for, and are already receiving, other SMHS
- Are a member of the "certified class"
- Are currently in a STRTP, or Rate Classification Level (RCL) 12 or higher group home, state mental health hospital or IMD, OR
- Are at risk for placement in a STRTP, RCL 12 or higher group home, hospital or IMD, OR
- Have had an emergency admission to an acute psychiatric inpatient unit in the preceding 24 months, OR
- Have previously received TBS

TBS services require a separate Plan of Care. In addition, TBS services must be referenced on the referring provider's Plan of Care. For documentation requirements for TBS, please see PPG 4.4.3.

INPATIENT SERVICES

Inpatient mental health services provide a specialized set of services to clients experiencing an acute psychiatric episode. Clients may present at the facility on a voluntary or involuntary basis (5150/5585).

Medical Necessity: Inpatient services have different medical necessity criteria than outpatient services. In order to meet criteria for inpatient medical necessity, the client must demonstrate one or more of the following conditions:

- A Danger to Self
- A Danger to Others
- Gravely Disabled

Documentation of Medical Necessity for Services: The clinical opinion of the psychiatrist or nursing notes that either Danger to Self, Danger to Others or Grave Disability is present, must be documented in the chart at least once in each 24-hour period of the inpatient stay. Failure to document this can result in a disallowance.

Acute versus Administrative Days: Acute days are defined as days when medical necessity is met and documented. Once a consumer no longer meets medical necessity for acute days, administrative days may be billed if the client remains inpatient because no appropriate residential placement options can be found. Placement attempts must be documented at least once a week to bill administrative days. Administrative days bill at a reduced daily rate.

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES

REASONS FOR RECOUPMENT – FISCAL YEAR 2020-2021

INPATIENT SERVICES – MEDICAL NECESSITY

Admission

a) Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.

c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:
   - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
   - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
   - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
   - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
   - Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized

CCR, Title 9, Section 1820.205(a); See Also Title 9, Sections 1820.220, 1820.225 and 1820.230.

Continued Stay Services

a) Documentation in the medical record does not establish the continued presence of a diagnosis contained in Section 1820.205(a)(1)(A-R)

b) Documentation in the medical record does not establish that the beneficiary

could not be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion

c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:

- Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
- Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized
- Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
- Presence of new indications that meet medical necessity criteria specified in 22.a above
- Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital

CCR, Title 9, Section 1820.205 See Also Title 9, Sections 1820.220, 1820.225 and 1820.230.

A hospital day was claimed and paid (1) for a day on which the beneficiary was not a patient in the hospital or (2) for the day of discharge, neither of which is reimbursable.

CCR, Title 9, Section 1840.320(b)(1), (3); Title 22, Section 51470(a) 840.320(b)(1)(3)

ADMINISTRATIVE DAY REQUIREMENTS

Documentation in the medical record does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

CCR, Title 9, Section 1820.205(b,) See Also Sections 1820.220(a)(5), (l)(5)(A), 1820.230(a)(2), (d)(1),(2)(A).

Documentation provided by the Provider does not establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:

- The Provider or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case, shall there be less than one (1) contact per week.
- The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:
    a. The status of the placement option
    b. The date of the contact
    c. Signature of the person making the contact

CCR, Title 9, Sections 1820.220(a)(5), (l)(5)(B), 1820.230(d)(2)(B)

CONCURRENT AUTHORIZATION OF SPECIALTY MENTAL HEALTH SERVICES

On March 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid Mental Health Parity Rule[36] to apply certain requirements of the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. Existing State guidance for authorization of psychiatric inpatient hospital services requires initial authorization by the MHP's Point of Authorization, the Managed Care Division.

To align with MCP policy as established in State statutes, MHPs will be expected to conduct concurrent review of treatment authorizations until discharge and complete the review within five (5) business days upon receipt of request. DHCS will ensure

[36] Medicaid Mental Health Parity Final Rule: https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf

consistency in the required timeframes for concurrent review of inpatient hospital services by amending the contract and regulatory guidance for SMHS. As this constitutes a significant shift in local operations related to authorization of services, DHCS is developing implementation standards that are currently in draft format. For the most updated information, please check the Fresno County DBH Managed Care – Contract Provider website.

PSYCHIATRIC HEALTH FACILITY (PHF) SERVICES

"Psychiatric Health Facility Services are therapeutic and/or rehabilitative services including one or more of the following: psychiatric, psychosocial, and counseling services; psychiatric nursing services, social services, and rehabilitative services provided in a psychiatric health facility licensed by the Department of Social Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders.

Services are provided in a psychiatric health facility under a multidisciplinary model. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis."

This service includes one or more of the following service components:

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral
- Crisis Intervention

Psychiatric Health Facilities (PHFs) are very similar to acute inpatient psychiatric facilities. PHFs provide acute short-term treatment in non-hospital settings that have more flexibility with facility and staffing requirements than do hospitals. They have the same medical necessity criteria as acute inpatient services, and also require documentation of medical necessity in the chart at least once in each 24 hour period. From a Medi-Cal billing standpoint, PHFs are not able to bill for administrative days.

Staffing Requirements: Rehabilitative Mental Health Services are provided by certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to

abide by the definitions, rules, and requirements for Rehabilitative Mental Health Services established by DHCS, to the extent authorized under state law.

Services are provided by or under the direction of (for those providers that may direct services) the following mental health professionals functioning within the scope of his or her professional license and applicable state law.

The following specific minimum provider qualifications apply for each individual delivering or directing services:

- Physicians
- Licensed or waivered/registered Psychologists
- Licensed or waivered/registered Clinical Social Workers
- Licensed or waivered/registered Professional Clinical Counselors
- Licensed or waivered/registered Marriage and Family Therapists
- Registered Nurses (RN)
- Certified Nurse Specialists (CNS)
- Nurse Practitioners (NP)
- Licensed Vocational Nurses (LVN)
- Psychiatric Technicians (PT)
- Mental Health Rehabilitation Specialists (MHRS)
- Physician Assistants (PA)
- Pharmacists
- Occupational Therapists (OT)
- Other Qualified Provider

Billing Lockouts: Psychiatric health facility services are not reimbursable on days when any of the following services are reimbursed, except for the day of admission to the PHF: adult residential treatment services, crisis residential treatment services, crisis intervention, day treatment intensive, day rehabilitation, psychiatric inpatient hospital services, medication support services, mental health services, crisis stabilization, or psychiatric nursing facility services.

No Federal Financial Participation (FFP) is available for psychiatric health facility services furnished in facilities with more than 16 beds for services provided to beneficiaries who are 21 years of age and older, and under 65 years of age.

DAY TREATMENT INTENSIVE/DAY REHABILITATION

"Day Treatment Intensive" is a structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals. It may also include rehabilitation, process groups and other interventions.

Day Treatment Intensive is a structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals. It may also include rehabilitation, process groups and other interventions. Additionally, Day Treatment Intensive programs must have a protocol established to respond to the client's mental health crises. See PPG 2.3.4A & PPG 2.3.4D

Day Treatment Intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living with a community setting. Services are available for at least three hours each day. The Day Treatment Intensive program is a program that lasts less than 24 hours each day.

"Day Rehabilitation" is a structured program including rehabilitation, skill building groups, process groups, and adjunctive therapies which provides services to a distinct group of individuals. It may also include therapy, and other interventions. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day, and is a program that lasts less than 24 hours each day.

Day Treatment Intensive/Day Rehabilitation services may include the following components:

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral

Day Treatment Intensive/Day Rehabilitation programs must include, at a minimum, the following service components:

- Therapeutic Milieu

- Community Meetings conducted at least once per day
- Process Groups
- Skill-building Groups
- Adjunctive Therapies
- Psychotherapy (individual or group)
- Written weekly schedules

The written weekly schedules must include all required service components, documentation of when and where services will be provided, and specify the program staff delivering each component of the program, including their qualifications and scope of responsibilities. The weekly detailed schedule must be available to beneficiaries and as appropriate, to their families, caregivers or significant support persons.

ATTENDANCE EXPECTATIONS FOR DAY TREATMENT INTENSIVE/DAY REHABILITATION

The beneficiary is expected to be present for ALL scheduled hours of operation for each day. A Day Treatment Program consists of the following:

- Half Day: Minimum of three (3) program hours
- Full Day: More than four (4) program hours

Breaks, including meals, cannot be counted towards the total hours of the daily program. Providers must document the actual number of hours and minutes a beneficiary attends a DTI program each day (e.g., 3 hours and 58 minutes).

Unavoidable Absences

Entire full or half days of services may be claimed *only if* the beneficiary was present for at least 50% of the program time on a given day and there is a documented reason for an "unavoidable absence" which clearly explains why the beneficiary could not be present for the full program. Examples include:

- Family emergency
- Beneficiary became ill
- Court appearance
- Appointment that cannot be rescheduled (note needs to explain why an appointment cannot be rescheduled)
- Family event (e.g., funeral, wedding)

- Transportation issues

In cases where absences are frequent, it is the responsibility of the MHP to ensure that the provider re-evaluates the beneficiary's need for the DTI program and takes appropriate action.

CHART DOCUMENTATION REQUIREMENTS-DAY TREATMENT INTENSIVE/DAY REHABILITATION

The documentation of both Day Treatment Intensive and Day Rehabilitation services shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the provider's type of professional degree, licensure or job title, date of signature and the total number of minutes/hours the beneficiary actually attended the program.

Day Treatment Intensive documentation requirements include the following:

- Daily progress note
- Weekly clinical summary that must be reviewed and signed by an MD, RN, NP, CNS, or licensed/waivered/registered psychologist, clinical social worker, LPCC or MFT who is either staff to the day treatment intensive program or the person directing the services
- Monthly—One documented contact with family, caregiver, or significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. Adults may decline this service component. If this service is declined, it must be documented that it was declined, and why, every month. This contact may be face-to-face, or by an alternative method (e.g., E-Mail, telephone, etc.). The contacts should focus on the role of the support person in supporting the beneficiary's community re-integration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

Day Rehabilitation documentation requirements include the following:

- Weekly progress note
- Monthly—One documented contact with family, caregiver, or significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. Adults may decline this service component. If this service is declined, it must be documented that it was declined, and why, every month. This contact may be face-to-face, or by E-mail or telephone. The contacts should focus on the role of the support person in

supporting the beneficiary's community re-integration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

Staffing Requirements: Day Treatment Intensive must include a provider whose scope of practice includes psychotherapy. Specific staff ratios must be maintained based on the number of clients in attendance. Services may be provided by MD/DO, PhD, PsyD, LCSW, LMFT, RN, CNS, LVN, PT, MHRS, PA, NP, OT or a Pharmacist and Other Qualified Provider.

Service Location: Day Treatment Intensive (DTI) programs must have a clearly established site for services, although all services need not be delivered at that site.

Billing Specifics:

- Day Treatment Intensive services must be available at least three (3) hours and less than 24 hours each day that the program is open
- During program hours, DTI is a "bundled" service which may include the services listed above, which are included in the daily rate and cannot be billed separately
- Each client gets a "Daily" note at the end of each day, and a "Weekly" note at the end of each week. Absence of a "Weekly" note will result in a disallowance each day of that corresponding week
- A staffing ratio is specified in the Medi-Cal regulations and must be followed for services to qualify for Medi-Cal reimbursement
- DTI staff must include at least one person whose scope of practice includes psychotherapy
- DTI services must receive prior authorization by the MHP and services must be re-authorized at least every three (3) months
- A Plan of Care for DTI is valid for a maximum of three (3) months
- If additional services outside of the treatment milieu are needed, they must be included and authorized on the DTI Plan of Care

Billing Lockouts: Staff cannot bill for day treatment intensive/day rehabilitation services when the client is in an acute inpatient hospital, PHF, crisis stabilization unit, Jail or Juvenile Hall unless the services were provided prior to admission, or if the juvenile has been adjudicated (does not apply to adults).

PATHWAYS TO WELL-BEING (FORMERLY KATIE A. SERVICES)

Source: CDSS

Katie A. v Bonta refers to a class action lawsuit filed in federal district court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of coming into care. In 2011, a settlement agreement approved by the court required State child welfare and mental health leaders to work together to ensure a specific array of intensive services be made available to Katie A. sub-class members.

Katie A. subclass members are children and youth (under the age of 21) who are full-scope Medi-Cal, meet medical necessity for SMHS, have an open child welfare services case, and the following conditions are present:

- The child is currently in, or being considered for: Wraparound services, Therapeutic Foster Care (TFC) or other intensive services, Therapeutic Behavioral Services (TBS), specialized care rate due to behavioral health needs or crisis stabilization/intervention; or
- The child is currently being considered for group home placement (RCL 10 or above), a psychiatric hospital, or 24 hour mental health treatment facility, or has had three or more placements within 24 months due to behavioral health needs.

Although the court's jurisdiction in the case ended in December 2014, the California Department of Social Services (CDSS) and DHCS remain committed to objectives that include:

- Facilitating the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach, which is referred to as the Core Practice Model (CPM)
- These more intensive services are referred to as Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC)
- Clarifying and providing guidance on state and federal laws and policies as needed so that counties and providers can understand and consistently apply them

Please note that Fresno County will be referring to "Katie A. services" as **Child Welfare Mental Health (CWMH) services**. When you hear the phrase Child Welfare Mental Health, know that it relates to the services provided to the Katie A. Subclass of children.

EARLY & PERIODIC SCREENING, DIAGNOSIS & TREATMENT - EPSDT

EPSDT Chart Documentation Manual

EPSDT Intensive Services Training 2017

EPSDT-A Guide for States

PPG 4.4.5 – EPSDT and TBS Notice

EPSDT is a comprehensive and preventive child health program for individuals under the age of 21. It was introduced by the federal government in 1989 to broaden and enhance mental health delivery services for children under State Medicaid plans. EPSDT SMHS are those services that are provided to correct or ameliorate the diagnoses listed in Title 9 CCR Section 1830.205, and that are not otherwise covered.

EPSDT "Mental Health Services" means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency for Medi-Cal beneficiaries under the age of 21. This most often includes: assessment, plan development, psychotherapy, rehabilitation, collateral, and case management, special day programs, and medication support services.

What you need to know: In order to provide ICC and IHBS, a child or youth must first have a Child and Family Team (CFT) formed and active to direct these service activities. MHSUDS Information Notice 16-049 specifically outlines the requirements and guidelines for creating and providing Child and Family Teams as required by California Assembly Bill 403, part of the broader Continuum of Care Reform package. Attachment 1 of the Notice offers answers to Frequently Asked Questions for Child and Family Teams.

EPSDT AND TBS NOTICES – PROVIDER NOTIFYING REQUIREMENTS

EPSDT and TBS Brochure - English

EPSDT and TBS Brochure - Spanish

The FCMHP must provide the EPSDT and TBS Notice to children and youth, and at least one adult who is a de facto or legally authorized representative of the child or youth, under the circumstances described below:

- At the time of admission to a skilled nursing facility or special treatment program (SNF/STP) or Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases (IMDs). *Noticing Responsibility*: DBH Conservatorship Team.
- At the time of placement in a RCL 13-14 foster care group home or Short Term Residential Therapeutic Program (STRTP). *Noticing Responsibility*: DBH Children's Mental Health Division.
- At the time of placement in an RCL 12 foster care group home, if the MHP is involved in the placement. *Noticing Responsibility*: DBH Children's Mental Health Division.
- When the child or youth go through the dependency courts. *Noticing Responsibility*: DBH Child Welfare Mental Health Team.
- When the child or youth has an emergency admission to inpatient psychiatric hospitals. *Noticing Responsibility*: DBH Managed Care Division.

PRESUMPTIVE TRANSFER FOR FOSTER CHILDREN PLACED OUT OF COUNTY

Assembly Bill 1299 – Chapter 603: Medi-Cal SMHS – Foster Children

Welfare & Institutions Code of SMHS, Section 14717.1(c) and 1417.1(g)

DHCS Information Notice 17-032: Implementation of Presumptive Transfer for Foster Children Placed Out of County

PRESUMPTIVE TRANSFER POLICY GUIDANCE

IN 18-027: Presumptive Transfer Policy Guidance

IN 18-027 Attachment A: AB 1299 Flow Chart

IN 18-027 Attachment B: AB 1299 Flow Chart – Waiver Scenarios

IN 18-027 Attachment C: Presumptive Transfer Informing Notice (Template)

IN 18-027 Attachment D: Notice of Transfer of Responsibility for SMHS (Template)

IN 18-027 Attachment E: Presumptive Transfer Waiver Request Form (Template)

IN 18-027 Attachment F: Presumptive Transfer Waiver Determination Notification (Template)

To provide children and youth in foster care who are placed outside their counties of original jurisdiction timely access to SMHS in a timely manner, AB 1299 was enacted to establish presumptive transfer.[37] Presumptive transfer means a prompt transfer of the responsibility for the provision of, or arranging and payment for SMHS from the county of original jurisdiction to the county in which the foster child resides (host county).

- The MHP in the child's county of residence is required to accept an assessment, if one exists, of needed SMHS from the county of original jurisdiction.
- Nothing should preclude the MHP of residence from updating the assessment or conducting a new assessment if clinically indicated, but this may not delay the timely provision of SMHS.

Effective July 1, 2017, the responsibility for authorization, provision, and payment of SMHS will transfer from the county of original jurisdiction to the county of residence.[38]

Each time a child is placed outside of the county of original jurisdiction, presumptive transfer and the waiver process apply. In the event that a child's placement status changes and the child is placed back within the county of original jurisdiction, the placing agency in the county of original jurisdiction must notify the MHP in the former county of residence as well as the MHP in the county of original jurisdiction that the responsibility for providing or arranging for the provision of SMHS is returning to the county of original jurisdiction. This notification should be made through each county MHPs designated presumptive transfer single point of contact. County placing agencies may align or coordinate their existing policies and processes, including the use of locally developed forms, to ensure the notification requirements described above are met.[39]

PRESUMPTIVE TRANSFER AND THE CHILD AND FAMILY TEAM (CFT)[40]

Child and Family Team Resources

Presumptive transfer must be discussed by the CFT in situations in which a child or youth is to be placed outside the county of original jurisdiction. The use of an effective

[37] Presumptive transfer only applies to children and youth who experience inter-county moves within California and does not apply to children and youth placed out of state.
[38] Welfare & Institutions Code § 14717.1(f).
[39] IN 18-027 Presumptive Transfer Policy Guidance
[40] About Child and Family Teams

CFT process is especially important when an out of county placement is being considered, and is the primary vehicle for coordinating care.

In the context of presumptive transfer, the CFT process informs placement decisions, as well as the child or youth's foster care case plan, and mental health treatment plan. If an out of county placement occurs and SMHS are presumptively transferred to the county of residence, the SMHS provider(s) from the county of residence MHP becomes part of the child or youth's CFT.

The child welfare agency or probation department that maintains jurisdiction of the foster care case must ensure a CFT exists for the child or youth in foster care and is responsible for convening the CFT meetings regardless of the county of residence or the MHP responsible for providing SMHS. The county of original jurisdiction child welfare or probation agency responsible for placement must collaborate with the county of residence MHP, and the MHPs contract providers if applicable, to ensure a CFT exists and meetings occur.

The placing agency and all involved entities must coordinate to ensure that there is a single CFT for each child or youth and his or her family. CFT membership is intentionally flexible and dynamic, so team participants will continue to change as needs and strengths change. Counties are encouraged to consider agreements and relationships established through the CFT process as a way to address questions, discuss concerns, develop resources, and solicit the input of other team members. When children, youth, and families give input and see their ideas reflected in the decisions and plans being implemented, they are more likely to reach a positive result.

An effective CFT process allows the child or youth and families to actively participate in case planning, and may over time lead to an increase in positive outcomes, including improvements in placement stability. The CFT process represents an opportunity to mitigate the negative impacts a change in placement can have on a foster child or youth and his or her family. The CFT strives for permanency with the foster child or youth's own family or other resource families. As such, the CFT should develop a plan for the foster child or youth to return to his or her community with clear milestones, goals, and timelines, when appropriate. The plan should consider the desired outcomes for the foster child or youth, including keeping the foster child or youth connected to relationships in the county of original jurisdiction if and when appropriate.[41]

[41] MHSUDS IN 18-027: Presumptive Transfer Policy Guidance

CANS-50 ASSESSMENT TOOL WITHIN A CHILD AND FAMILY TEAM

MHSUDS IN 18-027 Presumptive Transfer Policy Guidance

MHSUDS IN 18-029 Clarifications Regarding Sharing of CANS Assessments by County Placing Agencies and Mental Health Programs

MHSUDS IN 18-007: Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool within a CFT

IN 18-007 Attachment 2: CA CANS-50 Form

IN 18-007 Attachment 3: CFT Authorization for Use of Protected Health and Private Information

MHSUDS IN 18-048: EPSDT SMHS Performance Outcomes System Functional Assessment Tools for Children and Youth

Per the MH SUDS Information Notice 18-048, the CA CANS-50 is administered to all children/youth and non-dependent minors from age 6 through age 20. The 50 core items, known as the CANS Core 50, is approved by both DHCS and CDSS as the child welfare and mental health assessment tool for children ages five to 21.[42] The CANS Core 50 represents the minimum required common items to be used across the state.

It is essential that the Child and Family Team obtain an ***Authorization for Use of PHI and Private Information*** before commencing team meetings. Please use the following attachment for this purpose: MH SUDS IN 18-007 Attachment 3: CFT Authorization for Use of Protected Health and Private Information.

INQUIRIES

You may direct Child and Family Team questions, including CANS-related inquiries, to the CDSS Integrated Services Unit at (916) 651-6600 or Email to CWScoordination@dss.ca.gov, or contact the DHCS Mental Health Services Division at (916) 322-7445 or Email KatieA@dhcs.ca.gov.

[42] MH SUDS IN 18-007: Requirements for Implementing the CANS Assessment Tool Within a CFT

EXCEPTIONS TO PRESUMPTIVE TRANSFER & WAIVER DETERMINATIONS

Presumptive transfer is intended to ensure the timely provision of SMHS to foster children and youth placed outside of the county of original jurisdiction by promptly transferring the responsibility for providing SMHS to the county of residence.

There are some situations when the responsibility should remain with the county of original jurisdiction. A set of exceptions to presumptive transfer are specified in the following:

Welfare & Institutions Code § 14717.1(d)(f)(A-D)

MHSUDS IN 17-032: Implementation of Presumptive Transfer for Foster Children Placed out of County

PRESUMPTIVE TRANSFER NOTIFICATION AND WAIVER TEMPLATES

IN 18-027 Attachment C: Presumptive Transfer Informing Notice Template

IN 18-027 Attachment D: Notice of Transfer of Responsibility for SMHS Template

IN 18-027 Attachment E: Presumptive Transfer Waiver Request Form Template

IN 18-027 Attachment F: Presumptive Transfer Waiver Determination Notification Template

FRESNO COUNTY MHP PRESUMPTIVE TRANSFER REFERRAL PROCESS

FCMHP Presumptive Transfer AB1299 Referral Process

Fresno County Behavioral Health are committed to timely and effective delivery and payment of specialty mental health services to children and youth in foster care who are placed outside of their county of jurisdiction and into a different county of residency (host county). In Fresno County, presumptive transfer is handled by our Youth Wellness Center.

The County of Jurisdiction is responsible for preparing and sending a ***complete*** presumptive transfer packet to Aimee Rojas, LCSW, Fresno County DBH. The county of jurisdiction should call Ms. Rojas to confirm receipt.

- The county of jurisdiction should complete a mental health assessment prior to placing the child/youth; the host county may use as a basis for treatment
- The onus is on the accepting STRTP to obtain a copy of the presumptive transfer packet from the social worker in the county of jurisdiction
- The placing agency in the county of jurisdiction is responsible for changing the client's MEDS information
- MEDS address should be the STRTP address
- The AID code must be a foster aid code

For Presumptive Transfer referrals to Fresno County, please be sure to include all of the following information:

- Identifying information about the child: name, date of birth, address (Include contact information for the caretaker, including name and phone number)
- Name, location, and contact information of the referring placing agency
- Name and contact information of who can sign release of information
- Name and contact information of who can sign consents
- Send the most recent consent for services (minute order), JV-220, and consent for medication
- Send, or arrange to have sent, the most recent mental health records, including the most recent mental health assessment.

Referrals may be sent to the following Email:
DBHAB1299@co.fresno.ca.us

Presumptive Transfer Contact:
Aimee Rojas, LCSW
(559) 600-8918

MH SUDS IN 18-027: Presumptive Transfer Policy Guidance

THE CHILD AND FAMILY TEAM-CFT

MH SUDS IN 18-022 The California Children, Youth, and Families Integrated Core Practice Model and the California Integrated Training Guide

A Child and Family Team (CFT) is a group of individuals that includes, at a minimum, the child or youth, family members, providers, natural community supports, and other individuals identified by the family who are invested in the child, youth, and family's

success. Team members also include representatives from the placing agency, the MHP, or its contracted providers, and any other formal systems supporting the child, youth, or family.

The CFT process drives case planning for children and youth involved in the child welfare and probation systems. The CFT process is also vital to effective care coordination when children and youth are also receiving SMHS. Since every child and youth in foster care is required to have a CFT, CDSS and DHCS strongly encourage county placing agencies, MHPs or their contracted providers, and community provider organizations to actively participate in an inclusive CFT process. Social workers and probation officers are required to consult with the CFT when discussing placement needs, services and supports to youth and families, and when developing a case plan for a child or youth.[43]

The Core Practice Model incorporates the practice of teaming for all children or youth that are Medi-Cal beneficiaries and their families. The CFT is central to the CPM. The CFT is comprised of the child or youth and family and all of the ancillary individuals who are working with them to address the child or youth's needs and strengths, successful mental health treatment, and achieving plan goals.

EPSDT INTENSIVE SERVICES THAT MAKE UP THE PATHWAYS TO WELL-BEING: ICC, IHBS & TFC

Medi-Cal Manual for ICC, IHBS, & TFC

Intensive Care Coordination and Intensive Home Based Services (formerly known as Katie A. services) are intensive, needs-driven, and strength-based services intended for children and youth and their families in addition to other EPSDT mental health services. These children and youth qualify to receive a more intensive array of medically necessary mental health services in their own home, a family setting, or the most home-like setting in order to meet their needs for safety, permanence, and well-being. Service provision is guided by the Core Practice Model.

INTENSIVE CARE COORDINATION (ICC)

ICC is similar to the activities routinely provided as Targeted Case Management (TCM); ICC services must be delivered using a Child and Family Team described above to

[43] *MH SUDS IN 18-027: Presumptive Transfer Policy Guidance*

develop and guide the planning and service delivery process. Although more than one mental health provider/practitioner may participate in the CFT, there must be an identified mental health ICC coordinator that ensures participation by the child or youth, family or caregiver and significant others so that the child or youth's assessment and plan addresses their needs and strengths in the context of the CPM.

While the key service components of ICC are similar to TCM, ICC differs in that it is fully integrated into the CFT process and it typically requires more frequent and active participation by the ICC coordinator to ensure that the needs of the child or youth are appropriately and effectively met.

INTENSIVE HOME BASED SERVICES (IHBS)

IHBS are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child or youth and his/her significant support persons and to help the child or youth develop skills and achieve the goals and objectives of the plan. IHBS are not traditional therapeutic services.

The difference between IHBS and more traditional outpatient SMHS is that the service is expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the plan and the CPM, and will be predominantly delivered outside an office setting and in the home, school, or community.

Staffing Requirements: TFC is a short-term, intensive, highly coordinated, trauma-informed, and individualized intervention provided by a TFC parent. The TFC Agency is responsible for ensuring that the TFC parent meets both Resource Family Approval (RFA) program standards and the required qualifications as a TFC parent. The TFC parent will work under the supervision of the TFC Agency, and under the direction of a Licensed/Registered/Waivered Mental Health Professional employed by the TFC agency. IHBS are typically (but not only) provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS.

The TFC Agency will provide oversight of a network of parents. The TFC Agency activities include:

- Recruiting, approving (unless already approved by the county), and annually re-approving TFC parents, following the RFA process, as well as Medi-Cal SMHS requirements as a TFC parent who has the ability to meet the diverse therapeutic needs of the child or youth
- Providing, at a minimum, 40 hours of required training for the TFC parent, prior to the TFC parent providing TFC

- Actively participating in the CFT to identify supports for the child/youth and family, including linking the child or youth with a TFC parent who can best meet the child's or youth's individual needs
- Integrating the parent and appropriate staff into the existing CFT
- Providing competency-based training to the TFC parent, both initially and ongoing
- Providing ongoing supervision and intensive support to the TFC parent
- Monitoring the child's/youth's progress in meeting client plan goals related to TFC
- Maintaining documentation (progress notes) related to interventions used by the TFC parent to assist the child/youth in meeting the child's/youth's client plan goals

Service Locations: ICC and IHBS may be provided in any setting where the child or youth is naturally located, including the home, group home, schools, recreational settings, child care centers, and other community settings. TFC is provided in a family-like home, in a community setting, thereby avoiding residential, inpatient or institutional care.

Billing Lockouts: Staff cannot bill for ICC or IHBS during the same hours of the day as Day Treatment Intensive, Day Treatment Rehabilitation, Group Therapy, or Therapeutic Behavioral Services (TBS).

As of July 1, 2017, ICC and IHBS services may be provided to and reimbursed for children and youth who are placed in group homes or Short-Term Residential Therapeutic Programs (STRTPs) and meet medical necessity criteria to receive these services. MHSUDS Information Notice No. 17-055 removed the lockout for ICC and IHBS services provided to children and youth in Group Homes.

THERAPEUTIC FOSTER CARE – TFC

Therapeutic Foster Care Training Resource Toolkit December 2017

Therapeutic Foster Care is a short-term, intensive, highly coordinated, trauma-informed and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. TFC is available as an EPSDT benefit to children and youth. Therapeutic Foster Care is provided under the EPSDT benefit to all children and youth who:

- Are under age 21
- Are eligible for the full scope of Medi-Cal services

- Meet medical necessity criteria for SMHS

Membership in the Katie A. subclass is not a prerequisite to receiving TFC. It is not necessary for a child or youth to have an open child welfare case, or be involved in juvenile probation, to be considered for TFC. In addition, TFC must be provided to all children and youth who meet medical necessity criteria for TFC.

The MHP must make individualized determinations of need for TFC based on each child's or youth's strengths and needs. TFC is appropriate for children and youth with more intensive needs, or who are in or at risk of placement in residential or hospital settings, but who could be effectively served in the home and community.[44]

Child welfare departments, juvenile probation, and MHPs have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. The following are the circumstances in which TFC may be appropriate to address the child's or youth's mental health needs. These circumstances should be considered as indicators of need for TFC, and are intended to be used to identify children and youth who should be assessed to determine if TFC is medically necessary. These indicators of need are not requirements or conditions, but are provided as guidance in order to assist counties in identifying children and youth who are in need of TFC:

- The child or youth is at risk of losing his or her placement and/or being removed from his or her home as a result of the caregiver's inability to meet the child's or youth's mental health needs; and, either:
- There is recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the child's or youth's mental health needs, and the child or youth is immediately at risk of residential, inpatient, or institutional care; or
- In cases when the child or youth is transitioning from a residential, inpatient, or institutional setting to a community setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the child or youth, or support effective rehabilitation.

[44] Medi-Cal Manual for ICC, IHBS and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018

TFC PARENT REQUIRED QUALIFICATIONS

To qualify as a Medi-Cal provider, the TFC parent must be approved as a TFC provider, and as a resource parent by the TFC Agency.

The TFC parent must meet and comply with all basic foster care or resource parent requirements, as set forth in California Code of Regulations (CCR) Title 22, Division 6, Chapter 9.5 and Welfare and Institutions (W&I) Code 16519.5; and the Written Directives issued by CDSS to administer the Resource Family Approval (RFA) program operated by counties. Every TFC parent will be required to meet RFA standards.

PLAN DEVELOPMENT

Plan development (limited to when it is part of the CFT meeting): The TFC parent will participate in care planning, monitoring, and review processes, as a member of the CFT meeting. The TFC parent also will observe, monitor, and alert the TFC Agency and members of the CFT about changes in the child's or youth's needs. Please refer to the *Medi-Cal Manual for ICC, IHBS and TFC Services for Medi-Cal Beneficiaries, 3rd Edition* for examples of treatment plans and behavioral goals.

DOCUMENTING CHILD / YOUTH PROGRESS IN TREATMENT

TFC parents write progress notes on days they provide *clinically meaningful engagement* with the child/youth being served and chart the person's response to treatment and current level of impairment. *Monitoring* the child's/youth's response to treatment and describing current level of impairment and/or observed progress towards a behavioral goal is clinically meaningful engagement. This clinically meaningful engagement should have a significant duration of engagement, and that direct engagement time must be documented in minutes, even if the TFC service claim is a daily rate.

If, on the other hand, if there was no engagement on a particular day, Medi-Cal does not require a notes, as there is no claim for that day. You may choose to write a "non-billable" note so that the TFC parent communicates why no engagement occurred that day.

EPSDT SMHS PERFORMANCE OUTCOME SYSTEM FUNCTIONAL ASSESSMENT TOOLS FOR CHILDREN and YOUTH

MHSUDS Information Notice No. 17-052 –EPSDT SMHS Performance Outcomes Systems Tools

MHSUDS IN 18-007: Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool within a Child and Family Team

IN 18-007 Enclosure 3 – CFT Authorization for Use of Protected Health & Private Information

In the spirit of fulfilling the mandates of California Welfare and Institutions Code Section 14707.5, DHCS contracted with the University of California, Los Angeles, (UCLA), to recommend evidence-based tool(s) to measure children and youth functional outcomes in California. DHCS is adopting UCLA's recommendation to use the parent/caregiver version of the Pediatric Symptom Checklist-35 (PSC-35).

In addition, DHCS determined it would also be beneficial to adopt a tool representing the clinician's perspective of the child/youth functioning formed through a collaborative assessment process including the youth, caregivers and other individual identified by the youth and family. Using information obtained from a UCLA study, along with stakeholder and county MHP input, DHCS selected the California Child and Adolescent Needs and Strengths 50 CA CANS-50) as the tool that would benefit this effort the most. Providers will need to be trained and certified in the use of the CANS tool. The FCMHP will ensure training for those all who will be administering this outcomes measure.

STATEWIDE FUNCTIONAL ASSESSMENT TOOLS FOR CHILDREN AND YOUTH

Effective July 1, 2018, all FCMHP providers will be required to utilize these two performance outcomes measures for children and youth. These assessment tools need to be completed at the beginning of treatment, every six months following the first administration, and at the end of treatment. DHCS may revisit this methodology in the future if it is deemed this timeframe is insufficient.

CALIFORNIA CANS-50 TRAINING

The CA CANS-50 measure may be administered by any mental health staff, as long as he/she has completed the training and certification. DHCS expects MHPs to provide or arrange for training to all providers who will be administrating CANS. The Praed Foundation provides

this training and certification either in person or via internet-based training, and is an optimal training resource as Praed is current on the advances in CANS training curriculum. It is important MHPs ensure CANS training is provided to their staff by a trainer who holds a current CANS training certificate. For more information, please visit the Training and Certification page on the Praed Foundation website: https://praedfoundation.org/training-and-certification/

The PSC-35 does not require training because it is completed by the parent/caregiver. For more information about the tool, including implementation, scoring and clinical utility, please visit the Pediatric Symptoms Checklist webpage at: http://www.massgeneral.org/psychiatry/services/psc_home.aspx.

PEDIATRIC SYMPTOM CHECKLIST-35 (PSC-35)

The Pediatric Symptom Checklist-35 (PSC-35) is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so appropriate interventions can be initiated as early as possible. Parents/caregivers will complete the PSC-35 (parent/caregiver version) for all children and youth from age 3 through age 18.

CALIFORNIA CHILD AND ADOLESCENT NEEDS AND STRENGTHS ASSESSMENT TOOL (CA CANS-50)

MHSUDS IN 18-048: EPSDT SMHS Performance Outcomes System Functional Assessment Tools for Children and Youth

MHSUDS IN 18-007: Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool within a Child and Family Team

MHSUDS IN 18-007 Enclosure 3 – CFT Authorization for Use of Protected Health & Private Information

MHSUDS IN 18-029 Clarification Regarding Sharing of CANS Assessments by County Placing Agencies and Mental Health Programs

FCDBH News You Can Use #30 – Statewide Functional Assessment Tools for Children & Youth Implementation, CANS & PSC-35

The Child and Adolescent Needs and Strengths (CANS) tool is a structured assessment used for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes.

Providers with complete the California CANS through a collaborative process which includes all children and youth from age 6 through age 20, and their caregivers (at a minimum).

Please refer to the following chart regarding these two tools. There are links to the forms in the chart:

	CA CANS 50	PSC-35
ABOUT	The Child and Adolescents Needs and Strengths (CANS) tool is a structured assessment used for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes.	The Pediatric Symptom Checklist-35 (PSC-35) is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so appropriate interventions can be initiated as early as possible.
WHO WILL COMPLETE	Mental Health Providers who have been trained and certified will complete the CA CANS-50 through a collaborative process which includes all children and youth age 6 through age 20, and their caregivers (at a minimum).	Parents/caregivers will complete this form.
AGE GROUP	*All* children and youth age 6 through age 20.	*All* children and youth age 3 through age 18.
WHEN	At the beginning of treatment At every six months following the first administration At the end of treatment	At the beginning of treatment At every six months following the first administration At the end of treatment
HOW	In Avatar, use the "Search Forms" function, type in "Child and Adolescent Needs and Strengths," & click "Search" Paper form: IN 17-052 *Enclosure 3 – California CANS - 50 Tool*	In Avatar, access from the "Assessment" console view Paper form: IN 17-052 *Enclosure 2 – PSC-35 Tool*
LINKS TO THE FORMS	CA CANS-50	Pediatric Symptom Checklist-35 PSC-35 - English PSC-35 - Spanish PSC-35 - Hmong

CLAIMING FOR SPECIALTY MENTAL HEALTH SERVICES PROVIDED

BILLABLE DOCUMENTATION

DHCS Medi-Cal Billing Manual - 2019

Claiming and Billing FAQs

Individuals, groups, and/or organizational providers who have been screened and credentialed with the MHP to provide SMHS may claim for Medi-Cal reimbursement if they are operating within their scope of practice and, if required, under the direction of a licensed mental health professional in accordance with the State Plan.

Documentation of SMHS needs to include information indicating that services are medically necessary. Write a signed progress note for each service billed--include your educational level or licensure status with your signature and unique numerical identifier.

All services should be based on the goals and objectives stated on the treatment plan. The Electronic Signature Agreement *(PPG 1.3.8G)* needs to be signed prior to entering any billing or clinical documentation into an electronic health record.

- Mental health services that require a provider with mental health expertise
- Mental health services that are provided within your scope of practice
- Consultations with other professionals involved in the client's care, and each staff member's role and involvement in the service must be clearly noted
- Documentation and travel time connected with a billable service provided to a Medi-Cal beneficiary

CLAIMS FOR SERVICES PROVIDED TO A BENEFICIARY WITH A SUBSTANCE USE DISORDER

If there is a co-occurring substance use disorder, interventions are claimable as long as the primary focus of the interventions is to address the functional impairment(s) that are a result of the included *mental health* diagnosis. The treatment of a beneficiary who has met medical necessity criteria for SMHS is reimbursable through Medi-Cal, regardless of the co-occurrence of a substance use disorder. (*CCR Title 9, Sec. 1820.205(a)(1)(H)* and *1830.205*).

CLAIMING FOR CANS ADMINISTRATION SERVICES

DHCS is developing rates for the administration of the CANS assessment tool, as well as on outcomes measure. It is regarded as assessment time, and this will be factored in to the rates. The time will be claimed for the mental health assessment time as is normally done, and the CANS will be a separate claim, which will be a *flat rate* TBD.

CLAIMING FOR SERVICE FUNCTIONS BASED ON MINUTES OF TIME

CCR Title 9, sec. 1840.316

For the following services, the billing unit is the time of the person delivering the service in minutes of time:

- Mental Health Services
- Medication Support Services
- Crisis Intervention
- Targeted Case Management (TCM)
- Therapeutic Behavioral Services (TBS)
- Intensive Care Coordination (ICC)
- Intensive Home-Based Services (IHBS)

The following requirements apply for claiming of services based on minutes of time:

1. The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one person during a one-hour period.
2. When a person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.
3. The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity. (CCR, Title 9, sec. 1840.316)

NON-BILLABLE DOCUMENTATION

- Mental health services provided while a beneficiary (age 21-64) is in an IMD
- Any service other than Case Management-Placement when a beneficiary is in an acute inpatient psychiatric hospital or psychiatric health facility (PHF) setting
- Outpatient mental health services can be billed, only on the day of admission to the inpatient facility
- Any services except medication support during Day Treatment Intensive or Day Rehabilitation service hours; these services must be provided by staff outside of the Day Treatment staff to be reimbursable
- Preparing documents for court testimony
- Any documentation after client is deceased
- Academic or educational services (tutoring or helping with homework)
- Vocational services (helping someone find a job or teaching them how to work)
- Recreational or socialization activities (going to the zoo, taking a consumer to the movies)
- Transporting a client (unless part of another reimbursable activity)
- Language interpreting/translating only
- No service provided: missed visit; waiting for a “no-show;” documenting that a client missed an appointment; traveling to a sight and it is a “no-show”
- One -way communications (E-mails, appointment setting, leaving messages, etc.)
- Paperwork that is not directly related to a service provided (writing letters, CPS/APS reports, completing outcome measures).
- Supervision of staff
- Utilization management, peer review, or other quality improvement activities
- Services provided while a consumer is incarcerated in jail, prison or juvenile hall, unless the minor in juvenile hall has been adjudicated and is awaiting placement
- More than one staff member providing services to a consumer at the same time (exceptions: ICC, IHBS, CFT)
- Exception: group therapy with more than one provider; providers determine how time will be split, documented and billed

Maximum Service Time and Lockouts: Multiple Services are claims for services for the same day and recipient that are approved for reimbursement, up to the maximum payment allowed per unit of time for each Service Category. For inpatient claims, the discharge day (the day the patient leaves the hospital) will not be counted since there is no service on that day. Services for the same day for the same recipient may be approved for reimbursement if the claim contains an appropriate repeat procedure code.

Lockouts: Lockouts (L) are claims for mutually exclusive activities. Lockouts are also services that should never occur on the same day for the same recipient and will not be approved for reimbursement. Some claims for services may occur on the day of

CLAIMING FOR GROUP THERAPY-SUBMITTING CLAIMS FOR CO-PRACTITIONERS

MHSUDS IN 18-002 – Co-Practitioner Claim Submission Requirements

The Department of Health Care Services has established new policies and procedures for claim submissions involving multiple rendering practitioners. The new policy was established to prevent the approval of payments for services rendered by providers who are excluded, terminated or suspended from participating in the Medicaid program.[45]

The Department of Health Care Services requires MHPs to submit a separate claim for each rendering provider using each rendering provider's assigned National Provider Identifier (NPI) number. This policy will primarily affect group services in which there are two practitioners providing services. Providers are required to create separate notes and/or billing in order to accurately capture each provider's service time and their specific profile information (NPI, Title, and/or Licensure) on the claim submitted. The practitioner and co-practitioner should consult to some extent to ensure consistency.

As always, each progress note should stand alone and not simply make reference to other documentation as a means to substantiate Medi-Cal Billing. Group services include therapy, rehabilitation, collateral, and medication education.

A progress note must be completed for every client in the group. When services are being provided by two or more persons at one point in time, the number of staff group facilitators and the unique involvement of each shall be documented in the context of

[45] Fresno County DBH News You Can Use, Notice No. 28, March 15, 2018 – *New Policy & Procedure for Submitting Claims for Co-Practitioners*

the mental health needs of the beneficiary. The progress note should include the total number of group participants (Medi-Cal and non-Medi-Cal participants) and clearly indicate length of group session with documentation time included. In addition, when multiple providers render a covered service to more than one participant, the total number of minutes of the session must be distributed among the group participants (regardless of payer source), and prorated among the providers at the group session. *CCR, Title 9, section 1840.314(c); Medi-Cal Billing Manual Chapter 7, section 7.5.5).* **Claims that are submitted through Avatar will automatically calculate the correct formula.**

Group Therapy (82) progress notes should include the following:

- Demonstrate a service that focuses on symptom reduction and is provided to multiple clients in one session
- The group note must be individualized to speak to the specific progress of the individual client
- Time is properly apportioned to all clients present and, if applicable, to multiple providers
- Group formula components are included on the progress note
- When services are being provided to, or on behalf of, a client involving one or more providers at one point in time, the progress notes or other relevant documentation include:
    - Medical necessity for having more than one provider
    - The total number of providers and their specific involvement in the context of the mental health needs of the beneficiary
    - The specific amount of time of involvement of each provider in providing the service, including documentation and travel time if applicable
    - The total number of beneficiaries participating in the service activity

Group Collateral (153) progress notes should include the following:

- Show a service that focuses on symptom reduction and is provided to multiple significant support persons in one session
- The notes must be individualized to speak to the specific progress of each beneficiary representing
- The group formula is applied to the number of beneficiaries represented
- The group service meets the criteria of Group Therapy noted above

Group Rehabilitation (85) should include the following:

- Show the beneficiary was offered assistance, training, counseling, support, or encouragement with mental health stated symptoms and impairments per the Plan of Care
- Group notes must be individualized to speak to the specific progress of each client represented
- Group formula is applied to the number of clients represented
- The group service meets the criteria of Group Therapy noted above

Medication Education (41) notes should include the following:

- Focus on informing the client and significant support persons about the psychotropic medications being prescribed
- (41) May also be used for general nursing interventions such as MD consultation, MD consent (completion of the JV 220) and other nursing services which do not fall under the category of medication refill/injection

The example below demonstrates the number of minutes each provider would be claiming for each Medi-Cal beneficiary participating in the group session.

EXAMPLE OF GROUP SERVICE TIME CALCULATIONS

Group Session face-to-face time: 90 minutes

Providers: 2

Participants: 12

Provider #1: 90 minutes of service time and 36 minutes of documentation time

Provider #2: 90 minutes of service time and 48 minutes of documentation time

Please note: If the group is facilitated by a clinician and case manager, then the group must be billed under *group rehabilitation*.

CALCULATION TO DETERMINE THE NUMBER OF MINUTES EACH PROVIDER MAY CLAIM FOR EACH GROUP PARTICIPANT

Provider #1: 90 minutes of service time + 36 minutes of documentation & travel time / 12 group participants = 10.5 minutes

Provider #2: 90 minutes of service time + 48 minutes of documentation & travel time / 12 group participants = 11.5 minutes

TARDY GROUP MEMBERS

If a client leaves early or comes late to group, make sure to adjust the total "service time" documented in the client's individualized progress note to reflect the decrease. Failure to adjust the group billing formula for these "tardy" group members results in an overpayment, which is another reason for recoupment. In this example, one client was 10 minutes late:

Provider #1: 80 minutes of service time + 36 minutes of documentation & travel time / 12 group participants = 9.66 minutes for the tardy client

Provider #2: 80 minutes of service time + 48 minutes of documentation & travel time / 12 group participants = 10.66 minutes for the tardy client

As you can see by the group calculations examples above,

Please note that providers are able to individualize the amount of time for each participant in the Avatar system. Avatar will do the calculations for you.

EXAMPLES OF GROUP PROGRESS NOTES – 2 PRACTITIONERS

EXAMPLE #1

Provider #1:

B - Ct presents with symptoms of depression, anxiety, and trauma that impair Ct's daily, social, and occupational functioning. These symptoms show in the life of the Ct as elevated energy, hyperactivity, grandiosity, rapid speech, racing thoughts, sadness, low energy, low motivation, hopelessness, helplessness, isolation, negative self-thoughts, low self-image, sleep disturbance, appetite disturbance, irritability, anger, worry, feeling overwhelmed, nervousness, shaky body, difficulty breathing, increased heart rate, intrusive memories, flashbacks, hypervigilance, nightmares and dysregulation of emotions, thoughts and behaviors.

I - Writer led cls in an opening mindfulness exercise to practice observe and describe skills. Educated cls on Evaluating Options skills by using handouts and relevant examples throughout the session. Provided clarity and gave feedback as appropriate. Reminded cls that next week there will be no group due to writer

being out for training.

O - Cl has trouble with focus and being present during group, but does use relevant examples regarding his children and his struggles to parent at times. He is often fidgety or appears to be struggling to pay attention.

P - Writer will begin and end group with mindfulness exercise and will review mindfulness how and what skills and will welcome and introduce any new clients entering the group. Will review group guidelines and limits of confidentiality.

Provider #2:

B - Behavior/symptoms related to Tx plan impairments/symptoms and goals: Cs presents with symptoms of depression, anxiety, mania, and trauma that impair Cs's daily, social, and occupational functioning. These symptoms show as elevated energy, hyperactivity, grandiosity, rapid speech, racing thoughts, sadness, low energy, low motivation, hopelessness, helplessness, isolation, negative self-thoughts, low self-image, sleep disturbance, appetite disturbance, irritability, anger, worry, feeling overwhelmed, dysregulation of emotions, thoughts and behaviors. Cs is in DBT skills group to develop skills to regulate emotions, thoughts, and behaviors to reduce symptoms.

I - Intervention/referrals/linkage/Tx provided: Facilitator led Cs's in an opening mindfulness exercise to practice Observe and Describe skills using an object that was passed around. Cs's were reminded of the What and How skills used during the exercise and facilitator led group in practicing Participation skills. Facilitators introduced Evaluating Options skills by using handouts and relevant examples throughout the session. Facilitators solicited feedback from the group, used examples and clarified questions when needed.

O - Outcome of intervention/progress in Tx: Cs participated in group and provided examples of when he used skills and/or struggled with them. He interacted appropriately with other group members and appears to be aware of social skills, attempting to not interrupt and appropriately self disclosing. At times he appears disinterested and fidgety and stated that he becomes very vulnerable in and after group due to what he's attempting to learn and incorporate into his daily life.

P - Plan for current/future services: Reminded Cs's that next week there will be no group due to writer and co-facilitator being out for training. Facilitator will begin and end group with mindfulness exercise and will review mindfulness How and What skills and will welcome and introduce any new members entering the group. Will review group guidelines and limits of confidentiality.

EXAMPLE #2

Provider #1:

B - Ct presents with depressed mood, sadness, loss of interest in activities, sleep disturbance, appetite disturbance, loss of energy, hopelessness, difficulty concentrating, irritability, nervousness, worry that is difficult to control, racing thoughts, intrusive memories, external triggers, guilt, self-blame, hypervigilance, and avoidance. These symptoms impair client's daily, social, and occupational functioning. She is in DBT skills group to develop skills to regulate emotions, thoughts, and behaviors to reduce symptoms.

I - Group was opened by clients being asked to introduce themselves to one another. Informed group of group guidelines, which covered limits of confidentiality. Distributed skills training and mindfulness handouts for this week's group and walked through each handout with clients while reading information aloud. Handouts covered group guidelines, mindfulness skills, *Wise Mind,* and goals of mindfulness. This provider led clients in mindfulness exercise using *Observe and Describe* skills in vivo and asked for cl feedback/experience.

O - She gave feedback and expressed what she was learning and/or is currently struggling with. She seems to be developing healthy rapport with other group members.

P – This facilitator will lead clients in a mindfulness exercise before reviewing mindfulness skills taught the week prior then will distribute handouts for next week's lesson on the *How* skills of mindfulness. Group will go through each handout together in order to learn new mindfulness skills during the second hour of group.

Provider #2:
B - Client experiences worry, irritability, distractibility, sadness, hopelessness and overall depressed mood and these symptoms impair her socially and occupationally.

I - Group was opened by consumers being asked to introduce themselves to one another and to tell the group one unique thing about themselves. This facilitator led group in a mindfulness exercise using a prop and then processed with the group what their experience was like during the exercise. Informed group of group guidelines, which covered limits of confidentiality. Writer assisted with distribution of skills training and mindfulness handouts for this week's group and provided examples and solicited feedback from consumers. Handouts covered group guidelines, mindfulness skills, *Wise Mind*, and goals of mindfulness.

O - Client participated and shared how she was unsure of continuing the group due to writer being an unknown and different facilitator. Client engaged with the other members appropriately and shared relevant examples. Client expressed that she is hopeful the she will continue to learn skills to assist with her relationships.

P – This facilitator will lead consumers in a mindfulness exercise before reviewing mindfulness taught the week prior then will distribute handouts for that week's lesson. Group will go through each handout together in order to learn new mindfulness skills during the second hour of group.

CLAIMING FOR TRAVEL TIME

The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity, as follows:

- Travel time from a provider site (office) to an off-site location(s) where Medi-Cal SMHS are delivered is claimable. The travel time must be directly linked or related to the services provided, which should be clearly documented in the progress note. In addition, the amounts of travel time and service time should each be reflected in the progress note.
- Travel time between provider sites or from a staff member's residence to a provider site may not be claimed
- Travel time must be from a provider site to an off-site location(s) where Medi-Cal specialty mental health services are delivered
- Travel time cannot be claimed for travel between provider sites or from a staff member's residence to a provider site
- A "provider site" is defined as a site with a provider number, including affiliated satellite and school site operations
- It is possible to claim for travel time between a staff's home and the client's home as long as the MHP permits such activity and MHP travel guidelines are adhered to.

Travel Vs. Transportation

- Travel involves the provider going from his/her location, to the location where a mental health service will be provided, and **this is time that is billable**
- Transportation involves the provider taking the client/family from one location to another, and **this time is not billable**

- If a behavioral health service is provided during the time a provider is transporting the client/family, then the time spent providing the service is not "transportation," and that portion of service time **can be** claimed

Please note that safety is of the utmost importance, and providing a service while driving is not recommended. This should be reserved for rare situations where some clinical intervention is necessary during that time.

CLAIMING FOR CHART REVIEW

Record review is reimbursable when performed as part of the following services and service activities:

- Mental Health Services (assessment, plan development, collateral, rehabilitation, therapy)
- Targeted Case Management
- Medication Support Services
- Crisis Intervention

Chart review is included in the hourly, half day, full day, or calendar day rate for the following services and **cannot** be claimed separately:

- Day Treatment Intensive and Day Rehabilitation Services are claimed as either half or full days
- Adult Residential, Crisis Residential, and Psychiatric Health Facility services are claimed based on calendar days. Crisis Stabilization services are claimed based on hours of time where each one-hour block that the beneficiary receives Crisis Stabilization services shall be claimed. Only twenty (20) hours of Crisis Stabilization services may be claimed in a 24-hour period.

If a provider reviews a beneficiary's chart in preparation for a session with a beneficiary, and the beneficiary no shows, the time spent to review the chart in preparation for the appointment **is** reimbursable. A provider may submit a subsequent claim for chart review in preparation of the beneficiary's next appointment. The provider must document the circumstances of the beneficiary no show and the time spent to review the chart.

REASONS FOR RECOUPMENT FY 2020-2021 - NON-HOSPITAL SERVICES

MH SUDS IN 20-007, Annual Review Protocol for Specialty Mental Health Services and Other Funded Services for Fiscal Year 2019/2020

MH SUDS IN 20-007, Enclosure 4-Reasons for Recoupment FY 2019-2020

MH SUDS IN 17-040, Enclosure 4 (CCR, Title 9, Section 1810.380(b); MHP Contract)

Fresno County MHP Chart Review Tool

Pursuant to responsibilities outlined in the MHP Contract, and Welfare and Institutions Code Section 5614, the State DHCS provides oversight and monitoring of the MHP SMHS. DHCS will review program and fiscal operations of each MHP to verify medically necessary services are provided in compliance with state and federal laws and regulations and/or the terms of the contract between DHCS and the MHP.

If DHCS determines the medical record documentation does not meet medical necessity criteria and/or documentation standards required pursuant to the MHP Contract, DHCS will disallow associated claims and recoup Federal Financial Participation (FFP) dollars in accordance with Enclosure 4, Reasons for Recoupment. The following areas are reviewed. *Please refer to Enclosure 4 for specific regulatory citations.*

MEDICAL NECESSITY/ASSESSMENT

1. The Mental Health Plan (MHP) did not submit documentation substantiating it complied following requirements:
    A. The MHP uses the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as the clinical tool to make diagnostic determinations. *(MHP Contract, Exhibit A, Attachment 3)*
    B. Once a DSM-V diagnosis is determined, the MHP shall determine the corresponding mental health diagnosis, in the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) and use the ICD-10 diagnosis code(s) to submit a claim for specialty mental health services (SMHS) to receive reimbursement of Federal Financial Participation (FFP) in accordance with the covered diagnoses for reimbursement of outpatient and inpatient SMHS.

MHP Contract, Exhibit A, Attachment 3; Title 9 of the California Code of Regulations § 1830.205(b)(1) and 1830.210; and, Mental Health and Substance Use Disorder Services Information Notices

Please note: The applicable ICD-10 diagnoses are subject to change. If applicable, changes in covered ICD-10 diagnosis codes will be detailed in MHSUDS Information Notices.

2. Services, except for Crisis Intervention and/or services needed to establish medical necessity criteria, shall be provided, in accordance with the State Plan, to beneficiaries who meet medical necessity criteria, based on the beneficiary's need for services established by an Assessment. The MHP did not submit documentation substantiating the beneficiary's need for services was established by an Assessment.

MHP Contract, Exhibit A, Attachment 2

3. The MHP did not submit documentation substantiating that, as a result of an included ICD-10 diagnosis, the beneficiary has, at least, one of the following impairments:
    a) A significant impairment in an important area of life functioning;
    b) A probability of significant deterioration in an important area of life functioning;
    c) A probability the child will not progress developmentally as individually appropriate; or
    d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, title 9, chapter 11, section 1830.205(b)(2)(A-C); CCR, title 9, chapter 11, section 1830.210(a)(3)

CLIENT PLAN

4. Services shall be provided, in accordance with the State Plan, based on the beneficiary's need for services established by an Assessment and documented in the Client Plan. Services were claimed:
    A. Prior to the initial Client Plan being in place; or
    B. During the period where there was a gap or lapse between client plans; or,
    C. When the planned service intervention was not on the current client plan.

An approved client plan must be in place prior to service delivery for the following SMHS:

- Mental health services (except assessment, client plan development)
- Intensive Home-Based Services (IHBS)
- Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs
- Therapeutic Behavioral Services (TBS)
- Day treatment intensive
- Day rehabilitation
- Adult residential treatment services
- Crisis residential treatment services
- Medication Support (non-assessment/evaluation, non-plan development and non-urgent)
- Psychiatric Health Facility Services *(CCR, title 22, § 77073)*
- Psychiatric Inpatient Services *(CFR, title 42, § 456.180(a); CCR, Title 9 §§ 1820.230 (b), 1820.220 (l)(i))*

MHP Contract; State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025), page 2c; MHSUDS Information Notice 17-040

PROGRESS NOTES

5. The MHP did not submit documentation substantiating that the focus of the intervention is to address the beneficiary's included mental health condition.
    a) A significant impairment in an important area of life functioning;
    b) A probability of significant deterioration in an important area of life functioning;
    c) A probability the child will not progress developmentally as individually appropriate; and
    d) For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.

CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

6. The MHP did not submit documentation substantiating the expectation that the intervention will do, at least, one of the following:
    a) Significantly diminish the impairment;
    b) Prevent significant deterioration in an important area of life functioning;
    c) Allow the child to progress developmentally as individually appropriate; or
    d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.

CCR, title 9, chapter 11, 1830.205(b)(3)(B); CCR, title 9, chapter 1810.345(c)

7. The progress note does not describe how services provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.

MHP Contract, Exhibit A, Attachment 9

8. The MHP did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:
    a) No progress note submitted
    b) The progress note provided by the MHP does not match the claim submitted to DHCS for reimbursement in terms of the following:
        1) Specialty Mental Health Service claimed.
        2) Date of service, and/or
        3) Units of time.

CCR title 9, sections 1840.316 - 1840.322, and 1810.440(c), CCR, title 22, section 51458.1(a)(3)(4); MHP Contract; CCR, title 9, section 1840.112(b)(3)

9. The service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation (e.g., Institution for Mental Disease [IMD], jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11).

NOTE: When a beneficiary who resides in a setting in which s/he would normally be ineligible for Medi-Cal is moved off grounds to an acute psychiatric inpatient hospital or PHF, that individual again becomes Medi-Cal eligible (unless the hospital is free-standing with more than 16 beds and is thus considered an IMD and the beneficiary is between the ages of 21-64).

CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, part 435, sections 435.1008 –435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d

10. The service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (A dependent minor in a juvenile detention center prior to disposition, if there is a plan to make the minor's stay temporary, is Medi-Cal eligible. See CCR, title 22, section 50273(c)(5) A delinquent minor is only Medi-Cal eligible after adjudication for release into community. *See CCR, title 22, section 50273(c)(1)*

Code of Federal Regulations, title 42, sections 435.1009 – 435.1010; CCR, title 22, section 50273(a)(5-8), (c)(1, 5)

11. The service provided was solely for one of the following:
    a) Academic educational service
    b) Vocational service that has work or work training as its actual purpose
    c) Recreation
    d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors
    e) Transportation
    f) Clerical
    g) Payee Related

CCR, title 9, sections 1810.247, 1810.345(a), 1810.355(a)(2), 1830.205(b)(3), and 1840.312(a-f); title 22, chapter 3, section 51458.1(a)(5)(7);

12. The claim for a group activity, which is provided as a Mental Health Service, Medication Support, Crisis Intervention, or TCM service, was not properly apportioned to all clients present, and resulted in excess time claimed.

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

13. For service activities involving one (1) or more providers, progress notes, or other relevant documentation in the medical record, did not clearly include the following:

    a) The total number of providers and their specific involvement r in the context of the mental health needs of the beneficiary; **or**

    b) The specific amount of time of involvement of each provider in providing the service, including travel and documentation time if applicable; ***or***

    c) The total number of beneficiaries participating in the service activity.

CCR, title 9, section 1840.316(b)(2); Medi-Cal Billing Manual, Chapter 7, section 7.5.5.; MHSUDS Information Notice 17-040

14. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

MHP Contract; MHSUDS Information Notice 17-040

15. The MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:

    a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a "no show'), or

    b) Service provided did not meet the applicable definition of a SMHS.

CCR, title 9, section 1840.112(b)(3); title 22, section 51470(a); MHSUDS Information Notice 17- 040; MHP Contract, Exhibit E, Attachment 1

16. The service provided was not within the scope of practice of the person delivering the service.

CCR, title 9, section 1840.314(d); MHSUDS Information Notice 17-040

DAY TREATMENT INTENSIVE/DAY REHABILITATION

17. On a day where the beneficiary was present for at least 50% of the scheduled DTI/DR program time, but was not in attendance for the full hours of operation for that day, there is no documentation of the reason for an "unavoidable absence" which clearly explains why the beneficiary could not be present for

the full program on the day claimed.

CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

18. The actual number of hours and minutes the beneficiary attended the DTI/DR program (e.g., 3 hours and 58 minutes) is not documented and for this reason it cannot be established that the beneficiary was present for at least 50% of the program time for the day reviewed.

    DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040;

19. Documentation reviewed, including the written weekly schedule for DTI/DR along with the progress notes, reflects that the program does not meet the time requirements for a half-day or full-day program as follows:

    a) Breaks and/or meal times were counted in order to meet the time requirements,

    b) Half day program was less than 3 hours (requirement is for 4 hours or less, but a minimum of 3 hours)

    c) Full day program was 4 hours or less (requirements is for more than 4 hours)

    CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

20. Required DTI/DR documentation was not present as follows:

    a) There was not a clinical summary present for Day Treatment Intensive Services for the week of the service reviewed

    b) There was not a daily progress note present for Day Treatment Intensive Services for the day of the service reviewed

    c) There was not a weekly progress note present for Day Rehabilitation Services for the week of the service reviewed

    CCR, title 9, 1840.318; DMH Information Notice 03-03; MHP Contract; MHSUDS Information Notice 17-040

REASONS FOR RECOUPMENT FY 2020-2021
HOSPITAL SERVICES

MEDICAL NECESSITY

21. Admission

a) Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.

c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires admission to an acute psychiatric inpatient hospital for one of the following reasons:

- Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
- Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized

CCR, title 9, section 1820.205(a); See Also title 9, sections 1820.220, 1820.225 and 1820.230

22. Continued Stay Services

a) Documentation in the medical record does not establish the continued presence of a diagnosis contained in Section 1820.205(a)(1)(A-R)

b) Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion

c) Documentation in the medical record does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires continued stay services in an acute psychiatric inpatient hospital for one of the following reasons:

- Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
- Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized
- Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
- Presence of new indications that meet medical necessity criteria specified in 22a), above
- Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital

CCR, title 9, section 1820.205 See Also title 9, sections 1820.220, 1820.225 and 1820.230

ADMINISTRATIVE DAY REQUIREMENTS

23. Documentation in the medical record does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

CCR, title 9, section 1820.205(b,) See Also sections 1820.220(a)(5), (l)(5)(A), 1820.230(a)(2), (d)(1), (2)(A)

24. Documentation provided by the MHP does not establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:

a) The MHP or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one (1) contact per week.

b) The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

i. The status of the placement option

ii. The date of the contact

iii. Signature of the person making the contact

CCR, title 9, sections 1820.220(a)(5), (l)(5)(B), 1820.230(d)(2)(B)

CLIENT PLAN

25. The medical record does not contain a written plan of care (also referred to as a client plan) for a beneficiary.

CFR, title 42, section 456.180; CCR, title 9, section 1820.210

26. The physician did not establish a written plan of care (or client plan) prior to the authorization of payment, which must be done either by the MHPs Point of Authorization prior to admission of the beneficiary or by the hospital Utilization Review Committee or its designee, "no later than the third working day from the day of [the beneficiary's] admission."

NOTE: The physician's signature and date on the written plan of care indicates their establishment of the plan.

Code of Federal Regulations, title 42, section 456.180(a): CCR, title 9, sections 1820.210, 1820.220(a)(1) and 1820.230(a)(1), (2) and (b)

OTHER

27. A hospital day was claimed and paid (1) on which the beneficiary was not a patient in the hospital or (2) for the day of discharge, neither of which is reimbursable.

CCR, title 9, section 1840.320(b)(1), (3); Title 22, section 51470(a) 840.320(b)(1)(3)

COMPLIANCE

PPG 1.3.4 – Compliance & Work Standards Code of Conduct

PPG 1.3.9 Prevention, Detection, and Correction of Fraud, Waste and Abuse

Fresno County is firmly committed to full compliance with all applicable laws, regulations, rules, and guidelines that apply to its specialty mental health services and operations. Fresno County maintains a comprehensive Compliance Program that includes auditing, monitoring, and reporting methods to prevent, detect, and correct fraud, waste and abuse.

The Fresno County MHP has established a Compliance Program which is committed to ensuring that all services are provided in a professional manner and promote prevention, detection, and resolution of any activities that do not conform with all federal and state standards. A compliance plan has been developed to help maintain these standards and correct problems. To ensure that all staff are aware of documentation standards, all direct service staff are required to attend training on documentation standards each year. Part of this compliance plan is the ability for staff members to report violations.

IF YOU WITNESS A VIOLATION of federal or state standards, you must report this by letter, E-mail, or telephone to the Fresno County MHP. This includes reporting fraud. The MHP prohibits retaliation against any person making a report. Any employee engaging in any form of retaliation will be subject to disciplinary action.

Reporting may be done anonymously. The Compliance Hotline is available 24/7 at 888-262-4174. The direct number for the Compliance Officer is 559-600-6728. E-mail may be sent anonymously through the Fresno County MH Compliance website anonymous reporting form: http://www.co.fresno.ca.us/webform.aspx?id=10838

Mail:
FCMHP Compliance Program
1925 E Dakota Avenue
Fresno, CA 93726
E-Mail: evasquez@co.fresno.ca.us
Fax: 559-453-4554

All reports of compliance violations will be reviewed and investigated by the Compliance Office.

APPENDIX A – AVATAR SERVICE CODES

Specifiers: C = Cancelled by client; **P** = Cancelled by Provider; **N** = No Show; **T** = Telephone

Code	Description	Note
25	Individual Therapy **via Telephone**	
31	Crisis Intervention	
40	Meds Refill - Injection	
41	Meds Education – Administration	
43	Meds Education – Group	
47	Meds Support – Telephone	
57	Group Day Treatment Intensive – Half Day	
58	Group Day Treatment Intensive – Full Day	
61	Day Treatment Intensive – Half Day	
62	Day Treatment Intensive – Full Day	
64	Day Treatment Rehabilitation – Half Day	
65	Day Treatment Rehabilitation – Full Day	
68	Inpatient Treatment – PHF	PHF Only
82	Group Therapy	
83	Individual or Family Therapy (MC Only)	Managed Care FFS Only
85	Group Rehabilitation	
90	Crisis Stabilization	
96	Psychiatric Evaluation Per Minute (MC Only)	Managed Care FFS Only
97	Bonding Study Per Minute (MC Only)	Managed Care FFS Only
98	Psychodynamic Evaluation Per Minute MC only	Managed Care FFS Only
99	Attachment Assessment Per Minute (MC Only)	Managed Care FFS Only
103	Assessment	
106	Assessment Using Play Equipment	
126	Individual Therapy (Face to Face)	
127	Intensive Home-Based Services (IHBS)	
129	Individual Play Therapy	
150	Collateral	
153	Collateral Group – Non-MD	
156	Family Therapy with Patient	
158	Rehabilitation	
159	Plan Development	
165	Family Therapy Without Patient	
170	Medication Evaluation Management Assessment	
172	Medication Evaluation Management Brief	
173	Medication Evaluation Management Expanded	

Code	Description	Note
180	Crisis Intervention Assessment	
181	Crisis Intervention Therapy	
190	Medication Evaluation Mgmt Assess – Telemed	
192	Medication Evaluation Mgmt Brief – Telemed	
193	Medication Evaluation Mgmt Expanded – Telemed	
205	Case Management - Linkage/Consultation/TCM	
206	Case Management - Placement	
207	ICC – Intensive Care Coordination	
956	Note to Chart – Individual	
956D	Note to Chart – Hospital Follow Up – Decline Appt.	UCWC Only
956L	Note to Chart – Hospital Follow Up – Letter	UCWC Only
956S	Note to Chart – Hospital Follow Up – Scheduled	UCWC Only
956T	Note to Chart – Hospital Follow Up – Telephone	UCWC Only
956W	Note to Chart – Hospital Follow Up – Walk-In	UCWC Only
957	Triage	
958	Note to Chart - Group	

APPENDIX B – OUTPATIENT INCLUDED ICD-10 CODES

BHIN 20-043

Effective October 1, 2019

**Indicates ADDED Diagnosis; +Indicates Diagnosis Description Change/Correction from 2018 list*

Diagnosis Code	Diagnosis Description
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorder
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
F30.11	Manic Episode Without Psychotic Symptoms, Mild
F30.12	Manic Episode Without Psychotic Symptoms, Moderate
F30.13	Manic Episode, Severe, Without Psychotic Symptoms
F30.2	Manic Episode, Severe, With Psychotic Symptoms
F30.3	Manic Episode in Partial Remission
F30.4	Manic Episode in Full Remission
F30.8	Other Manic Episodes
F30.9	Manic Episode, Unspecified
F31.0	Bipolar Disorder, Current Episode Hypomanic
F31.10	Bipolar Disorder, Current Episode Manic, Without Psychotic features, Unspecified

F31.11	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Mild
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, Without Psychotic Features
F31.5	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
F31.61	Bipolar Disorder, Current Episode Mixed, Mild
F31.62	Bipolar Disorder, Current Episode Mixed, Moderate
F31.63	Bipolar Disorder, Current Episode Mixed, Severe, Without Psychotic Features
F31.64	Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features
F31.70	Bipolar Disorder, Currently in Remission, Most Recent Episode Unspecified
F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
F31.72	Bipolar Disorder, in Full Remission, Most Recent Episode Hypomanic
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.74	Bipolar Disorder, in Full Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
F31.76	Bipolar Disorder, in Full Remission, Most Recent Episode Depressed
F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
F31.78	Bipolar Disorder, in Full Remission, Most Recent Episode Mixed
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.5	Major Depressive Disorder, Single Episode, in Full Remission
F32.81*	Premenstrual dysphoric disorder
F32.89	Other Specified Depressive Episodes
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate

F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.40	Major Depressive Disorder, Recurrent, in Remission, Unspecified
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.42	Major Depressive Disorder, Recurrent, in Full Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified
F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.01	Agoraphobia With Panic Disorder
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.210	Arachnophobia
F40.218	Other Animal Type Phobia
F40.220	Fear of Thunderstorms
F40.228	Other Natural Environment Type Phobia
F40.230	Fear of Blood
F40.231	Fear of Injections and Transfusions
F40.232	Fear of Other Medical Care
F40.233	Fear of Injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of Bridges
F40.243	Fear of Flying
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.291	Gynophobia
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F40.9	Phobic Anxiety Disorder, Unspecified
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety Disorder]
F41.1	Generalized Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders

F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified
F43.0	Acute Stress Reaction
F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder with Depressed Mood
F43.22	Adjustment Disorder with Anxiety
F43.23	Adjustment Disorder with Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder with Disturbance of Conduct
F43.25	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder with Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.4	Conversion Disorder with Motor Symptom or Deficit
F44.5	Conversion Disorder with Seizures or Convulsions
F44.6	Conversion Disorder with Sensory Symptom or Deficit
F44.7	Conversion Disorder with Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.20	Hypochondriacal Disorder, Unspecified
F45.21	Hypochondriasis
F45.22	Body Dysmorphic Disorder
F45.29	Other Hypochondriacal Disorders
F45.41	Pain Disorder Exclusively Related to Psychological Factors
F45.42	Pain Disorder with Related Psychological Factors
F45.8	Other Somatoform Disorders

F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.8	Other Eating Disorders
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive-Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.0	Pathological Gambling
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania
F63.81	Intermittent Explosive Disorder
F63.89	Other Impulse Disorders
F63.9	Impulse Disorder, Unspecified
F64.0	Transsexualism
F64.2	Gender Identity Disorder of Childhood
F64.8	Other Gender Identity Disorders
F64.9	Gender Identity Disorder, Unspecified
F65.0	Fetishism
F65.1	Transvestic Fetishism
F65.2	Exhibitionism
F65.3	Voyeurism
F65.4	Pedophilia
F65.50	Sadomasochism, Unspecified

F65.51	Sexual Masochism
F65.52	Sexual Sadism
F65.81	Frotteurism
F65.89	Other Paraphilias
F65.9	Paraphilia, Unspecified
F68.10	Factitious Disorder Imposed on Self, Unspecified
F68.11	Factitious Disorder Imposed on Self, With Predominantly Psychological Signs and Symptoms
F68.12	Factitious Disorder Imposed on Self, With Predominantly Physical Signs and Symptoms
F68.13	Factitious Disorder Imposed on Self, With Combined Psychological and Physical Signs and Symptoms
F68.A	Factitious Disorder Imposed on Another
F80.82	Social (Pragmatic) Communication Disorder
F80.9	Developmental Disorder of Speech and Language, Unspecified
F84.0*	Autistic disorder (Autism spectrum disorder)
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome
F84.8	Other Pervasive Developmental Disorders
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive Type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactive Disorder, Other Type
F90.9	Attention Deficit/Hyperactivity Disorder, Unspecified Type
F91.0	Conduct Disorder Confined to Family Context
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.8	Other Conduct Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood
F94.2	Disinhibited Social Engagement Disorder
F94.8	Other Childhood Disorders of Social Functioning

F94.9	Childhood Disorder of Social Functioning, Unspecified
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.0	Enuresis Not Due to a Substance or Known Physiological Condition
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Early Childhood
F98.3	Pica of Infancy and Childhood
F98.4	Stereotyped Movement Disorders
F98.8	Other Specified Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence
F98.9	Unspecified Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence
G21.0	Malignant neuroleptic syndrome+
G21.11	Neuroleptic-Induced Parkinsonism
G24.4	Idiopathic Orofacial Dystonia
G25.1	Drug-Induced Tremor
G25.70	Drug-Induced Movement Disorder, Unspecified
G25.71	Medication-Induced Acute Akathisia
G25.9	Extrapyramidal and Movement Disorder, Unspecified
R15.0	Incomplete Defecation
R15.9	Full incontinence of feces
~~R69~~	Diagnosis deferred (Illness unspecified)-This diagnosis is **DELETED** from the list
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out+

APPENDIX C – INPATIENT INCLUDED ICD-10 CODES

BHIN 20-043

Effective October 1, 2019

**Indicates ADDED Diagnosis; +Indicates Diagnosis Description Change/Correction from 2018 list*

Diagnosis Code	Diagnosis Description
F01.51	Vascular Dementia with Behavioral Disturbance
F10.14	Alcohol Abuse with Alcohol-Induced Mood Disorder
F10.150	Alcohol Abuse with Alcohol-Induced Psychotic Disorder with Delusions
F10.151	Alcohol Abuse with Alcohol-Induced Psychotic Disorder with Hallucinations
F10.159*	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol Abuse with Alcohol-Induced Anxiety Disorder
F10.24	Alcohol Dependence with Alcohol-Induced Mood Disorder
F10.250	Alcohol Dependence with Alcohol-Induced Psychotic Disorder with Delusions
F10.251	Alcohol Dependence with Alcohol-Induced Psychotic Disorder with Hallucinations
F10.259*	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.280	Alcohol Dependence with Alcohol-Induced Anxiety Disorder
F10.94	Alcohol Use, Unspecified, with Alcohol-Induced Mood Disorder
F10.950	Alcohol Use, Unspecified, with Alcohol-Induced Psychotic Disorder with Delusions
F10.951	Alcohol Use, Unspecified, with Alcohol-Induced Psychotic Disorder with Hallucinations
F10.959*	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.980*	Alcohol use, unspecified with alcohol-induced anxiety disorder
F11.14	Opioid Abuse with Opioid-Induced Mood Disorder
F11.150	Opioid Abuse with Opioid-Induced Psychotic Disorder with Delusions
F11.151	Opioid Abuse with Opioid-Induced Psychotic Disorder with Hallucinations
F11.159*	Opioid Abuse with opioid-induced psychotic disorder, unspecified
F11.24	Opioid Dependence with Opioid-Induced Mood Disorder
F11.250	Opioid Dependence with Opioid-Induced Psychotic Disorder with Delusions
F11.251	Opioid Dependence with Opioid-Induced Psychotic Disorder with Hallucinations
F11.259*	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.94	Opioid Use, Unspecified, with Opioid-Induced Mood Disorder
F11.950	Opioid Use, Unspecified, with Opioid-Induced Psychotic Disorder with Delusions

F11.951	Opioid Use, Unspecified, with Opioid-Induced Psychotic Disorder with Hallucinations
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.988	Opioid-Induced Anxiety Disorder without Opioid Use Disorder
F12.150	Cannabis Abuse with Psychotic Disorder with Delusions
F12.151	Cannabis Abuse with Cannabis-Induced Psychotic Disorder with Hallucinations
F12.159*	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis Abuse with Cannabis-Induced Anxiety Disorder
F12.250	Cannabis Dependence with Psychotic Disorder with Delusions
F12.251	Cannabis Dependence with Cannabis-Induced Psychotic Disorder with Hallucinations
F12.259*	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis Dependence with Cannabis-Induced Anxiety Disorder
F12.950	Cannabis Use, Unspecified, with Psychotic Disorder with Delusions
F12.951	Cannabis Use, Unspecified, with Cannabis-Induced Psychotic Disorder with Hallucinations
F12.959*	Cannabis use, unspecified with psychotic disorder, unspecified
F12.980	Cannabis Use, Unspecified, with Cannabis-Induced Anxiety Disorder
F13.14	Sedative, Hypnotic or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
F13.150	Sedative, Hypnotic, or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Delusions
F13.151	Sedative, Hypnotic, or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Hallucinations
F13.159*	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, Hypnotic or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F13.24	Sedative, Hypnotic or Anxiolytic Dependence with Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
F13.250	Sedative, Hypnotic, or Anxiolytic Dependence with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Delusions
F13.251	Sedative, Hypnotic, or Anxiolytic Dependence with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Hallucinations
F13.259*	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.280	Sedative, Hypnotic or Anxiolytic Dependence with Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F13.94	Sedative, Hypnotic or Anxiolytic Use, Unspecified, with Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder

F13.950	Sedative, Hypnotic, or Anxiolytic Use, Unspecified, with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Delusions
F13.951	Sedative, Hypnotic, or Anxiolytic Use, Unspecified, with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Hallucinations
F13.959*	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.980	Sedative, Hypnotic or Anxiolytic Use, Unspecified, with Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F14.14	Cocaine Abuse with Cocaine-Induced Mood Disorder
F14.150	Cocaine Abuse with Cocaine-Induced Psychotic Disorder with Delusions
F14.151	Cocaine Abuse with Cocaine-Induced Psychotic Disorder with Hallucinations
F14.159*	Cocaine Abuse with Cocaine-Induced Psychotic Disorder, unspecified
F14.180	Cocaine Abuse with Cocaine-Induced Anxiety Disorder
F14.24	Cocaine Dependence with Cocaine-Induced Mood Disorder
F14.250	Cocaine Dependence with Cocaine-Induced Psychotic Disorder with Delusions
F14.251	Cocaine Dependence with Cocaine-Induced Psychotic Disorder with Hallucinations
F14.259*	Cocaine Dependence with Cocaine-Induced Psychotic Disorder, unspecified
F14.280	Cocaine Dependence with Cocaine-Induced Anxiety Disorder
F14.94	Cocaine Use, Unspecified, with Cocaine-Induced Mood Disorder
F14.950	Cocaine Use, Unspecified, with Cocaine-Induced Psychotic Disorder with Delusions
F14.951	Cocaine Use, Unspecified, with Cocaine-Induced Psychotic Disorder with Hallucinations
F14.959*	Cocaine Use, Unspecified with Cocaine-Induced Psychotic Disorder, Unspecified
F14.980	Cocaine Use, Unspecified, with Cocaine-Induced Anxiety Disorder
F15.14	Other Stimulant Abuse with Stimulant-Induced Mood Disorder
F15.150	Other Stimulant Abuse with Stimulant-Induced Psychotic Disorder with Delusions
F15.151	Other Stimulant Abuse with Stimulant-Induced Psychotic Disorder with Hallucinations
F15.159*	Other Stimulant Abuse with Stimulant-Induced Psychotic Disorder, Unspecified
F15.180	Other Stimulant Abuse with Stimulant-Induced Anxiety Disorder
F15.24	Other Stimulant Dependence with Stimulant-Induced Mood Disorder
F15.250	Other Stimulant Dependence with Stimulant-Induced Psychotic Disorder with Delusions
F15.251	Other Stimulant Dependence with Stimulant-Induced Psychotic Disorder with Hallucinations

F15.259*	Other Stimulant Dependence with Stimulant-Induced Psychotic Disorder, Unspecified
F15.280	Other Stimulant Dependence with Stimulant-Induced Anxiety Disorder
F15.94	Other Stimulant Use, Unspecified, with Stimulant-Induced Mood Disorder
F15.950	Other Stimulant Use, Unspecified, with Stimulant-Induced Psychotic Disorder with Delusions
F15.951	Other Stimulant Use, Unspecified, with Stimulant-Induced Psychotic Disorder with Hallucinations
F15.959*	Other Stimulant Use, Unspecified with Stimulant-Induced Psychotic Disorder, Unspecified
F15.980	Other Stimulant Use, Unspecified, with Stimulant-Induced Anxiety Disorder
F16.14	Hallucinogen Abuse with Hallucinogen-Induced Mood Disorder
F16.150	Hallucinogen Abuse with Hallucinogen-Induced Psychotic Disorder With Delusions
F16.151	Hallucinogen Abuse with Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.159*	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen Abuse with Hallucinogen-Induced Anxiety Disorder
F16.183	Hallucinogen Abuse with Hallucinogen Persisting Perception Disorder (Flashbacks)
F16.24	Hallucinogen Dependence with Hallucinogen-Induced Mood Disorder
F16.250	Hallucinogen Dependence with Hallucinogen-Induced Psychotic Disorder With Delusions
F16.251	Hallucinogen Dependence with Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.259*	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen Dependence with Hallucinogen-Induced Anxiety Disorder
F16.283	Hallucinogen Dependence with Hallucinogen Persisting Perception Disorder (Flashbacks)
F16.94	Hallucinogen Use, Unspecified, with Hallucinogen-Induced Mood Disorder
F16.950	Hallucinogen Use, Unspecified, with Hallucinogen-Induced Psychotic Disorder With Delusions
F16.951	Hallucinogen Use, Unspecified, with Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.959*	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16.980	Hallucinogen Use, Unspecified, with Hallucinogen-Induced Anxiety Disorder
F16.983	Hallucinogen Use, Unspecified, with Hallucinogen Persisting Perception Disorder (Flashbacks)

F18.14	Inhalant Abuse with Inhalant-Induced Mood Disorder
F18.150	Inhalant Abuse with Inhalant-Induced Psychotic Disorder With Delusions
F18.151	Inhalant Abuse with Inhalant-Induced Psychotic Disorder With Hallucinations
F18.159*	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.180	Inhalant Abuse with Inhalant-Induced Anxiety Disorder
F18.24	Inhalant Dependence with Inhalant-Induced Mood Disorder
F18.250	Inhalant Dependence with Inhalant-Induced Psychotic Disorder With Delusions
F18.251	Inhalant Dependence with Inhalant-Induced Psychotic Disorder With Hallucinations
F18.259*	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.280	Inhalant Dependence with Inhalant-Induced Anxiety Disorder
F18.94	Inhalant Use, Unspecified, with Inhalant-Induced Mood Disorder
F18.950	Inhalant Use, Unspecified, with Inhalant-Induced Psychotic Disorder With Delusions
F18.951	Inhalant Use, Unspecified, with Inhalant-Induced Psychotic Disorder With Hallucinations
F18.959*	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18.980	Inhalant Use, Unspecified, with Inhalant-Induced Anxiety Disorder
F19.14	Other Psychoactive Substance Abuse with Psychoactive Substance-Induced Mood Disorder
F19.150	Other Psychoactive Substance Abuse with Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.151	Other Psychoactive Substance Abuse with Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.159*	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.180	Other Psychoactive Substance Abuse with Psychoactive Substance-Induced Anxiety Disorder
F19.24	Other Psychoactive Substance Dependence with Psychoactive Substance-Induced Mood Disorder
F19.250	Other Psychoactive Substance Dependence with Psychoactive Substance-Induced Psychotic Disorder with Delusions
F19.251	Other Psychoactive Substance Dependence with Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.259*	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.280	Other Psychoactive Substance Dependence with Psychoactive Substance-Induced Anxiety Disorder

F19.94	Other Psychoactive Substance Use, Unspecified, with Psychoactive Substance-Induced Mood Disorder
F19.950	Other Psychoactive Substance Use, Unspecified, with Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.951	Other Psychoactive Substance Use, Unspecified, with Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.959*	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
F19.980	Other Psychoactive Substance Use, Unspecified, ith Psychoactive Substance-Induced Anxiety Disorder
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorders
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
F30.11	Manic Episode Without Psychotic Symptoms, Mild
F30.12	Manic Episode Without Psychotic Symptoms, Moderate
F30.13	Manic Episode, Severe, Without Psychotic Symptoms
F30.2	Manic Episode, Severe, With Psychotic Symptoms
F30.3	Manic Episode in Partial Remission
F30.8	Other Manic Episodes
F30.9	Manic Episode, Unspecified
F31.0	Bipolar Disorder, Current Episode Hypomanic

F31.10	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Unspecified
F31.11	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Mild
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, Without Psychotic Features
F31.5	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
F31.61	Bipolar Disorder, Current Episode Mixed, Mild
F31.62	Bipolar Disorder, Current Episode Mixed, Moderate
F31.63	Bipolar Disorder, Current Episode Mixed, Severe, Without Psychotic Features
F31.64	Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features
F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate
F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified

F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.01	Agoraphobia With Panic Disorder
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.210	Arachnophobia
F40.218	Other Animal Type Phobia
F40.220	Fear of Thunderstorms
F40.228	Other Natural Environment Type Phobia
F40.230	Fear of Blood
F40.231	Fear of Injections and Transfusions
F40.232	Fear of Other Medical Care
F40.233	Fear of Injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of Bridges
F40.243	Fear of Flying
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.291	Gynophobia
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety]
F41.1	Generalized Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified
F43.0	Acute Stress Reaction

F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder With Depressed Mood
F43.22	Adjustment Disorder With Anxiety
F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder With Disturbance of Conduct
F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder with Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.4	Conversion Disorder With Motor Symptom or Deficit
F44.5	Conversion Disorder With Seizures or Convulsions
F44.6	Conversion Disorder With Sensory Symptom or Deficit
F44.7	Conversion Disorder With Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.20	Hypochondriacal Disorder, Unspecified
F45.21	Hypochondriasis
F45.22	Body Dysmorphic Disorder
F45.29	Other Hypochondriacal Disorders
F45.41	Pain Disorder Exclusively Related to Psychological Factors
F45.42	Pain Disorder With Related Psychological Factors
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder

F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.2	Antisocial Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.1	Pyromania
F63.81	Intermittent Explosive Disorder
F63.89	Impulse Disorder, Unspecified
F84.0	Autistic Disorder (Autism spectrum disorder)+ (changed from “Autistic Disorder” to “Autistic Disorder (Autism spectrum disorder)”)
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome
F84.8	Other Pervasive Developmental Disorder
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactivity Disorder, Other Type
F90.9	Attention-Deficit/Hyperactivity Disorder, Unspecified Type
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.8	Other Conduct Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood

F94.2	Disinhibited Attachment Disorder of Childhood
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.0	Enuresis Not Due to a Substance or Known Physiological Condition
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Early Childhood
F98.3	Pica of Infancy and Childhood
F98.4	Stereotyped Movement Disorders
G21.0*	Malignant neuroleptic syndrome
G21.11*	Neuroleptic induced parkinsonism
R15.0	Incomplete Defecation
R15.9	Full Incontinence of Feces
~~R69~~	Diagnosis Deferred (illness unspecified) This diagnosis code is DELETED from the covered list
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out+ This diagnosis description is changed from “No diagnosis” to “Encounter for observation for other suspected diseases and conditions ruled out.”

APPENDIX D – SUBSTANCE USE DISORDER INCLUDED ICD-10 CODES

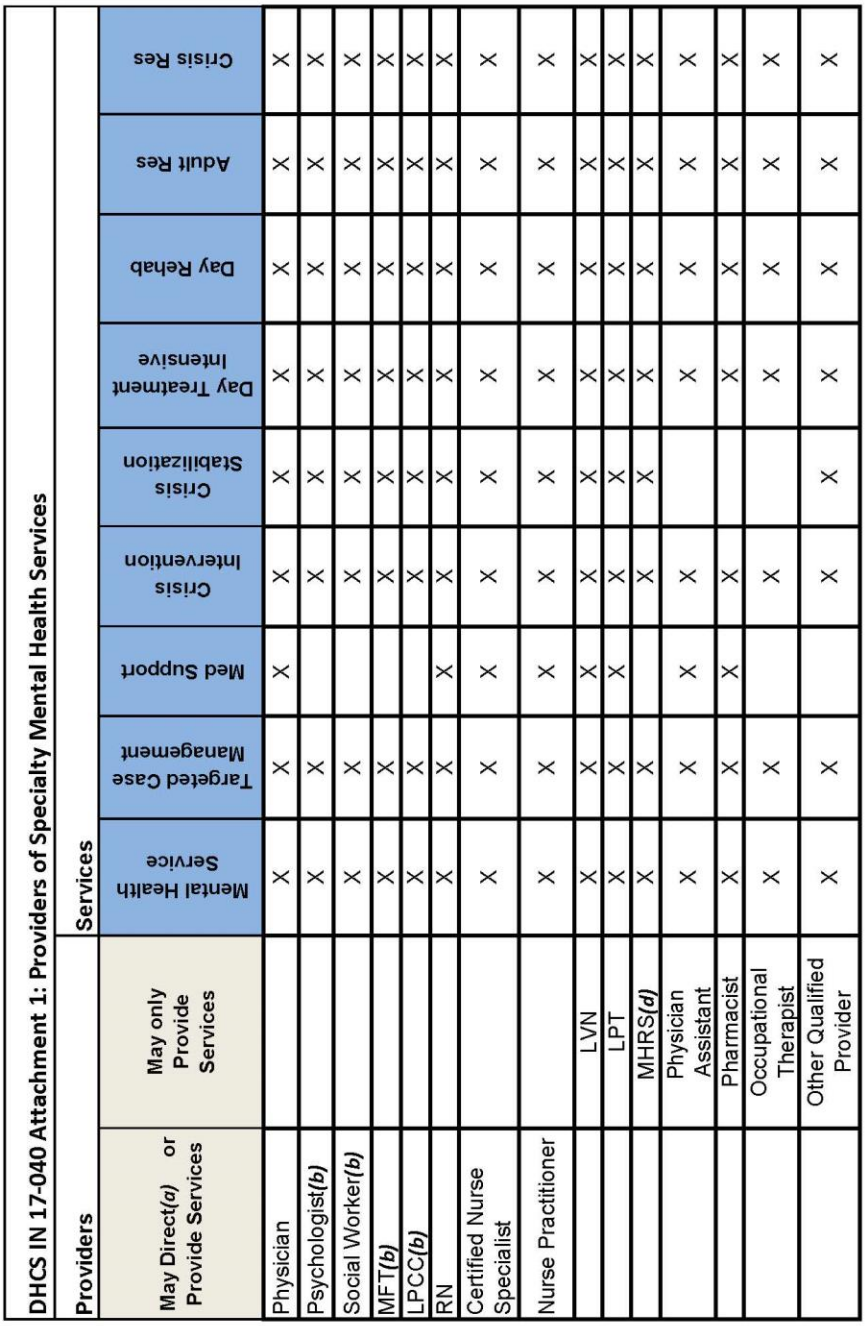
ICD-10 Code	ICD-10 Code Description
F1010	Alcohol abuse, uncomplicated
F1011*	Alcohol abuse, in remission
F10120	Alcohol abuse with intoxication, uncomplicated
F10129	Alcohol abuse with intoxication, unspecified
F1020	Alcohol dependence, uncomplicated
F1021	Alcohol dependence, in remission
F10220	Alcohol dependence with intoxication, uncomplicated
F10229	Alcohol dependence with intoxication, unspecified
F10230	Alcohol dependence with withdrawal, uncomplicated
F10239	Alcohol dependence with withdrawal, unspecified
F10920	Alcohol use, unspecified with intoxication, uncomplicated
F10929	Alcohol use, unspecified with intoxication, unspecified
F1110*	Opioid abuse, uncomplicated
F1111*	Opioid abuse, in remission
F11120	Opioid abuse with intoxication, uncomplicated
F11129	Opioid abuse with intoxication, unspecified
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F11220	Opioid dependence with intoxication, uncomplicated
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1190	Opioid use, unspecified, uncomplicated
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1210	Cannabis abuse, uncomplicated
F1211*	Cannabis abuse, in remission
F12120	Cannabis abuse with intoxication, uncomplicated
F12129	Cannabis abuse with intoxication, unspecified
F1220	Cannabis dependence, uncomplicated

F1221	Cannabis dependence, in remission
F12220	Cannabis dependence with intoxication, uncomplicated
F12229	Cannabis dependence with intoxication, unspecified
F1223*	Cannabis dependence with withdrawl
F1290	Cannabis use, unspecified, uncomplicated
F12920	Cannabis use, unspecified with intoxication, uncomplicated
F12929	Cannabis use, unspecified with intoxication, unspecified
F1293*	Cannabis use, unspecified with withdrawl
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F1311*	Sedative, hypnotic, or anxiolytic abuse, in remission
F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F1321	Sedative, hypnotic or anxiolytic dependence, in remission
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F1410	Cocaine abuse, uncomplicated
F1411*	Cocaine abuse, in remission
F14120	Cocaine abuse with intoxication, uncomplicated
F14129	Cocaine abuse with intoxication, unspecified
F1420	Cocaine dependence, uncomplicated
F1421	Cocaine dependence, in remission
F14220	Cocaine dependence with intoxication, uncomplicated
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal

F1490	Cocaine use, unspecified, uncomplicated
F14920	Cocaine use, unspecified with intoxication, uncomplicated
F14929	Cocaine use, unspecified with intoxication, unspecified
F1510	Other stimulant abuse, uncomplicated
F1511*	Other stimulant abuse, in remission
F15120	Other stimulant abuse with intoxication, uncomplicated
F15129	Other stimulant abuse with intoxication, unspecified
F1520	Other stimulant dependence, uncomplicated
F1521	Other stimulant dependence, in remission
F15220	Other stimulant dependence with intoxication, uncomplicated
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1590	Other stimulant use, unspecified, uncomplicated
F15920	Other stimulant use, unspecified with intoxication, uncomplicated
F15929	Other stimulant use, unspecified with intoxication, unspecified
F1593	Other stimulant use, unspecified with withdrawal
F1610	Hallucinogen abuse, uncomplicated
F1611*	Hallucinogen abuse, in remission
F16120	Hallucinogen abuse with intoxication, uncomplicated
F16129	Hallucinogen abuse with intoxication, unspecified
F1620	Hallucinogen dependence, uncomplicated
F1621	Hallucinogen dependence, in remission
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16229	Hallucinogen dependence with intoxication, unspecified
F1690	Hallucinogen use, unspecified, uncomplicated
F16920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16929	Hallucinogen use, unspecified with intoxication, unspecified
F1810	Inhalant abuse, uncomplicated
F1811*	Inhalant abuse, in remission
F18120	Inhalant abuse with intoxication, uncomplicated
F18129	Inhalant abuse with intoxication, unspecified
F1820	Inhalant dependence, uncomplicated

*F1821	*Inhalant dependence, in remission
F18220	Inhalant dependence with intoxication, uncomplicated
F18229	Inhalant dependence with intoxication, unspecified
F1890	Inhalant use, unspecified, uncomplicated
F18920	Inhalant use, unspecified with intoxication, uncomplicated
F18929	Inhalant use, unspecified with intoxication, unspecified
F1910	Other psychoactive substance abuse, uncomplicated
F1911*	Other psychoactive substance abuse, in remission
F19120	Other psychoactive substance abuse with intoxication, uncomplicated
F19129	Other psychoactive substance abuse with intoxication, unspecified
F1920	Other psychoactive substance dependence, uncomplicated
F1921	Other psychoactive substance dependence, in remission
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F1990	Other psychoactive substance use, unspecified, uncomplicated
F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19929	Other psychoactive substance use, unspecified with intoxication, unspecified

APPENDIX E – PROVIDERS OF SPECIALTY MENTAL HEALTH SERVICES



DHCS IN 17-040 Attachment 1: Providers of Specialty Mental Health Services													
Providers		**Services**											
May Direct*(a)* or Provide Services	**May only Provide Services**	**Mental Health Service**	**Targeted Case Management**	**Med Support**	**Crisis Intervention**	**Crisis Stabilization**	**Day Treatment Intensive**	**Day Rehab**	**Adult Res**	**Crisis Res**
Physician		X	X	X	X	X	X	X	X	X
Psychologist*(b)*		X	X		X	X	X	X	X	X
Social Worker*(b)*		X	X		X	X	X	X	X	X
MFT*(b)*		X	X		X	X	X	X	X	X
LPCC*(b)*		X	X		X	X	X	X	X	X
RN		X	X	X	X	X	X	X	X	X
Certified Nurse Specialist		X	X	X	X	X	X	X	X	X
Nurse Practitioner		X	X	X	X	X	X	X	X	X
	LVN	X	X	X	X	X	X	X	X	X
	LPT	X	X	X	X	X	X	X	X	X
	MHRS*(d)*	X	X		X	X	X	X	X	X
	Physician Assistant	X	X	X	X		X	X	X	X
	Pharmacist	X	X	X	X		X	X	X	X
	Occupational Therapist	X	X		X		X	X	X	X
	Other Qualified Provider	X	X		X	X	X	X	X	X

NOTE: Designated staff may provide those services that have an "X" *that are "within their scope of practice."* Providers listed in the "May Only Provide Services" column must work "under the direction of" a licensed, waivered or registered professional listed in the "May Direct or Provide Services" column who is acting within their scope of practice. (See State Plan, Section 3, Supplement 3 to Attachment 3.1-A (SPA 12-025); See also Cal. Code Regs., tit. 9, §§ 1840.314) The scope of practice for all providers, including "Other Qualified Providers," is determined by the Business and Professions Code and the MHP.B1
Regarding Assessment, a service activty under Mental Health Services, the diagnosis, mental status exam, 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 his/her scope of practice under California State law, who is licensed, waivered, or registerd, and/or under the direction of a licensed mental health professional. Non-licensed/registered/waivered staff, e.g., Mental Health Rehabilitation Specialists and "Other Qualified Providers" as determined to be qualified by the MHP, may contribute to assessment, e.g., gathering medical history, mental health history, substance exposure/substance use information, strengths, risks, and additional clarifying information. In addition, In addition, if allowed by the MHP, graduate students who are under the direction of a licensed, registered, or waivered staff may conduct all components of the assessment.
(a) "Under the direction of" means that the individual directing the service is either directly providing the service or acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval, and signing client plans. … The licensed professional directing a service assumes ultimate responsibility for the rehabilitative mental health services provided." (State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025) page 2b) (b) Licensed, Waivered or Registered (See State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025) page 2b for definition of "Waivered/Registered Professional"). A waivered or registered professional can only direct services if he/she is working under the supervision of a "Licensed Mental Health Professional," as defined in the State Plan, Sec. 3, Supp. 3 to Att. 3.1-A (SPA 12-025) page 2) (Cal. Code Regs., tit. 9 §1840.314 (e)(1)(F)) . (c) Physician must be a psychiatrist or have training and/or experience in psychiatry (d) See State Plan, Section 3, Supplement 3 to Attachment 3.1-A (SPA 12-025) page 2o for minimum provider qualifications for mental health rehabilitation specialists.

APPENDIX F – BI-DIRECTIONAL REFERRAL FORM - CHILDREN

Fresno County CHILDREN AND YOUTH Mental Health Severity Analysis & Bidirectional Referral Form

Mental Health Plan will follow Medical Necessity Criteria for Medi-Cal Specialty Mental Health Services described in Title 9, CCR, Chapter 11, Section 1830.210

Client Name: First Name, Last Name	**DOB:** MM/DD/YYYY	**Medi-Cal CIN #:** #########	**Sex:** F☐ M☐
Address: 1234 Street	**State:** Click here to enter text.	**Age:** # Years	
Phone: (###) ###-####	**City:** Click here to enter text.	**Zip Code:** Click here to enter text.	
Client's Primary Language: Click here to enter text.		**Member consented to referral:** Y☐ N☐	
Parent/Legal Guardian Name: Click here to enter text.		**Parent/Legal Guardian Language:** Click here to enter text.	

Element	Mild	Moderate	Severe
Risk	☐ No DTS/DTO history ☐ Comments about death/dying made in the context of being angry or frustrated ☐ Impulse control poor for age ☐ Lapses in judgement ☐ Immature choices ☐ Decline in educational performance due to mood/behavior	☐ Passive suicidal ideation/non-suicidal self-injury ☐ Immature judgement ☐ Choices cause impairment in school/family/social settings ☐ Little insight ☐ Educational decline despite intervention ☐ Mid-level non-violent arrests	☐ Current/recent suicidal ideation, intent, plan or recent attempt with clear expectation of death ☐ Recurrent psychiatric hospitalizations/ crisis stabilization ☐ Minimal insight ☐ At risk of losing educational or home placement due to mood/behavior ☐ Running away overnight on multiple occasions ☐ Deliberate fire setting ☐ Violence related arrests, carries a weapon, intentional choices to harm others or property
Clinical Complexity	☐ Adjustment reaction/minor depression or anxiety ☐ Prior SMI history ☐ ADHD only diagnosis ☐ No significant AOD use	☐ Mood/anxiety causing minor problems with school/family/peers ☐ ADHD with comorbidity ☐ AOD misuse ☐ Concern for prodromal symptoms	☐ Mood/anxiety interferes with daily functioning in all domains (school/family/peers) ☐ Significant change in emotional or behavioral functioning ☐ Emotional/behavioral problems for which interventions have not led to significant improvement ☐ Psychosis ☐ AOD dependence
Life Circumstances	☐ Emotional distress arising in the course of normal life stressors ☐ Adequately resourced & supported ☐ Resilient ☐ Occasional conflict with family, school staff, peers	☐ Primary caretaker has serious emotional impairment or substance use problems ☐ Fair familial support ☐ Poor coping skills ☐ Worsening issues with peers ☐ Known to authority figures for issues with peers	☐ Symptoms related to history of abuse, neglect and/or removal from home ☐ Symptoms related to loss of significant care giver or sibling ☐ No or minimal familial support ☐ Loss of educational placement for emotional/behavioral disturbance ☐ No friends/loner, avoids former friends ☐ Frequent problems with the law
Benefit of Integrated Care	☐ Est. effective care in primary care setting for chronic stable medical + co-occurring mild mental illness/emotional distress ☐ Adequately resourced & supported	☐ Est. effective care in primary care setting, needs additional support ☐ Limited resources & support	☐ Est.(or pending) care with County provider for complex SMI or complex trauma ☐ Relies on behavioral health system for resources & support
Total	Click here to enter # of checked boxes above.	Click here to enter # of checked boxes above.	Click here to enter # of checked boxes above

The category with the highest number of checked boxes is likely the level of impairment (mild, moderate or severe)

☐ Meds only – Referred to primary care or FQHC due to stable symptoms and client request for meds only – no referral to health plan needed
☐ Mild/Moderate or Autism Spectrum Disorder- Referred to Health Plan
☐ Severe- Referred to Fresno County Behavioral Health

Care Coordination/Referral Contact Information

Cal Viva/Health Net (MHN)	Anthem Blue Cross Partnership Plan	Fresno County DBH
Phone: 1-888-893-1569/ 1-800-675-6110 MHNAdminGroup@centene.com	Phone: (888) 831-2246, Option 1, then Option 2 BHCMReferrals@anthem.com	Adults: UCWCAccess@co.fresno.ca.us Children/Youth: DBHYouthWellnessCenter@co.fresno.ca.us

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APPENDIX G – BI-DIRECTIONAL REFERRAL FORM - ADULTS

Fresno County ADULT Mental Health Severity Analysis & Bidirectional Referral Form

Mental Health Plan will follow Medical Necessity Criteria for Medi-Cal Specialty Mental Health Services described in Title 9, CCR

Client Name: First Name, Last Name	**DOB:** MM/DD/YYYY	**Medi-Cal CIN #:** #########	**Sex:** F☐ M☐
Address: 1234 Street	**State:** Click here to enter text.		**Age:** # Years
Phone: (###) ###-####	**City:** Click here to enter text.		**Zip Code:** Click here to enter text.
Client's Primary Language: Click here to enter text.			**Member consented to referral:** Y☐ N☐

Element	Mild	Moderate	Severe
Risk	☐ Passive ideation or fantasy—no danger to self/danger to others (DTS/DTO) history ☐ Good impulse control ☐ Minimal criminal background ☐ Good insight ☐ Ego dystonic (unacceptably viewed thoughts, impulses, and behaviors, distressing, or inconsistent with one's self-concept)	☐ Passive or low level active ideation with DTS/DTO history ☐ Rare loss of impulse control ☐ Mid-level nonviolent arrests, brief jail time ☐ Fair insight ☐ Ego dystonic	☐ Recent or current active ideation, intent or plan ☐ Poor impulse control ☐ Violence related arrests, jail or prison time ☐ Poor insight ☐ Ego syntonic (acceptably viewed instincts, ideas, and behaviors of one's self, compatible with one's values and thinking, or consistent with one's personality or beliefs)
Clinical Complexity	☐ Adjustment reaction/minor depression or anxiety ☐ Grief, job loss, marital distress, relationship difficulty ☐ No cognitive impairment ☐ No prior serious mental illness (SMI) history ☐ Limited AOD use	☐ Schizophrenia, major mood or anxiety disorder – stable on medications, baseline function, sustained recovery ☐ Prior history of effective treatment, uncomplicated management ☐ Minimal cognitive impairment ☐ No recent hospitalizations ☐ AOD misuse (e.g., multiple emergency room visits at different hospitals)	☐ Schizophrenia, major mood or anxiety disorder, recent instability or worsening function, precarious recovery ☐ Cognitive impairment ☐ Recent/repeated hospitals ☐ AOD dependence ☐ Prior history of treatment resistance or complexity (e.g., polypharmacy)
Life Circumstances	☐ Emotional distress arising in the course of normal life stresses ☐ Adequately resourced & supported ☐ Resilient	☐ Intermittent emotional distress as a manifestation of a mental illness which is worsened by life stresses ☐ Limited resources & support ☐ Strained resilience	☐ Persistent emotional distress a manifestation of chronic mental illness ☐ Relies on behavioral health system for resources & support ☐ Limited resilience
Benefit of Integrated Care	☐ Already established, effective care in primary care setting for chronic stable medical + co-occurring mild mental illness/emotional distress ☐ Adequately resourced & supported ☐ Higher recovery	☐ Already established, effective care in primary care setting, needs some additional support ☐ Limited resources & support ☐ Moderate recovery	☐ Already established (or pending) care with County provider for complex SMI ☐ Relies on behavioral health system for resources & support ☐ Lower recovery
Total	Click here to enter # of checked boxes above.	Click here to enter # of checked boxes above.	Click here to enter # of checked boxes above.

The category with the highest number of checked boxes is likely the level of impairment (mild, moderate or severe)

☐ Meds only - Referred to primary care or FQHC due to stable symptoms and client request for meds only – no referral to health plan needed
☐ Mild/Moderate - Referred to Health Plan
☐ Severe - Referred to Fresno County Behavioral Health

Care Coordination/Referral Contact Information

Cal Viva/Health Net (MHN) Phone: 1-888-893-1569/ 1-800-675-6110 MHNAdminGroup@centene.com	Anthem Blue Cross Partnership Plan Phone: 1-888-831-2246, Option 1, then Option 2 BHCMReferrals@anthem.com	Fresno County DBH Adults: UCWCAccess@co.fresno.ca.us Children/Youth: DBHYouthWellnessCenter@co.fresno.ca.us

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APPENDIX H – TAXONOMY CODES, JOB TITLES & DESCRIPTIONS

TAXONOMY NUMBER	TITLE	DESCRIPTION
101YM0800X	ASW	Associate Social Worker
1041C0700X	LCSW	Licensed Clinical Social Worker
101Y00000X	CMHS	Community Mental Health Specialist
101Y00000X	MHRS	Mental Health Rehabilitation Specialist 1. AA + 6 yrs. Experience, or 2. BS + 4 yrs. Experience, or 3. Non-waivered or non-registered intern with MA/MS/MSW/PhD/PsyD
101Y00000X	MHC	Mental Health Counselor
106H00000X	LMFT	Licensed Marriage and Family Therapist
106H00000X	AMFT	Associate Marriage and Family Therapist
390200000X	MFT Trainee/Student	Student in a MH/Healthcare program (Master's Degree or higher)
101YM0800X	LPCC	Licensed Professional Clinical Counselor
101YM0800X	APCC	Associate Professional Clinical Counselor
390200000X	PCC Trainee/Student	Student in a MH/Healthcare program (Master's Degree or higher)
167G00000X	LPT	Licensed Psychiatric Technician
363LP0808X	NP	Nurse Practitioner
163WP0808X	RN	Registered Nurse with an AA/BA
2084P0800X	MD or DO	Psychiatrist
363A00000X	PA	Physician Assistant
103T00000X	PhD, PsyD	Psychologist-Registered or Waivered; Trainee/Student in a MH Healthcare program (Master's Degree or higher)
171M00000X	TFC Parent	Therapeutic Foster Care Parents
171M00000X	CM/CC	Case Manager/Care Coordinator
101YA0400X	AOD Counselor	Substance Use Disorder Counselor- Certified or Registered 4ith CAADE/CADTP/CCAPP
225800000X	RT	Recreation Therapist
174400000X	Admin Staff	Administrative and Support Staff
No Taxonomy	MHW	Mental Health Worker-no NPI, no Taxonomy

APPENDIX I – SAMPLE TELEPHONE & TELEHEALTH SCRIPTS[46]

- ***Telehealth (audio & video)*:** Before we proceed with our session today, I want to talk with you about our video-based services. We call it "telehealth." After we review this together briefly, I'll need to obtain your verbal consent to receive telehealth services. Is that alright?
- ***Telephone (audio only)*:** Before we proceed with our session today, I want to talk with you about our telephone services. After we review this together briefly, I'll need to obtain your verbal consent to receive telephone services. Is that alright?
- If for some reason we get disconnected, what is a good call back number?
- If there is an emergency during our session, what is your current location (address)? Is there anyone there with you?
- If there is a crisis or emergency, let's review how we will handle that (discuss your emergency management protocols)
- You have the right to stop our session today at any time and the right to cancel your consent to receive telehealth or telephone services at any time.
- Some potential drawbacks or risks to telehealth or telephone services include:
    - Being unable to maintain a private setting
    - The possibility of electronic transmission difficulties
    - Unauthorized access to phone/computer records
    - The possibility of interruptions during the session (both for you or for me)
    - Limitations of not being in the same room together
    - Handling of emergencies
    - Difficulties with technology
- Some benefits to telehealth or telephone services include:
    - Access to services from home or other convenient location
    - *For telehealth*: Using video telehealth – we can "see" each other
- The same confidentiality limits apply to telehealth or telephone sessions (describe further as clinically indicated)
- You will have the same access to your records as you do for in-person sessions
- Video and audio of our sessions will ***not*** be recorded or saved
- Do you have any questions?
- Do you give verbal consent for this telehealth/telephone session and future sessions

[46] Adapted from Santa Clara County Behavioral Health

APPENDIX J – DBH GUIDANCE REGARDING CONSENT FOR BEHAVIORAL HEALTH CARE FOR MINORS (UNDER AGE 18)

PARENT OR LEGAL GUARDIAN CONSENT

Right of Parent/Legal Guardian to Consent

It is the general rule that the parent or legal guardian must consent to medical or behavioral health care for minor clients, unless the minor has the right to consent to the care under minor consent laws. Only one parent is necessary to provide consent, and unless the provider is aware of evidence to the contrary, it can be assumed that the other parent has not objected. Adoptive parents have the same rights as natural parents. In a same-sex couple only the biological parent would have authority to consent unless the other partner adopts the child. If same-sex partners both adopt the same rules would apply and either adoptive parent could consent. If only one partner is an adoptive parent, and the other is not the biological parent, only that partner could consent.

A parent who is him/herself still a minor (under 18) may consent to their minor child's medical care so long as they are sufficiently mature to rationally weigh the risks and benefits of that care and understand the nature of the treatment proposed.

Implied Consent in an Emergency

In an emergency, care may be provided to a minor without parent/guardian consent if necessary to alleviate pain or prevent serious medical harm if the parent or guardian has not yet been located. Unless there is evidence to indicate that the parent/guardian would object to the care, consent may be implied.

What the Right to Consent Includes

When services are provided to a minor client who does not qualify for minor consent, the parent/guardian will have the right to consent to or refuse the recommended medical treatment. In the case of outpatient behavioral health services this would typically involve minors under 12 years of age, or minors who are living at home with their parents (or legal guardians) and receiving services at the request of their parents or the school. The parent or guardian shall also have a right to know how the minor's private medical information will be used or disclosed, and how the parent or guardian may access that information. If the parent is unable to communicate, translation services should be found, or if the parent lacks capacity, someone else must be found to provide consent.

The Right to Refuse Treatment

The parent/guardian's right to consent includes the right to refuse treatment. Health care providers who believe that the refusal of care will harm a minor client should immediately discuss the situation with a supervisor; if the refusal of care triggers suspicion of medical neglect, child protective services should be immediately contacted pursuant to mandated child abuse reporting requirements (i.e., the refusal of care will likely harm the child, a report must be made).

Divorced Parents

When parents divorce, the Court decides who will have physical custody and who will have legal custody of the child/children. In most situations, the parent who has physical custody also has legal custody. Often, the parents will have "joint" or shared legal custody. The parent(s) who has legal custody has the right to consent to medical care. If only one parent has legal custody, then only that parent may consent to medical care. If the parents have "joint legal custody" usually either parent can consent to the treatment unless the court has required both parents to consent to the proposed care. Such an order is rare. In most situations, providers can presume that either parent can consent unless there is evidence to the contrary (some providers like to obtain consent from both divorced parents when treatment is provided to the minor child, but again, this is not usually required by the court). However, if either parent disputes the other parent's legal right to make medical decisions the providers should ask to see documentation of the court's order and place a copy in the chart. If you are unsure, discuss it with your supervisor. Document any discussions or concerns.

Delegation of Authority to a Third Party

A parent or guardian who has the legal authority to consent to care for the minor child/youth has the right to delegate this authority to other third parties (aged 18 and older); for example, the parent may delegate authority to consent to medical care to the school, to a coach, to the step-parent, or to a baby-sitter who is temporarily caring for the child while the parent is away or at work. A copy of the written delegation of authority shall be kept in the chart. Many providers use the California Hospital Association Form 2-3. "Authorization for Third Party to Consent to

Treatment of Minor Lacking Capacity to Consent" (Attachment A1), but a handwritten note that clearly delegates authority to consent to an adult person (18 or older) is also acceptable. Typically, providers will limit care to routine procedures that the parent already has consented to, or to emergency situations when relying on delegated consent. If the person with delegated authority is requesting a new course of treatment, change in medications, or other non-routine procedure, it is recommended that the new treatment be deferred until the parent's return, unless it is clearly medically indicated. If you are unsure, discuss it with your supervisor. Document any discussions or concerns.

Caregiver Affidavits and Caregiver Authority to Consent

In some cases, a minor child/youth lives with and is being raised by a "surrogate parent." If this adult is a "qualified relative" (often the grandparent, or an aunt or other sibling) who has stepped into the role of parent because the biological parents are no longer willing or able to care for the child he or she may fill out a Caregiver's Affidavit. Many providers in California use the California Hospital Association Form 2-2, "Caregiver's Authorization Affidavit" (Attachment A2). These so called "caregivers" who have "unofficially" undertaken the care of the child are authorized by law to consent to most medical and mental health care and to enroll these children in school; the use of this form does not legally bind the caregiver to the child or imply any other legal obligations. Once they have completed the "Caregiver's Affidavit" form (which is then placed in the chart) they may consent to medical care for the minor child. The affidavit is valid for one year after the date on which it is executed and a new form should be completed and placed in the chart each year as needed. If the parent(s) returns, the "caregiver's" authority is ended, and once again the parent has authority to consent to or refuse care for the child.

Financial Liability of Parent / Guardian

If the parent or guardian consents to the treatment of a minor, the parent or guardian is financially liable for that treatment. The parent or legal guardian is also financially responsible when care is provided pursuant to delegated consent or a Caregiver's Affidavit. The parent or guardian is not financially responsible for services provided to emancipated or self-sufficient minors, or for "sensitive services" that the minor is receiving subject to minor consent. However, if the parent or guardian participates in outpatient mental health treatment or counseling, or alcohol or drug abuse treatment, the parent or guardian is financially liable for those services rendered with their participation (even though the services are being provided pursuant to minor consent).

DEPENDENTS AND WARDS OF THE COURT

Minors who are dependents or wards of the court do not lose their own rights re: consent to sensitive services, and the provider should not deny such services if the minor otherwise qualifies to provide his/her own consent.

Dependents (Welfare and Institutions Code Section 300)

A minor who has been neglected, abused, abandoned, or otherwise has no parent(s) or guardian willing or able to exercise appropriate care or control can be adjudged a "dependent child" of the juvenile court. When a child is adjudged a dependent child of the court on the ground that the child is a person described in W & I Code Section 300, the court may make any and all reasonable orders for the care, supervision, custody, conduct, maintenance, and support

of the child, including medical treatment, subject to the further order of the court.

Children in Temporary Custody (WIC Section 305)

A police officer may take a child into temporary custody if the child is believed to be a dependent described under Section 300, and who is in need of medical care or who is in danger; also included are children who are about to be released from a hospital into the care of a parent where there is a danger of harm to the child, and children who are found in a street or public place suffering from a sickness or injury that requires care. A social worker may authorize care for such a minor upon the recommendation of the provider after notifying the parent or guardian that such care will be provided. If the parent or guardian objects, a court order authorizing the necessary care is necessary.

Authority to Provide Medical Care to Dependents: Children in Temporary Custody

Welfare and Institutions Code Section 369(a) states that "Whenever any person is taken into temporary custody under Article 7 (commencing with Section 305) and is in need of medical, surgical, dental, or other remedial care, the social worker may, upon the recommendation of the attending physician and surgeon or, if the person needs dental care and there is an attending dentist, the attending dentist authorize the performance of the medical, surgical, dental, or other remedial care." The social worker must notify the parent or guardian, if any, of the care found to be needed before that care is provided and if the parent or guardian objects, the care shall only be given upon order of the court in the exercise of its discretion. Authority to Provide Medical Care to Dependents: Children Concerning Whom a Petition has Been Filed (Unadjudicated Cases)

Welfare and Institutions Code Section 369(b) states that whenever it appears to the court that any person concerning whom a petition has been filed with the court is in need of medical, surgical, dental, or other remedial care, and that there is no parent, guardian, or person standing in loco parentis capable of authorizing or willing to authorize the remedial care or treatment for that person, the court, upon the written recommendation of a licensed physician and surgeon, or if the person needs dental care, a licensed dentist, and after due notice to the parent, guardian, or the person standing in loco parentis, if any, may make an order authorizing the performance of the necessary care for that person.

Authority to Provide Medical Care to Dependents: Children Placed by Court Order with the Care and Custody of Social Worker

Welfare and Institutions Code Section 369(a) states that when a dependent child is placed by the court within the care and custody or under the supervision of a social worker of the county in which the dependent child resides, and it appears to the court that there is no parent, guardian,

or person standing in loco parentis capable of authorizing or willing to authorize medical, surgical, dental, or other remedial care or treatment, that the court may after due notice to the parent or guardian, if any, order that the social worker may authorize the care for the dependent child by licensed practitioners as may from time to time appear necessary.

Authority to Provide Medical Care to Dependents: Children who Require Immediate Medical, Surgical or other Remedial Care

Welfare and Institutions Code Section 369(d) provides that in an emergency situation, care may be provided without a court order upon the authorization of a social worker. The social worker must make reasonable efforts to obtain the consent of, or notify the parent, guardian or person standing in loco parentis prior to authorizing that care. "Emergency situation" means that the child requires immediate treatment to alleviate severe pain, or there is a need for an immediate diagnosis and treatment of an unforeseeable medical, surgical, dental or other remedial or contagious disease which, if not immediately diagnoses and treated, would lead to serious disability or death.

Release of Information

In any case in which the court orders the performance of any medical, surgical, dental or other remedial care for dependent minors, the court may also make an order authorizing the release of information concerning that care to social workers, parole officers, or any other qualified individuals or agencies caring for or acting in the interest and welfare of the child under order, commitment or approval of the court.

Dependent Minors Who Have Been Removed From The Physical Custody Of A Parent Under Welfare And Institutions Code Section 361

If a child is found to be a dependent of the court under Section 300 and has been removed from the physical custody of the parent under Section 301, only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications for that child. The juvenile court may issue a specific order delegating this authority to a parent upon making findings on the record that the parent poses no danger to the child and has the capacity to authorize psychotropic medications. Court authorization for administration of psychotropic medications shall be based upon a request from a physician, including the reasons for the request, a description of the child's diagnosis and behavior, the expected results of the medication, and a description of the side effects of the medication.

Fresno County Superior Court-Juvenile Court Order re: Dependents of the Court

The Juvenile Dependency Court in Fresno issues child-specific orders related to mental health treatment and does not have a "blanket" or standing order for its dependent minors. The Court order can include mental health evaluation and recommended treatment and the free exchange of information between the Department of Social Services and all treating agencies (refer to page 2 of 2 of the Court Order)

Wards of the Court (Section 601 and 602)

A minor who refuses to obey his parents or who violates curfew, or who is deemed to be a habitual truant, may be adjudged a ward of the court (Section 601). A minor who violates the law may also be adjudged a ward of the court (Section 602).

Welfare and Institutions Code Section 727 provides that "When a minor is adjudged a ward of the court on the ground that he or she is a person described by Section 601 or 602, the court shall make any and all reasonable orders for the care, supervision, custody, conduct, maintenance, and support of the minor, including medical treatment, subject to further order of the Court." Documentation supporting the authority of a probation worker, social worker, juvenile justice staff, etc. should be obtained and placed in the record prior to providing services pursuant to such an order.

Foster Parents

A foster parent's right to consent to treatment for a minor depends upon whether the minor has been placed with the foster parent by court order, or with the consent of the minor's legal custodians, or on a temporary basis before a detention hearing has been held. Written evidence of the foster parent's authority (e.g., a copy of a court order or the consent of the minor's parent or legal guardian) should be placed in the minor's medical record before proceeding with treatment. Finally, the court order must specifically allow the foster parent to consent to medical treatment. A placement order alone is insufficient.

Documentation When Treating Dependents and Wards of the Court

In situations where someone other than the parent or guardian is providing consent, (unless it is an emergency) care must be taken to establish a non-parent's legal authority to consent to care before treatment begins. Often this requires identification of the child's status as well as the ability or inclination of the natural parents to provide consent. A copy of the Court Order delegating this authority (to a Foster Care, for example) should be placed in the client's medical

record before care is provided. If a ward or dependent qualifies for "sensitive services minor consent," and could therefore legally provide his/her own consent to the treatment, the provider should not seek authorization from the court appointed legal guardian or from the parent. The ward or dependent possesses the same consent privileges and confidentiality as a minor in the care and custody of the parent.

COURT AUTHORIZATION TO CONSENT

In rare situations a court may summarily grant consent to medical treatment upon verified application of a minor aged 16 or older who resides in California if consent for medical care would ordinarily be required of the parent or guardian, but the minor has no parent or guardian available to give the consent. (If the minor is suspected of being a runaway, Child Protective Services should be notified.) For example, if a non-emancipated minor, non-self-sufficient 16 year old in a non- emergency situation would clearly benefit from antipsychotic medications, but the parent or guardian was out of the state and had not delegated authority to any other adult, the provider might choose to get such an order rather than delay the medical treatment while a surrogate decision maker could be found. A copy of the court order should be obtained and placed in the patient's medical chart before treatment is provided pursuant to the order.

In rare situations a court may summarily grant consent to medical treatment upon verified application of a minor aged 16 or older who resides in California if consent for medical care would ordinarily be required of the parent or guardian, but the minor has no parent or guardian available to give the consent. (If the minor is suspected of being a runaway, Child Protective Services should be notified.) For example, if a non-emancipated minor, non-self-sufficient 16 year old in a non- emergency situation would clearly benefit from antipsychotic medications, but the parent or guardian was out of the state and had not delegated authority to any other adult, the provider might choose to get such an order rather than delay the medical treatment while a surrogate decision maker could be found. A copy of the court order should be obtained and placed in the patient's medical chart before treatment is provided pursuant to the order.

FINANCIAL LIABILITY: DEPENDENTS AND WARDS OF THE COURT

Services for minors who are dependents or wards of the Court, or who are referred through DSS-Child Welfare, will generally be paid through full- scope Medi-Cal or through the parent's insurance. If needed, supplemental coverage is also available through a special DSS fund for this purpose. Unresolved billing questions may be referred to the DBH Business Office.

MINORS TREATED AS ADULTS

EMANCIPATED AND SELF-SUFFICIENT MINORS' RIGHT TO CONSENT

Certain minors are considered to be "adults" under the law for purposes of medical consent. They can consent to both "sensitive services" and to non-sensitive services. They still have to have mental capacity to consent, but they do not suffer automatic legal incapacity due to their young age. These minors are clearly defined under the law and include "emancipated minors" and "self-sufficient minors."

DEFINITION OF EMANCIPATED MINOR

Emancipated minors include 1) minors 14 and older who have been emancipated by court order, 2) minors who are serving in the active US military forces, and 3) minors who are married or who have been married (parenthood by itself does not emancipate a minor).

DEFINITION OF SELF-SUFFICIENT MINOR

Self-sufficient minors are defined by law as minors aged 15 and older who are living separate and apart from their parents and who are also managing their own financial affairs regardless of their source of income. The law permits "notification" of the parent or guardian of the care (as opposed to "consent") if the minor has told the provider where the parent is located, however such disclosures are discretionary and not mandatory. It is recommended that the self-sufficient minor be consulted regarding parental notification and that in general, such notification be in accordance with the wishes of the minor. The wishes of the minor regarding parental notification should be documented in the client's medical record.

USE OF THE CHECKLIST FOR MINOR CONSENT FORM

When minors seek medical services pursuant to their status as "adults" they may also independently qualify for minor consent for "sensitive services." For example, they may be receiving "sensitive services" such as outpatient mental health care that is described by Family Code Section 6924(b) or Health and Safety Code Section 124260 or outpatient substance abuse services described in Family Code Section 6929, and they may be consenting to their own antipsychotic medications pursuant to their status as an emancipated minor. A copy of this form must be kept in the client's medical record and copy sent to the Business Office.

The minor's medical care is confidential, and information about the care should not be divulged to parents/guardians without the minor's specific authorization except in rare instances when required or permitted by law. In the case of self-sufficient minors receiving non-sensitive services (e.g. antipsychotic medications), a parent or guardian may be contacted regarding the care if the

minor has provided information about the parent/guardian's whereabouts; however, prudent providers would not make such a disclosure without first notifying the minor and getting the minor's consent to make such a disclosure. The minor's consent should be documented in the client's medical record.

Financial Responsibility – Emancipated and Self-sufficient Minors

Generally, a minor seeking services as an "adult" (emancipated or self- sufficient minor) will be financially responsible for his/her own care. When the minor is still "covered" by the parent's insurance plan, the issue of whether insurance will be billed or not must be discussed with the minor, and specific permission to bill insurance should be obtained. Failure to obtain permission, or billing without the minor's knowledge and consent, could result in a breach of confidentiality.

Note: If the emancipated or self-sufficient minor receives services that also qualify under "sensitive services minor consent" it is important not to bill the parents directly or indirectly (through their insurance plan). Other sources are often available to pay for the care.

MINORS SEEKING "SENSITIVE SERVICES"

Minor's Right to Consent to Treatment for "Sensitive Services"

Minors seeking certain sensitive services may be legally authorized to provide their own consent to those services. The minor also controls whether or not the parent will have access to records generated as a result of receiving those services. When minor consent applies, sensitive services should never be provided over the minor's objection; in other words, even if the parent provides consent, non-consent by the qualified minor bars treatment.

Overview of Sensitive Services

"Sensitive services" that may be provided to minors aged 12 and older without parental consent (or knowledge) include rape care and treatment (see discussion of additional, separate provision of law below), treatment of infectious reportable conditions (including HIV testing), outpatient mental health and residential care treatment (not Electroconvulsive Therapy or psychotropic medications) if certain conditions are met (see discussion below), and outpatient substance abuse treatment (not methadone).

Minors of any age may consent to their own care and treatment for sexual assault and rape under a separate provision of the law; however, if the minor is under the age of 12, or 12 and older and seeking sexual assault care as opposed to rape care and treatment, the provider must attempt to notify the parent or guardian of the care and treatment unless the provider believes that the parent or guardian committed the rape or assault.

Outpatient Mental Health Care and Minor Consent

The law allows two approaches to providing services to minors:

Family Code Section 6924 states that minors 12 and older may consent to mental health treatment or counseling on an outpatient basis if both of the following requirements are satisfied:

- Age 12 or older
- The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services
- The minor would either present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling, or is the alleged victim of incest or child abuse

Health and Safety Section 124260 states that a minor can consent to mental health treatment if he or she meets both of the following requirements:

- Age 12 or older
- The minor is mature enough to participate intelligently in the treatment

The attending professional conducts an assessment to determine presenting issues and consent. Completing an initial assessment and determining eligibility for mental health minor consent services may take multiple sessions. In those cases, the charting should clearly describe why the clinician believes that the minor may qualify for minor consent under Family Code Section 6924 or Health and Safety Code Section 124260. If criteria cannot be established within the next few sessions, please consult with a supervisor. Parent/guardian consent is required if psychotropic medications are prescribed or if inpatient mental health facility services are provided. The law also does not authorize a minor to consent to convulsive therapy or psychosurgery.

Financial Liability

Please use "minor consent" episode with Realignment as primary guarantor or contact the Business Office for further clarification as needed.

Involvement/Notification of Parent or Guardian in Outpatient Behavioral Health Services

If outpatient mental health treatment or counseling services are provided pursuant to "sensitive services minor consent" (Family Code 6924) or (Health and Safety Code 124260) the law states that it shall include the involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. When services are being provided under Health and Safety Code 124260, the professional person must consult with the minor before making the determination concerning

parental or guardian involvement. The professional person must state in the record that minor was consulted before making the determination to involve the parent or guardian, whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

Substance Abuse Programs and Minor Consent

The law states that minors aged 12 and older may consent to primarily outpatient drug-free counseling services; outpatient services for the treatment of alcohol and drug abuse (Family Code 6929). This does not include methadone treatment (Note: if minor is pregnant, methadone treatment may be provided under Family Code 6925 as part of her reproductive health care.) See the previous discussion in part 4.d. above, regarding involvement of the parent or legal guardian, unless the provider deems it inappropriate. The same rules for involving the parent or legal guardian, and charting the decision to involve them, or not, apply in the case of substance abuse treatment.

Behavioral health care providers providing services at government funded substance abuse programs should consult 42 USC Section 290dd-2 and 42 CFR Part 2 Section that address the rights of participants in those programs. It should be noted that because minors 12 or older may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem, parents or guardians have no legal authority to demand drug testing of their minor children who are 12 or older. Furthermore, parents and guardians should not be advised of their minor child's participation unless written authorization is received from the minor permitting such a disclosure. California Family Code Section 6929(g) includes a provision for parental access to the record which only applies to private programs that receive no federal or state funding; that subsection should therefore not be followed in County programs, as it is in direct conflict with federal statutes.

Minors who are under 12, or who require methadone treatment, require parent or guardian consent.

Financial Liability

Refer to Substance Abuse Services Division or the Business Office.

Minor Consent Aid Codes

Alcohol and Other Drugs, (AOD) treatment services may be provided to all minors in Aid Code 7M and 7P and to pregnant/postpartum females in Aid Code 7N. AOD treatment services may not be provided to minors in Aid Code 7R. In order to bill AOD treatment services under minor consent, the program must be a certified Drug Medi-Cal (DMC) program.

Minor consent eligibility is for a 30-day period. The minor must reapply in person at the Department of Social Services to receive subsequent minor consent services. Children receiving minor consent Drug Medi-Cal services are not eligible for Early and Periodic Screening Diagnosis and Treatment Supplemental Services (EPSDT).

APPENDIX K – INTERIM STRTP REGULATIONS (VERSION II)

SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM (STRTP) Interim Regulations (Version II)

SECTION 1. APPLICATION OF CHAPTER

These regulations shall apply to mental health programs operated by STRTPs. STRTPs are licensed by California Department of Social Services pursuant to California Health and Safety Code Section 1562.01.

SECTION 2. DEFINITIONS AND TERMS

(a) Meaning of words. A word or phrase shall have its usual meaning unless the context or a definition clearly indicates a different meaning. Words and phrases used in their present tense include the future tense. Words and phrases in the singular form include the plural form. Use of the word "shall" denotes mandatory conduct and "may" denotes permissive conduct.

(b) "Administrator" means the individual who holds an administrator's certificate issued by the Department of Social Services pursuant to Section 1522.41 of the Health and Safety Code.

(c) "Applicant" means any firm, association, corporation, county, city, public agency or other entity that has submitted an application for an initial STRTP mental health program approval.

(d) "Approval holder" means the, firm, association, corporation, county, city, public agency or other entity that has an approved STRTP mental health program documented by a certificate issued to them by the Department or delegate.

(e) "Approval task" means the processes of approving or denying an application submitted by an applicant, oversight, annual renewal, imposing sanctions, revocation, notice and review, and all other duties necessary to carry out the delegate responsibilities identified in Welfare and Institutions Code 4096.5 and these regulations. The approval task shall include an initial onsite inspection, investigation of complaints, annual onsite inspections, ongoing verification that the STRTP continues to meet the requirements set forth in these regulations, and imposition of sanctions (excluding imposition of monetary penalties) or revocation of approval if the STRTP does not meet the requirements set forth in these regulations.

(f) "Arrival" means the point in time when the child physically enters the STRTP.

(g) "Authorized Legal Representative" means any person or entity authorized by law to act on behalf of the child.

(h) "Child" means an individual under the age of 21. For purposes of these regulations, any reference to child shall also include youth and non-minor

dependents.

(i) "Client record" means the documents related to the child's admission, treatment, and transition determination in the STRTP, including assessments, treatment plan, STRTP mental health program progress notes, and clinical reviews reflecting the services the STRTP provides to the child.

(j) "Delegate" means a county Mental Health Plan to which the Department has delegated the approval task. References to the "Department or delegate" shall mean the delegate when the STRTP is located in a county that has accepted delegation.

(k) "Department" means the State Department of Health Care Services. References to the "Department or delegate" shall mean the Departmentwhen the STRTP is located in a county that has not accepted delegation of the approval task or when the STRTP is county owned and operated.

(l) "Full-time equivalent" means one individual employed a minimum of forty (40) hours per week or a combination of employees who each do not work full-time, but in combination work a total of at least forty hours per week.

(m) "Half-time equivalent" means one individual employed a minimum of twenty (20) hours per week or a combination of employees who each do not work half-time, but in combination work a total of at least twenty hours per week.

(n) "Head of Service" means a person who oversees and implements the STRTP mental health program.

(o) "Licensed Clinical Social Worker" means a licensed clinical social worker within the meaning of subdivision (a) of Section 4996 of the Business and Professions Code.

(p) "Licensed Marriage and Family Therapist" means a licensed marriage and family therapist within the meaning of subdivision (b) of Section 4980 of the Business and Professions Code.

(q) "Licensed Mental Health Professional" means a physician licensed under Section 2050 of the Business and Professions Code, a licensed psychologist within the meaning of subdivision (a) of Section 2902 of the Business and Professions Code, a licensed clinical social worker within the meaning of subdivision (a) of Section 4996 of the Business and Professions Code, a licensed marriage and family therapist within the meaning of subdivision (b) of Section 4980 of the Business and Professions Code, or a licensed professional clinical counselor within the meaning of subdivision (e) of Section 4999.12. For purposes of these regulations, licensed mental health professionals shall have a minimum of one year of professional experience in a mental health setting.

(r) "Licensed Professional Clinical Counselor" means a licensed professional clinical counselor within the meaning of subdivision (e) of Section 4999.12.

(s) "Mental Health Plan" means individual counties or counties acting jointly pursuant to Welfare and Institutions Code section 14712.

(t) "Placing Agency" has the same meaning as "placement agency" in subdivision

(a) of Section 1536.1 of the Health and Safety Code.

(u) "Physician" means a physician licensed under Section 2050 of the Business and Professions Code.

(v) "Psychiatrist" means a physician licensed under Section 2050 of the Business and Professions Code who can show evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association, or the American Osteopathic Association.

(w) "Psychologist" means a licensed psychologist within the meaning of subdivision (a) of Section 2902 of the Business and Professions Code.

(x) "Psychotropic Medication" means those medications administered for the purpose of affecting the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti- Parkinson agents, hypnotics, medications for dementia, and psychostimulants.

(y) "STRTP" means a short-term residential therapeutic program as defined in Section 1502, subdivision (a)(18) of the Health and Safety Code.

(z) "STRTP Licensing Standards" means the standards and/or regulations adopted by the California Department of Social Services governing the licensing of STRTPs.

(aa) "STRTP mental health program progress notes" are written notes in the client record of a child's condition and the child's participation and response to mental health treatment provided by the STRTP.

(bb) "STRTP mental health program staff" means employees or contractors of the STRTP whose duties include but are not limited to the mental health treatment of the children admitted to the STRTP. A member of the STRTP mental health program staff must be one of the following: physician, psychologist, or psychologist that has received a waiver pursuant to Welfare and Institutions Code Section 5751.2, licensed clinical social worker or registered professional pursuant to Welfare and Institutions Code Section 5751.2, marriage, family and child therapist or registered professional pursuant to Welfare and Institutions Code Section 5751.2, registered nurse, licensed professional clinical counselor or registered professional pursuant to Welfare and Institutions Code Section 5751.2, licensed vocational nurse, psychiatric technician, occupational therapist, or mental health rehabilitation specialist as defined in section 630 of Title 9 of the California Code of Regulations."

(cc) "STRTP mental health program statement" means written policies, procedures, and documentation describing the manner in which the STRTP shall provide medically necessary mental health treatment services to children in accordance with these regulations.

(dd) "Trauma" the result of an event, series of events, or set of circumstances that is experienced by the child as physically or emotionally harmful or threatening and that is expected to have adverse effects on the child's functioning and physical, social, emotional, or spiritual well-being.

(ee) "Treatment Plan" means the written plan of all therapeutic, behavioral, and other interventions that are to be provided to the child during the child's stay in the STRTP, and that are necessary to achieve the desired outcomes or goals for the child.

(ff) "Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval signing treatment plans. An individual directing a service is not required to be physically present at the service site to exercise direction.

(gg) "Waivered/Registered Professional" means:

(1) For a psychologist candidate, "waivered" means an individual who either (1) is gaining the experience required for licensure or (2) was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by the Department to the extent authorized under state law.

(2) For a social worker candidate, a marriage and family therapist candidate or professional clinical counselor candidate, "registered" means a candidate for licensure who is registered with the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations, and "waivered" means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination and who has been granted a professional licensing waiver approved by the Department to the extent authorized under state law.

SECTION 3. STRTP MENTAL HEALTH PROGRAM APPROVAL APPLICATION CONTENT

To be considered for STRTP Mental Health Program Approval, an applicant shall submit the following:

(a) A completed Application for Mental Health Program Approval of the STRTP Mental Health Program DHCS Form 3131, which shall contain:
(1) The name or proposed name and address of the STRTP.
(2) Name, residence, and mailing address of applicant.

(b) A written STRTP mental health program statement and supporting documentation that contains the required information in Section 5.

SECTION 4. STRTP MENTAL HEALTH PROGRAM APPROVAL OF SEPARATE PREMISES

(a) A separate STRTP Mental Health Program Approval is required for each STRTP on separate premises. A separate STRTP Mental Health Program Approval is not required for separate residential units on the same lot or adjoining lots, provided that the residential units operate as one program using the same administrator and head of service.

SECTION 5. STRTP MENTAL HEALTH PROGRAM STATEMENT

(a) The STRTP shall operate in accordance with a STRTP mental health program statement that is approved by the Department or delegate. The STRTP mental health program statement shall include the following:

(1) A description of the STRTP mental health program, including:

(A) The anticipated length of stay.

(B) The expected population including age range, gender, demographics, languages, and special needs.

(C) Each of the mental health treatment services that the applicant will directly provide onsite to admitted children during their stay in the STRTP including any specialty mental health services, as medically necessary.

(2) Staffing policies, including:

(A) Job descriptions for the head of service, licensed mental health professionals, and other STRTP mental health program staff.

(B) The name of the proposed head of service and documentation evidencing that they are qualified in accordance with these regulations.

(C) A staffing organizational chart, which lists job descriptions, staff-to-child ratios, and professional licenses, if applicable, of the STRTP mental health program staff providing mental health treatment services to children in the STRTP.

(D) A staff training plan describing STRTP mental health program staff orientation procedures, in-service education requirements, and required continuing education activities to ensure STRTP mental health program staff complies with procedures contained in the STRTP mental health program statement.

(E) A description and true and correct copy of each agreement, contract, or memorandum of understanding with participating private or public mental health providers.

(3) The written, specific, and detailed policies and procedures the STRTP will follow, including policies and procedures for:

(A) Orienting new children to the mental health services available at the STRTP and for meeting the cultural and language needs for children admitted to the STRTP.

(B) Emergency intervention that includes interventions for children who present an imminent danger for injuring or endangering self or others pursuant to STRTP Licensing Standards and Health and Safety Code, Division 1.5, concerning the "Use of Seclusion and Behavioral Restraints in Facilities."
(C) Suicide prevention, which includes at a minimum: suicide risk assessments, safety precautions, visual observation levels, staffing to maintain compliance with visual observation policies, and documentation requirements. The suicide prevention policy shall require constant visual observation of children with passive suicidal ideation.
(D) Involving the child, parent, conservator, tribal representative, and/or person identified by the court as authorized to make decisions about the child, and child and family team, if applicable, in the child's treatment and/or transition plan.
(E) Confidentiality, which shall include privacy protections for information contained in a child's record and communications between STRTP mental health program staff members and children.
(F) Complying with the notification requirements in Section 6.
(G) Complying with the Client record documentation and retention requirements in Section 7.
    (i) The policies and procedures shall ensure secure client record storage in a locked room or container to protect confidentiality and prevent loss, defacement, tampering or use by unauthorized persons.
(H) Complying with the Mental Health Assessment requirements in Section 8.
(I) Complying with the Admission Statement requirements in Section 9.
(J) Complying with the Treatment Plan requirements in Section 10.
(K) Complying with the STRTP Mental Health Program Progress Notes requirements in Section 11.
(L) Complying with the Medication Assistance, Control and Monitoring requirements in Section 12 and for securing, storing, and administering medication.
(M) Complying with the Mental Health Treatment Services requirement in Section 13, including policies and procedures the STRTP will utilize to make available mental health services that the STRTP does not directly provide. The policies and procedure shall include the STRTP's process to refer children to outside mental health service providers and include the location mental health services will occur and method of transportation for any mental health services provided offsite. True and correct copies of all Medi-Cal certifications to provide Medi-Cal services and any contracts with outside mental health service providers shall be included with the program statement.
(N) Complying with the Clinical Reviews, Collaboration, and Transition Determination requirements in Section 14.
(O) Complying with the Transition Determination Plan requirements in

Section 15.

(P) Complying with the Head of Services requirements in Section 16.

(Q) Complying with the staff, characteristics, qualifications, duties and adequacy requirements in Section 17.

(R) Complying with the in-service education requirements in in Section 18.

(S) Complying with the personnel record requirements in Section 19.

(T) Complying with the documentation and recordkeeping requirements in Sections 26 and 34.

(b) The Department or delegate may disapprove a STRTP mental health program statement that does not comply with these regulations or fails to establish a safe, healthy, and/or therapeutic environment for the children admitted to the STRTP.

(c) Any changes to the STRTP mental health program statement are subject to Department or delegate approval. The STRTP shall submit any requests for approval of changes to the STRTP mental health program statement in writing, mailed or e-mailed to the Department and delegate sixty (60) calendar days prior to the anticipated date of implementing the change.

SECTION 6. NOTIFICATION TO DEPARTMENT AND DELEGATE

(a) The STRTP shall notify the Department and delegate in writing within ten (10) calendar days of changes to its name, location, mailing address, or head of service. If there is a change to the head of service, the notification shall include documentation that the new head of service meets all of the qualifications required for the position.

(b) The STRTP shall notify the Department and delegate in writing prior to any increases or decreases in licensed bed capacity.

(c) The STRTP shall notify the Department and delegate in writing when the STRTP is no longer certified to provide specialty mental health services pursuant to section 1810.435, subdivision (d) within seventy-two (72) hours from the date the certification expires or is terminated.

SECTION 7. CLIENT RECORD DOCUMENTATION AND RETENTION

(a) The STRTP shall ensure that each child residing in the STRTP has an accurate and complete client record.

(b) The client record shall be confidential and a STRTP shall only disclose the client record if the disclosure is authorized by applicable federal and state privacy laws, including but not limited to, Welfare and Institutions Code section 5328.

(c) The client record shall include:

(1) Signed informed consent for treatment;

(2) Mental health assessment;

(3) Admission statement;

(4) Treatment Plan;

(5) STRTP Mental health program progress notes;
(6) Child and Family Team meeting notes;
(7) Clinical review report and transition determination;
(8) Physician's orders related to mental health care, medication reviews, if applicable, and written informed consent for prescribed medication, pursuant to applicable law;
(9) A copy of any available court orders or judgments regarding: physical or legal custody of the child, conservatorship or guardianship of the child, the child's probation, or the child's juvenile court dependency or wardship;
(10) Documentation indicating each date and name(s) of individuals or groups of individuals who have participated in the development of the treatment plan, or transition, including, but not limited to, the child, parent, guardian, conservator, tribal representative, child and family team members, and/or authorized representative;
(11) A transition determination plan, which meets the requirements of Sections 15 and 16;

(d) The STRTP shall retain each client record for a minimum of ten (10) years from the child's transition, or whichever is later. For purposes of this section "audit" refers to any investigation of complaints and unusual occurrences, chart reviews, and financial audits. Audits can be conducted by the state, delegate, or federal agencies. The retention period required in this section shall be extended if the child's treatment is subject to any due process proceeding, including administrative review and litigation until all appeals have been exhausted.

SECTION 8. MENTAL HEALTH ASSESSMENT

(a) The STRTP shall ensure that within five (5) calendar days of the child'sarrival, the child has a completed and signed mental health assessment.

(b) The mental health assessment shall be completed by a licensed mental health professional or waivered/registered professional. Other STRTP mental health program staff acting within their scope of practice may assist the licensed mental health professional or waivered/registered professional in gathering information required to complete the assessment.

(c) The mental health assessment shall address the following:
(1) Presenting problem, including the history of the presenting problem(s), family history, and current family information.
(A) The presenting problem shall include the reason(s) for the child's referral to the STRTP.
(2) A mental status examination.
(3) Mental Health History, including previous treatment, inpatient admissions, therapeutic modalities, such as medications and psychosocial treatments, and response. If available, include information from other sources of clinical data,

such as previous mental health records, and relevant psychological testing or consultation reports.

(4) Medical History, including physical health conditions, name and address of current source of medical treatment, prenatal and perinatal events, developmental, and other medical information from medical records or consultation reports.
   (A) The medical history shall include all present medical condition(s).

(5) Medications, including information about medications the child has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment, the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications.
   (A) Medication information shall include all medications currently prescribed and dosage.

(6) Risks to the child and/or others.

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

(8) Psychosocial factors and conditions affecting the child's physical and mental health, including living situation, daily activities, social support, sexual orientation, gender identity, cultural and linguistic factors, academics, school enrollment, and employment.

(9) History of trauma.

(10) Child Strengths, including the child's strengths in achieving needs and services plan goals related to the child's mental health needs, challenges, and functional impairments as a result of the mental health diagnosis.

(11) A complete diagnosis shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data.

(12) Any additional clarifying information.

(d) To satisfy the mental health assessment requirement in subdivision (a), the STRTP may use an existing mental health assessment that was performed within the sixty (60) day period preceding the date of the child's arrival at the STRTP, subject to all of the following requirements:

(1) The mental health assessment was conducted or certified by an interagency placement committee, a licensed mental health professional, or waivered/registered professional or an otherwise recognized provider of mental health services acting within their scope of practice.

(2) A licensed mental health professional or waivered/registered professional shall review the prior assessment within five calendar days of the child's arrival at the STRTP program and determine whether to accept the existing mental health assessment or whether conducting a new assessment is more appropriate.

(3) As part of the review referenced in paragraph (2) of this subdivision, the licensed mental health professional or waivered/registered professional shall sign and complete an addendum documenting their acceptance of the existing assessment. The addendum shall include any available information required in subdivision (c) that was missing from the existing assessment, as well as updated information regarding the child's physical and mental condition at the time of arrival, diagnosis, and reason for referral, before signing and accepting.

(e) A mental health assessment that meets the requirements of this section shall be deemed to satisfy assessment documentation requirements for Medi-Cal beneficiaries.

(f) In the case of an emergency placement pursuant to Welfare and Institutions Code section 11462.01(h)(3), a licensed mental health professional or waivered/registered professional shall make a written determination that the child requires the level of services and supervision provided at the STRTP to meet their behavioral and mental health service needs. The determination shall occur as soon as possible after the child arrives at the STRTP, but no later than 72 hours from the time the child arrives at the facility.

(1) The licensed mental health professional or waivered/registered professional shall consider and address, in the written determination the following information:

(A) The child's presenting problem, including the history if it is available;

(B) Whether the STRTP meets the specific therapeutic needs of the presenting problem.

(C) The child's prior mental health diagnosis, if any.

(D) The child's current prescription and non-prescription medications, including dosages.

(E) The child's current medical conditions, including any prescribed treatment and medications.

(F) A risk assessment that addresses the child's likelihood of danger to self or others.

(G) Commonality of need with other children at the STRTP.

(H) Any other information necessary to determine whether the child requires the level of services provided at the STRTP.

(2) A child who receives a determination pursuant to paragraph (1) shall also have a mental health assessment as required in subdivision (a) to document the need for the STRTP level of care

(3) A mental health assessment that complies with subdivision (b), if completed within 72 hours of a child's arrival at the STRTP, shall satisfy the requirements of this subdivision.

SECTION 9. ADMISSION STATEMENT

(a) The head of service shall sign an admission statement within five calendar days of the child's arrival at the STRTP. In the statement, the head of service shall affirm that they have: read the child's referral documentation and any previous mental health assessments, if available; considered the needs and safety of the child; considered the needs and safety of the children already admitted to the STRTP; and concluded that admitting the child is appropriate. The admission statement shall affirm the following are reviewed and will ensure, if a referral for placement is made through the Interagency Placement Committee (IPC), the materials included in the IPC referral information has also reviewed:

(1) The child does not require inpatient care in a licensed health facility.

(2) The child has been assessed as requiring the level of services provided in a STRTP in order to maintain the safety and well-being of the child or others due to behaviors, including those resulting from traumas, that render the child or those around the child unsafe or at risk of harm, or that prevent the effective delivery of needed services and supports provided in the child's own home or in other family settings, such as with a relative, guardian, foster family, resource family, or adoptive family.

(3) The child meets at least one of the following conditions:

(A) The child has been assessed as meeting the medical necessity criteria for Medi-Cal specialty mental health services, as provided for in Section 1830.205 or 1830.210 of Title 9 of the California Code of Regulations.

(B) The child has been assessed as seriously emotionally disturbed, as defined in subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

(C) The child requires emergency placement.

(D) The child has been assessed as requiring the level of services provided by the STRTP in order to meet their behavioral or therapeutic needs.

SECTION 10. TREATMENT PLAN

(a) Each child admitted to a STRTP shall have a Treatment Plan reviewed and signed by a licensed mental health professional, waivered/registered professional, or the Head of Service within ten (10) calendar days of the child's arrival at the STRTP. The Treatment Plan shall include:

(1) Anticipated length of stay.

(2) Specific behavioral goals for the child and specific mental health treatment

services the STRTP shall provide to assist the child in accomplishing these goals within a defined period of time.

(3) One or more transition goals that support the rapid and successful transition of the child back to community based mental health care.

(4) The child and authorized legal representative's participation and agreement. The child and the child's authorized legal representative's participation and agreement shall be documented in the client record. If the child is unable to agree or refuses to agree to the treatment plan, the child's authorized legal representative's participation and agreement shall be sufficient, but the child's inability or refusal shall be documented in the Client Record. For a child who is a Medi-Cal beneficiary, the documentation of the refusal shall be in accordance with Section 1810.440(c)(2)(B) of Title 9 of the California Code of Regulations.

(5) Include participation of the child and family team, if one exists.

(6) Be reviewed by a member of the STRTP mental health program staff at least every thirty (30) calendar days. The member of the STRTP mental health program staff that completes the review shall document the review in the client record and include whether it is necessary to make changes to the treatment plan.

(7) A trauma-informed perspective, which includes planned services to promote the child's healing from any history of trauma.

(b) The child's treatment plan shall be updated as the child's mental health treatment needs change.

(c) The STRTP shall provide a copy of the treatment plan to the child's placing agency within ten (10) calendar days of the request of the placing agency and in compliance with all applicable privacy laws.

SECTION 11. STRTP MENTAL HEALTH PROGRAM PROGRESS NOTES

(a) For each child, the STRTP shall ensure that there is a minimum of one (1) written daily mental health progress note. The daily progress note shall document the following when applicable:

(1) The specific service(s) provided to the child.

(2) A child's participation and response to each mental health treatment service directly provided to the child.

(3) Observations of a child's behavior.

(4) Possible side effects of medication.

(5) Date and summaries of the child's contact with the child's family, friends, natural supports, child and family team, existing mental health team, authorized legal representative, and public entities involved with the child.

(6) Descriptions of the child's progress toward the goals identified in the treatment plan.

(b) In addition to the daily mental health progress note, the STRTP mental health program staff shall write a progress note whenever there is a significant change in condition or behavior, or a significant event involving the child, including the date and time of the event and the STRTP's response to the event.

(1) A significant event involving the child is any unintended or unexpected event, which could or did lead to physical or emotional harm. This includes incidents which did not cause harm but could have caused harm, or where the event should have been prevented.

(2) Whenever there is a significant event involving the child, the STRTP shall consider whether the child has a history of trauma and, if so, do the following:

(A) Determine whether the child's history of trauma has precipitated the significant event.

(B) Determine whether the significant event could be used to promote healing and growth from the child's history of trauma.

(C) Determine whether the significant event has created a need for changes to the child's treatment plan.

(D) Update the child's treatment plan with any additional services that the child needs, taking into account the significant event, the child's history of trauma, and any other relevant psychosocial factors which may include the child's living situation, daily activities, social support, sexual orientation, gender identity, cultural and linguistic factors, academics, and school enrollment.

(c) All mental health progress notes shall be completed, signed and dated (or electronic equivalent) within seventy-two (72) hours of the service provided.

(d) The mental health progress notes shall be maintained in the child's record.

(e) If the child is a Medi-Cal beneficiary, the STRTP shall complete separate progress notes for each specialty mental health service provided.

(f) If a progress note for a specialty mental health service is provided, this replaces the requirement for this daily mental health progress note.

SECTION 12. MEDICATION ASSISTANCE, CONTROL, AND MONITORING

(a) A nurse practitioner, physician's assistant or registered, licensed or vocational nurse acting within their scope of practice; may perform the functions in subdivisions (b), (c), and (d) under the direction of a psychiatrist. However, each child shall be examined by a psychiatrist at least one time during the child's stay at the STRTP.

(b) A physician or psychiatrist shall examine each child prior to prescribing any

psychotropic medication. The examination shall include a screening to determine whether there are potential medical complications from the medication that could impact the child's mental health condition. The examination shall be noted in the client record.

(c) A physician or a psychiatrist, shall sign a written medication review for each child prescribed psychotropic medication. This review shall be completed as often as clinically appropriate, but at least every forty-five (45) days. This review may be prepared by a STRTP mental health program staff member acting within the scope of their practice and shall be included in the client record. The medication review shall include:

(1) Observations of any side effects and review of any side effects reported by the child or noted in the client record.

(2) The child's response to each psychotropic medication currently prescribed and the child's perspective on the effectiveness of these medications.

(3) The child's compliance with taking psychotropic medication prescribed.

(4) Justification for continuing to prescribe psychotropic medication and/or changing the child's medication plan.

(5) A statement that the physician, psychiatrist has considered the goals and objectives of the child as listed in the child's needs and services plan and the treatment plan, and that the psychotropic medication prescribed is consistent with those goals and objectives.

(d) A psychiatrist shall review the course of treatment for all children who are not on psychotropic medication to treat mental health conditions as clinically appropriate, but at least every ninety (90) days and include the results of this review in a progress note signed by the psychiatrist at the time the review is completed.

(e) Psychotropic medications for a child residing in a STRTP shall be administered and dispensed in accordance with state and federal laws for pharmaceuticals, which include but are not limited to, laws related to authorization, administering and dispensing medication, psychotropic medication, storage and disposal, informed consent, and documentation of informed consent.

(f) The STRTP shall ensure the following is documented in the client record: the date and time a prescription or non-prescription medication was taken, the dosage taken or refused, and the child's response to medication.

SECTION 13. MENTAL HEALTH TREATMENT SERVICES

(a) The STRTP shall provide structured mental health treatment services in the day and evening, seven (7) days per week, according to the child's individual needs as indicated in the child's treatment plan.

(b) The STRTP shall be able to directly provide the following mental health treatment services onsite:

(1) Crisis Intervention as defined in Section 1810.209 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

(2) Mental Health Services as defined in Section 1810.227 for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

(3) Targeted Case Management as defined in Section 1810.249 for Medi- Cal beneficiaries and equivalent services for children who are not Medi- Cal beneficiaries.

(c) The STRTP shall make available the following mental health treatment services according to the child's treatment plan:

(1) Day treatment intensive as defined in Section 1810.213 of Title 9 of the California Code of Regulations for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

(2) Day rehabilitation as defined in Section 1810.212 of Title 9 of the California Code of Regulations for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

(3) Medication Support Services as defined in Section 1810.225 of Title 9 of the California Code of Regulations for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

(4) EPSDT services as defined in Section 1810.215 of Title 9 of the California Code of Regulations for Medi-Cal beneficiaries and equivalent services for children who are not Medi-Cal beneficiaries.

(5) Psychiatric nursing services, which shall include, but not be limited to, nursing assessments, taking vital signs, monitoring vital signs, coordinating medical care, administering, dispensing, and furnishing medication, and other services described in Business & Professions Code Section 2725. The psychiatric nursing services shall be provided by a registered nurse, licensed, or vocational nurse, licensed psychiatric technician, or another licensed professional acting within the scope of their practice.

(d) For purposes of this section "make available" means that the STRTP mental health program either directly provides the services or provides access to services provided by other providers. A child may receive services provided offsite by other providers to meet the child's needs as set forth in the child's treatment plan.

(e) If a child is a Medi-Cal beneficiary and the STRTP is not certified to provide a specialty mental health service that is medically necessary for that child, the STRTP shall arrange for the child to receive the service through the mental health plan with responsibility for providing or arranging for specialty mental health services for that child.

SECTION 14. CLINICAL REVIEWS, COLLABORATION, AND TRANSITION DETERMINATION

(a) Every ninety (90) days, a licensed mental health professional or waiver/registered professional, shall perform a clinical review of the child's current mental health status and progress in treatment to determine whether the child should be transitioned to a different level of care. The licensed mental health professional or waivered/registered professional shall summarize the reviews and determinations in the client record and update the child's treatment plan, as needed.

(1) As part of the review, the licensed mental health professional or waivered/registered professional shall consider:

(A) The types and frequency of services provided to the child and the impact of these services on the child's achievement of the goals outlined in the child's treatment plan.

(B) Whether the STRTP continues to meet the specific therapeutic needs of the child.

(C) Justification for the decision for continued stay or transition of the child based on the client record and licensed mental health professional's clinical opinion.

(b) As clinically appropriate (determined by a licensed mental health professional, waivered/registered professional, or head of service), the STRTP shall collaborate throughout the course of the child's treatment with the child's existing mental health team, parent, guardian, conservator, tribal representative, child and family team, authorized legal representative, placing agency or agencies, the probation department, county welfare department, and county mental health department, if any of these are applicable. The STRTP shall summarize and document the consultations in the client record.

(c) The STRTP mental health program staff shall meet at least once every ninety (90) days, or more often if needed, to discuss the diagnosis, mental health progress, treatment planning, and transition planning for the child. Prior to or during each meeting, the STRTP mental health program staff shall obtain information from direct care staff about their observations, if any, for the child. The head of service or a licensed mental health professional or waiver/registered professional shall attend each meeting along with other mental health program staff that provide mental health services to the child. The meeting should include the most active and informed members of the mental health program staff responsible for the child's mental health treatment.

SECTION 15. TRANSITION DETERMINATION PLAN

(a) A transition determination plan shall be developed, completed, and signed by a member of the STRTP mental health program staff prior to the date the child transitions out of the STRTP. A copy shall be provided prior to or at the time of the

child's transition, to the following, as applicable: parent, guardian, conservator, or person identified by the court to participate in the decision to place the child in the STRTP. The transition determination plan shall include:

(1) The reason for admission;

(2) The reason for transition, referencing the child's transition planning goals, or another reason for the child to be transferred to an alternative treatment setting;

(3) The course of treatment during the child's admission, including mental health treatment services, medications, and the child's response;

(4) The child's diagnosis at the time of transition;

(5) The child's aftercare plan, which shall include, the following components:

(A) The nature of the child's diagnosis and follow-up required.

(B) Medications, including side effects and dosage schedules.

(C) Goals and expected outcomes for any follow up treatment.

(D) Recommendations regarding treatment that are relevant to the child's care.

(E) Educational information, including grade level functioning, and any special education needs.

(F) Referrals to providers of medical and mental health services.

(G) Other relevant information.

SECTION 16. HEAD OF SERVICE

(a) The STRTP shall have a dedicated head of service employed forty (40) hours per week.

(b) The head of service shall meet the requirements of one of the professional disciplines in Sections 623 through 630 of Title 9 of the California Code of Regulations. The STRTP shall submit to the Department or delegate documentation establishing that the head of service satisfies the requirements of the applicable regulation in Sections 623 through 630 of Title 9 of the California Code of Regulations.

(c) If the head of service is not a physician, psychologist, licensed clinical social worker, licensed marriage and family therapist, licensed professional clinical counselor, registered nurse, the head of service shall perform the head of service duties under the direction of one or more of the following professionals:

(1) Physician or psychiatrist who meets the education and experience requirements in section 623.

(2) Psychologist who meets the education and experience requirements in section 624.

(3) Licensed Clinical Social Worker who meets the education and experience requirements in section 625.

(4) Licensed Marriage and Family Therapist who meets the education and experience requirements in section 626.

(5) Licensed Professional Clinical Counselor who meets the education and experience requirements in section 626.

(6) Nurse who meets the education and experience requirements in sections 627 or 628.

(d) A head of service that is the head of service for more than one STRTP shall not serve as an administrator. A head of service who is an administrator shall not be counted as part of the staffing ratio. A head of service who is also the administrator shall not hold any other position.

(e) The head of service is responsible for the STRTP mental health program's compliance with these regulations and applicable laws. The head of service shall manage the clinical and administrative components of the STRTP mental health program. The head of service's responsibilities shall include, but are not limited to, the following specific tasks:

(1) Maintaining a safe, healthy, and therapeutic environment at the STRTP.

(2) Ensuring that each child admitted to the program has a mental health assessment.

(3) Ensuring that each child in the STRTP has commonality of needs with the other children in the STRTP, including whether the child's presence is adverse to the safety or mental health needs of the child or other children admitted to the STRTP.

(4) Ensuring the mental health services identified on each treatment plan are provided and appropriate to meet the individual needs of the child.

(5) Monitoring the quality of the mental health services provided to the children.

(6) Making arrangements, including transportation, for children to receive mental health services that cannot be provided by the STRTP.

(7) Arrangements for special provision of mental health services to children with disabilities including visual and auditory impairment.

(8) Ensuring that documentation and recordkeeping requirements are met.

(9) Development of mental health staff schedules, training schedules, mental health treatment service schedules, medication schedules, and any other schedules for the operation of the STRTP mental health program.

(f) The Department or delegate may approve program flexibility for subdivision (a) of this

section subject to the following requirements:

(1) A single legal entity operating more than one STRTP may request program flexibility to have a single head of service employed forty (40) hours per week to manage a maximum of thirty (30) beds split among a maximum of five (5) STRTPs in good standing that are located on separate premises. To receive and maintain program flexibility approval under this subdivision:

(A) The head of service shall have a designated primary office at one of the STRTPs;

(B) No facility shall be more than five (5) miles distance from the head of service's primary office;

(C) The head of service shall be reachable at all times during their scheduled shift;

(D) Each facility shall have a designated individual in an acting capacity when the head of service is not on-site;

(E) The head of service shall be on-site at each facility for a minimum of two (2) hours at least three (3) times per week;

(F) The head of service shall maintain a time study, which indicates specific time spent at each facility; and

(2) Every program flexibility request, approval, renewal, denial, suspension, and revocation under this subdivision shall comply with the applicable program flexibility requirements in sections 33 and 34.

(3) The purpose of program flexibility for the head of service position is to accommodate the needs of small STRTPs located in close proximity to each other. A facility that is unable to meet the time or distance requirements of (a)(1)(ii) in this section, despite a demonstrated effort to comply, may apply in writing to the Department directly for program flexibility, which shall be approved on a case by case basis. In deciding the application, the Department shall consider whether the delegate, if applicable, supports the time and distance flexibility request. The Department shall consider the facility's special circumstances, which may include, but are not limited to, difficulty obtaining suitable premises within the time and distance area, financial hardship, rural location, and an absence of qualified candidates in the region. A delegate shall not have authority to approve time and distance program flexibility.

SECTION 17. STAFF CHARACTERISTICS, QUALIFICATIONS, DUTIES, AND ADEQUACY

(a) All licensed, waivered, or registered mental health professionals providing services in a STRTP shall meet all legal requirements for professional licensing, waiver, or registration, as applicable.

(b) A STRTP shall have at least one full-time equivalent STRTP mental health program staff from the following list employed for each six children or fraction thereof admitted to the program:

(1) Physicians

(2) Psychologists or psychologists who have received a waiver pursuant to Welfare and Institutions Code Section 5751.2.

(3) Licensed Clinical Social Workers or registered professionals pursuant to Welfare and Institutions Code Section 5751.2.

(4) Marriage, Family and Child Counselors or registered professionals pursuant to Welfare and Institutions Code Section 5751.2.

(5) Registered Nurses

(6) Licensed Professional Clinical Counselor or registered professionals pursuant to Welfare and Institutions Code Section 5751.2.

(7) Licensed Vocational Nurses

(8) Psychiatric Technicians

(9) Occupational Therapists

(10) Mental Health Rehabilitation Specialists as defined in Section 630 of Title 9 of the California Code of Regulations.

(c) Of the STRTP mental health program staff required in subdivision (b), a STRTP shall have one half-time equivalent licensed mental health professional or waivered/registered professional employed for each six children or fraction thereof admitted to the program. A licensed mental health professional or waivered/registered professional who is employed to meet this requirement may also be the head of service, if employed at least forty (40) hours per week.

(d) The STRTP shall have adequate numbers of STRTP mental health program staff scheduled, present, awake, and on duty between 9:00 am and 5:00 pm five (5) days per week. The STRTP shall have mental health program staff scheduled for additional hours as needed to ensure children have access to medically necessary specialty mental health services. The STRTP shall develop a daily STRTP mental health program staff schedule based on the number of children physically present at the STRTP and the children's meal times, class schedules, mental health programming, and other scheduled appointments or activities. The STRTP shall ensure that the mental health service schedule maximizes opportunities for service provision when children are present and available to receive the services. This subdivision shall not be construed to prohibit the STRTP from providing services that are appropriately provided without the child present, such as collateral services and targeted case management.

(e) The staffing requirements in this section shall be satisfied at all times. No staff members shall be counted in more than one staffing ratio during their assigned shifts.

A STRTP may schedule member(s) of the direct care staff as defined in section 87001 of the STRTP Licensing Standards to meet the staffing requirements of subdivision (b), if the direct care staff members are from the list of individuals described in subdivision (b)(1)-(10). A STRTP may schedule member(s) of the direct care staff to meet the licensed mental health professional or waivered/registered professional requirement of subdivision (c), if the direct care staff members are licensed mental health professionals or waivered/registered professionals. The staff schedule shall specify each time a member of the direct care staff is assigned to a STRTP mental health program staff shift.

(f) The Department or delegate may require a STRTP to provide additional STRTP mental health program staff, if the Department or delegate determines that additional staff are needed to provide for the mental health treatment services needs of the children residing at the STRTP. In making this determination, the Department or the delegate may consider the STRTP's census, experience and education of current STRTP mental health program staff, frequency of deficiencies, severity of deficiencies, as well as any other relevant considerations, including the mental health diagnoses, acuity, and needs of the children in the STRTP. The Department or delegate shall notify the STRTP in writing when additional staff are required.

(g) The STRTP shall have a psychiatrist available to provide psychiatric services as specified in these regulations.

(h) A STRTP may request program flexibility for subdivision (a) of this section as to the staff qualifications for prospective or existing employee(s) subject to the following requirements:

(1) The request shall include the supporting documentation for the Department or delegate to make a decision on the request, such as, but not limited to, the employee's resume, degree, registration for a licensing exam, and the employee's scheduled date of examination.

(2) No prospective or current employee who is the subject of a program flexibility request shall commence duties requiring flexibility approval until the Department or delegate approves the program flexibility request.

(3) Every prospective or current employee is responsible for ensuring their own compliance with their professional licensing board statutes, regulations, and rules.

(4) No program flexibility approval shall serve to permit the unauthorized practice of a profession that requires licensure.

(5) Every program flexibility request, approval, renewal, denial, suspension, and revocation under this subdivision shall comply with the applicable program flexibility requirements in sections 33 and 34.

(6) The Department or delegate may consider the employee's experience and education, the duration of the program flexibility, and any other reasons or factors

relevant to the program flexibility request.

(7) When the Department or delegate approves a program flexibility request for staff qualifications under this subdivision, the approval notice shall specify a date upon which the approval shall expire.

(8) At least five (5) business days prior to the expiration of the program flexibility approval, the STRTP shall submit to the Department or the delegate evidence that the staff member(s) who was the subject of the program flexibility request satisfies all qualification requirements, evidence that the staff member is no longer employed in a capacity requiring program flexibility, or a written request for an extension with justifications and supporting documents.

(9) The Department or delegate shall only consider one request for an extension and no extension shall exceed ninety (90) calendar days.

SECTION 18. IN-SERVICE EDUCATION

(a) All STRTP mental health program staff shall receive a minimum of twenty-four (24) hours per calendar year of ongoing, planned academic and on-the-job in- service education. This twenty four hour requirement may be prorated for part-time STRTP mental health program staff and new employees in their first calendar year of employment. A STRTP mental health program staff member who works twenty (20) hours per week or less shall be required to receive twelve (12) hours per calendar year of in-service education. At least eight (8) hours of the training shall focus specifically on preventing and managing assaultive and self-injurious behavior or other similar crisis services. At a minimum, the in-service education shall cover all of the following topics even if the STRTP mental health program staff must attend more than twenty-four (24) hours of training in a calendar year:

(1) Client-centered and trauma-informed approach to address the needs and goals of children admitted to the STRTP;

(2) Suicide prevention techniques;

(3) Preventing and managing assaultive and self-injurious behavior;

(4) Cultural competence;

(5) Interpersonal relationship and communication skills;

(6) Confidentiality of client information;

(7) Client rights and civil rights;

(8) Monitoring and documenting responses to psychotropic and other medications to treat mental illness and recognizing possible side effects in children and youth;

(9) All approved policies and procedures applicable to the STRTP.

(b) STRTP staff shall complete at least eight (8) hours of training on the topic of preventing and managing assaultive and self-injurious behavior prior to

commencing any employment duties involving direct contact with children.

(c) Subdivisions (a), (b), and (e) shall not apply to a psychiatrist or physician, who is not the head of service. Psychiatrists and physicians shall attend a minimum of one training per calendar year on preventing and managing assaultive and self-injurious behavior.

(d) The STRTP shall document all trainings by maintaining a record of the training title and date, syllabus or curriculum, and sign-in sheets of attendees.

(e) STRTP staff shall comply with all training requirements in the STRTP Licensing Standards.

SECTION 19. PERSONNEL RECORDS

(a) Each STRTP mental health program staff member's personnel file shall contain the following:

(1) A record of their in-service education, which shall include the signature of the staff member for each in-service education activity completed, the date the education occurred, the number of hours, and the subjects covered.

(2) A statement signed by the staff member certifying that he or she has read, understood, and shall comply with these regulations.

(3) A copy of their valid license, waiver, registration, and any other documentation establishing that the individual meets the requirements of being included as a member of the STRTP mental health program staff.

(b) The STRTP mental health program shall retain STRTP mental health program staff personnel records for a minimum of ten (10) years from the last date the staff member was employed by the STRTP, according to the terms of the provider's contract with the Mental Health Plan, or until the date of completion of any audit, whichever is later. For the purposes of this section "audit" refers to any investigation of complaints and unusual occurrences, chart reviews, and financial audits. Audits can be conducted by the state, delegate, or federal agencies. The retention period required in this section shall be extended if the STRTP mental health program staff member's provision of service is subject to any due process proceeding including administrative review and litigation until all appeals have been exhausted.

SECTION 20. APPLICATION PROCESS FOR STRTP MENTAL HEALTH PROGRAM APPROVAL

(a) An applicant shall mail a completed application for Mental Health Program Approval to the Department and to the delegate by certified mail or email.

(b) The Department or delegate shall provide written notice to an applicant if the application is incomplete.

(c) An applicant shall provide any missing information within thirty (30) calendar days of the date of the Department's or delegate's written notice of an incomplete application. If the applicant fails to provide the missing information within thirty (30) calendar days, the application is deemed denied and the applicant does not have a right to notice and review. Nothing in this subdivision shall prevent the applicant from submitting a new application.

(d) Prior to issuing a STRTP mental health program approval, the Department or delegate shall conduct an onsite review to verify that the applicant meets the requirements of these regulations and related statutes.

(1) The onsite review shall include a review of at least twenty percent of the client records for children admitted to the program at the time of the review, if at least one child is admitted.

(2) If the applicant has not admitted any children, the applicant shall notify the Department or delegate of the date it intends to begin admissions in the initial application. The Department or delegate may require a preliminary onsite review of the STRTP mental health program before the program begins to admit children.

(A) The applicant shall notify the Department or delegate in writing within twenty-four (24) hours of the admission of the first child.

(B) The Department or delegate shall conduct an onsite review within forty-five (45) days of receiving notice of the first admission. This onsite review shall include a review of at least twenty percent of the client records for children admitted to the program at the time of the review.

(e) The Department or delegate shall notify an applicant, in writing, of the Department's or delegate's decision to approve or deny the application within forty-five (45) calendar days of receiving the complete application.

(f) The Department or delegate may process an application pursuant to section 21.

(g) Except when an application is denied for being incomplete, an applicant shall have the right to notice and review pursuant to Section 31 when the Department or delegate has denied an application for STRTP Mental Health Program Approval.

SECTION 21. PROVISIONAL APPROVALS

(a) The Department or delegate may issue a provisional mental health program approval to an applicant that is a group home certified for rate classification levels of 13 or 14 without conducting an onsite review, if the submitted application and supporting documentation demonstrate that the applicant meets the requirements of these regulations and applicable statutes. The provisional approval period shall not exceed one year. The Department or delegate shall conduct an onsite review prior to issuing a renewal pursuant to Section 24. This subdivision shall be repealed and no longer be in effect as of January 1, 2020.

(b) The Department or delegate may, in its discretion, issue one provisional approval for a period of less than one year to an applicant submitting its initial application for STRTP mental health program approval. The application process shall be the same as Section 20.

Section 22. Duration of STRTP Mental Health Program Approval

Mental health program approvals shall be for one year from the date of issuance, except for provisional approvals issued pursuant to Section 21.

Section 23. Requirement to Post STRTP Mental Health Program Approval

The STRTP Mental Health Program Approval or a true and correct copy thereof shall be posted in a conspicuous location in the STRTP.

Section 24. Application for Renewal of STRTP Mental Health Program Approval

(a) The Department or delegate shall conduct a yearly onsite review to determine whether the STRTP continues to meet all requirements of these regulations and related statutes. This onsite review shall include a review of program compliance and a review of the client records of at least twenty percent of children residing in the STRTP on the day of the onsite review.

(b) If the results of this onsite review indicate that the STRTP continues to meet the requirements of these regulations and related statutes, the STRTP Mental Health Program Approval may be renewed.

(c) The Department or delegate shall notify the STRTP, in writing of the renewal or non-renewal with an explanation of the reasons for non-renewal within sixty (60) calendar days of the onsite review. The STRTP that received notice of non-renewal may request notice and review pursuant to Section 31.

(d) The Department or delegate shall notify the Department of Social Services of the renewal or non-renewal of the STRTP Mental Health Program Approval of each STRTP.

(e) Pending the issuance of a renewal pursuant to subdivision (a) or the notification of non-renewal pursuant to subdivision (c), the current STRTP Mental Health Program Approval shall remain in effect.

Section 25. Delegation of Approval Task

(a) If the Department has delegated the approval task to the county Mental Health Plan,

the county Mental Health Plan is deemed the delegate for all purposes related to STRTPs within its borders and is subject to the delegation regulations for STRTPs.

(1) Delegates shall process all applications for STRTP Mental Health Program Approval from licensed STRTPs within its county or counties' borders whether or not the delegate has a contract with the STRTP to serve the delegate's Medi-Cal beneficiaries.

(2) A county Mental Health Plan shall not have delegate authority over STRTP mental health programs located outside of its county or counties' borders.

(b) The delegate shall oversee and enforce compliance with all STRTP mental health program standards, except through the imposition of monetary penalties. The Department does not delegate its authority to impose monetary penalties. Delegates shall refer all matters that may warrant imposition of monetary penalties to the Department within thirty (30) days of identification.

(c) The delegate shall comply with the following requirements:

(1) Within five (5) business days of issuance, send via certified mail or email to the Department and to the Department of Social Services, a copy of the STRTP Mental Health Program Approval, denial, renewal, non-renewal, probation, suspension or revocation of any approval, on-site review report, notice of noncompliance, imposition of sanctions, and flexibility decisions.

(2) Submit documents or any other official communication upon a request by the Department.

(3) Maintain a file for each STRTP. The file shall contain all documents submitted to the delegate by the STRTP pursuant to these regulations. The file shall contain all documents issued to the STRTP by the delegate pursuant to these regulations. The file shall contain all documents from the Department with regard to the STRTP. The delegate shall:

(A) Retain a complete file for all facilities with an active STRTP Mental Health Program Approval.

(B) Retain complete files for denied applications and closed STRTPs for a period of ten (10) years.

(4) The delegate shall consult telephonically or in writing with the Department prior to denying an application or imposing sanctions pursuant to Section 29.

(5) Upon request, the delegate shall provide the Department with a current tracking log of all approved, denied, revoked, suspended, and probationary STRTP mental health programs within thirty (30) calendar days.

(d) The Department may inspect or audit the delegate at any time to ensure compliance with state and federal laws and regulations applicable to the STRTP mental health program. The delegate shall submit any records, documents, and

information requested by the Department within thirty (30) days of the request.

(e) The Department shall have authority at any time to override a decision by a delegate, provide technical assistance, and direct a particular delegate action consistent with policy guidance, regulations, and statutes.

(1) The delegate may request technical assistance and direction from the Department at any time.

(2) In delegate counties, the STRTP shall direct questions to the delegate. When responding, the delegate shall provide the answer in writing.

(f) All counties shall satisfy inquiries of applicants regarding whether the approval task has been delegated or remains with the Department. The Department shall maintain a publicly available list of delegate counties on its website.

(g) If a county that is not a delegate receives a STRTP Mental Health Program Approval application, the county shall immediately notify the STRTP that it is not a delegate, return the application to the applicant, and refer the applicant to the Department.

SECTION 26. OVERSIGHT

(a) At any time, the Department and/or delegate may conduct onsite reviews, with or without notice, for the purpose of determining that the STRTP is in compliance with the provisions of these regulations, including investigation of complaints. The STRTP must preserve and provide documentary evidence that it is meeting the requirements set forth in these regulations, which shall include, but not be limited to, employee records of attendance, employee qualifications, in-service education records, policies and procedures, child client records, any video and audio surveillance, and written agreements with any providers of mental health services. This onsite review shall include a review of at least twenty percent of the client records for children admitted to the program at the time of the review.

(b) The Department or delegate, whichever conducts the onsite review, shall prepare a written on-site review report and identify any corrective actions that are required, and shall provide the STRTP with a copy.

(c) The STRTP shall make space available onsite for the Department or delegate to conduct interviews of children and staff and examine records.

SECTION 27. COMPLAINTS

(a) Any person may submit a complaint to the Department or delegate concerning the STRTP mental health program of a STRTP. The Department or delegate shall investigate the complaint to determine whether the STRTP is out of compliance with the requirements of these regulations or related statutes.

(b) The Department of Social Services shall report to the Department and delegate when there is reasonable cause to believe that a STRTP is not in compliance with these regulations or related statutes.

(c) A complaint may be made to the Department or delegate either orally or in writing.

(d) The delegate shall provide the Department with a copy of any written complaint related to the STRTP mental health program within twenty-four (24) hours of receipt, excluding weekends and holidays. The delegate shall provide the Department with a written summary of any oral complaint related to the STRTP mental health program within twenty-four (24) hours of receipt, excluding weekends and holidays. For any complaint received on a weekend or holiday, the delegate shall provide the Department with a copy or written summary on the next business day.

SECTION 28. NONCOMPLIANCE

(a) When the Department or delegate determines that a STRTP is not in compliance with provisions of these regulations or the provisions of its approved STRTP Mental Health Program Statement, the Department or delegate shall issue a notice of noncompliance. This notice shall include details of the noncompliance, a date by which the STRTP must have the noncompliance corrected, and a requirement that the STRTP submit and comply with a corrective action plan, which is subject to the Department's or delegate's approval.

(b) The date for correcting the noncompliance shall be:

(1) Twenty-four (24) hours or less from the date the Department or delegate discovered the noncompliance if there is an immediate threat to the physical health, mental health, or safety of the children and youth.

(2) No more than thirty (30) calendar days following issuance of the notice of noncompliance, unless the Department or delegate determines that the deficiency cannot be completely corrected in thirty (30) calendar days.

(c) If the Department or delegate does not approve the STRTP's corrective action plan, the Department or the delegate may require the STRTP to comply with a specific corrective action and timeline for completion.

(d) The Department or delegate may place a STRTP on probation for a period of not less than thirty (30) or more than sixty (60) calendar days as determined by the Department or delegate. When a STRTP is placed on probation, the Department or delegate may increase monitoring, which may include requiring frequent submissions of documentation demonstrating compliance with these regulations and conducting more frequent onsite reviews.

(e) The Department may impose monetary penalties not less than fifty dollars ($50) nor more than one hundred dollars ($100) multiplied by the licensed bed capacity, per

day, for each violation. However, the monetary penalties shall not exceed three thousand dollars ($3,000) per day. A STRTP that is assessed a monetary penalty and repeats the noncompliance, may be subject to immediate suspension or revocation of its STRTP mental health program approval until the noncompliance is corrected.

Section 29. Revocation or Suspension of STRTP Mental Health Program Approval if License is Challenged, Expired, or Revoked

(a) The Department or the delegate may suspend or revoke the approval of a STRTP mental health program for noncompliance with a law applicable to the STRTP mental health program. The Department or delegate may suspend a STRTP Mental Health Program Approval whenever an allegation or action has been instituted for removal of the STRTP's licensure.

(b) The Department or delegate shall revoke the STRTP Mental Health Program Approval when licensure has expired or has been revoked. Revocation made pursuant to this section shall not be subject to Section 31 notice and review procedures.

Section 30. Written Notice of Action to Department of Social Services

The Department or delegate shall within fifteen (15) calendar days provide the Department of Social Services written notice of any revocation, suspension, probation, or non-renewal of a STRTP Mental Health Program Approval.

Section 31. Notice and Review Procedures

(a) When the Department or a delegate takes an action pursuant to section 28 and subdivision (a) of section 29, denies, or does not renew the STRTP Mental Health Program Approval of a STRTP, the Department or delegate shall provide written notice of the action by certified mail. The notice shall include a statement setting forth the reasons for the action.

(b) A STRTP may request review of an action specified in subdivision (a) by sending a written request for review by certified mail to the Department or delegate if the approval task has been delegated. A request for review must be postmarked no later than fifteen (15) calendar days after the date the Department or delegate sends the notification required by subdivision (a).

(c) A STRTP requesting review in accordance with this section shall be responsible for submitting, in writing, all relevant documents, information, and arguments which the STRTP wishes the Department or delegate to consider. The documents, information, and arguments shall be postmarked no later than thirty (30) calendar days after the Department or delegate sends the notice required in subdivision (a).

(d) If the Department or delegate deems clarification or additional information is

necessary to complete the review, it may request further written submissions from the STRTP.

(e) A decision shall become final when the Department or delegate sends the decision to the applicant or STRTP by certified mail.

SECTION 32. PROGRAM FLEXIBILITY REQUIREMENTS AND PROCEDURES

(a) All STRTPs shall comply with the requirements of these regulations. A STRTP shall only request STRTP mental health program flexibility for subdivision (a) of Section 16 and subdivision (a) of Section 17.

(b) To request program flexibility, the STRTP shall submit a letter in writing with supporting documentation to the Department or delegate. If the Department has delegated approval authority, the STRTP shall submit the letter and supporting documentation to the delegate and a copy to the Department. The letter shall identify the flexibility requested, the regulation authorizingflexibility, and the reasons for the program flexibility request.

(c) The Department or the delegate may require additional information or documents.

(d) To reach a decision, the Department or delegate may consider the reasons for the request, current or prior history of program flexibility, the STRTP's census, experience and education of staff, frequency of deficiencies, severity of deficiencies, as well as any other relevant considerations, including the mental health diagnosis, acuity, and needs of the children in the program.

(e) The Department shall decide program flexibility requests unless the Department has delegated the approval task to the county Mental Health Plan. If the Department has delegated the approval task to the county Mental Health Plan, the delegate shall decide the request for program flexibility in compliance with this section, the authorizing regulation, and the specific additional requirements in section 33.

(f) If the Department or delegate approves the program flexibility request, that approval shall be in writing. The Department or the delegate may approve a flexibility request for the term of the STRTP Mental Health Program Approval or for a shorter duration. In granting a flexibility request, the Department or the delegate shall impose any additional requirements it deems necessary to ensure safety and to ensure that medically necessary mental health services are provided to children consistent with their individual needs. These additional requirements will be applicable during the time the flexibility request is approved. The additional requirements shall be written, measurable, and enforceable. The Department or delegate's decision to approve or deny the flexibility request is effective the date it is signed. The decision is final and is not subject to notice and review.

(g) A STRTP shall post in a conspicuous location at the STRTP any approval received from

the Department or delegate granted under this section, or a true and correct copy thereof.

(h) A STRTP that has received flexibility approval shall comply with all conditions specified by the Department or delegate.

(i) The Department or delegate may suspend or revoke an approved flexibility request at any time. Suspension and revocation are final and are not subject to notice and review.

(j) The Department has ultimate authority to revoke, suspend, or override a delegate's program flexibility approval at any time. The Department's decision is effective the date it is signed. The decision is final and is not subject to notice and review.

(k) The Department's or delegate's approval of the flexibility request shall not be construed to exempt a provider of Medi-Cal services from compliance with applicable state and federal laws and regulations for Medi-Cal reimbursement.

SECTION 33. DELEGATE PROGRAM FLEXIBILITY DETERMINATIONS - SPECIFIC ADDITIONAL REQUIREMENTS

(a) A delegate shall only approve a request for flexibility if it is specifically authorized in the regulation(s) for which the STRTP is seeking flexibility.

(b) A delegate's approval of the flexibility request shall be in writing and include any additional requirements the delegate has deemed necessary, the term of the flexibility request approval, and the following minimum assurances:

(1) The delegate has verified that the STRTP Mental Health Program Approval is in good standing and there are no unresolved incidents of non- compliance, pending revocations, pending suspensions, pending probation, unpaid monetary penalties, or incomplete corrective actions.

(2) The delegate has verified that flexibility is specifically permitted in the regulation(s) for which flexibility is requested and is not a licensing requirement or other mandatory requirement per state statute or federal law.

(3) The delegate has verified that the requested flexibility provides equal or better safeguards than the STRTP Mental Health Program Approval regulations to ensure that medically necessary mental health treatment services are provided to children consistent with individual needs.

(4) The delegate has verified that the requested flexibility will not reduce safety or pose an increased risk of harm to children who reside or will reside in the STRTP.

(5) The delegate has verified that the requested flexibility is or would be consistent with other flexibility requests granted by the delegate and the

Department.

(6) The delegate has verified that the requested flexibility is consistent with the intent of the STRTP Mental Health Program Approval regulations.

(7) The delegate has verified that the requested flexibility will not conflict with other STRTP Mental Health Program Approval regulations.

(8) The delegate has verified either of the following:

(A) No additional requirements are necessary to ensure children's safety nor to ensure that medically necessary mental health treatment services are provided to children consistent with their individual needs; or

(B) Additional requirements are necessary to ensure children's safety or to ensure that medically necessary mental health treatment services are provided to children consistent with their individual needs and the delegate has imposed these additional requirements in its written approval.

(c) The delegate shall provide a copy of its approval and assurances, denial, and suspension or revocation of a flexibility request to the Department and to the STRTP that has requested flexibility.

(d) If the delegate is unable to verify that the flexibility will be safe and consistent with the intent of these regulations and therefore cannot provide the required assurances, the delegate shall deny the flexibility request. The delegate shall issue a written denial of a flexibility request that includes the basis for the denial and may include program recommendations. The delegate's denial is effective the date it is signed by the delegate and the delegate shall send a copy of the written denial to the Department and to the STRTP that has requested flexibility.

(e) If the delegate determines it is unclear whether the program flexibility request should be approved or denied, the delegate may deny the request or may submit the program flexibility request and all supporting documentation to the Department for the Department to make a final determination. The Department shall issue a written decision to approve or deny the program flexibility to the delegate and the STRTP that has requested flexibility. The Department's decision is effective the date the Department signs the decision. The decision is final, and is not subject to notice and review.

SECTION 34. RECORD OF COMPLIANCE

The STRTP shall keep a record, including written documentation, of its compliance with regulations and statutes applicable to the STRTP mental health program. The STRTP shall keep the written documentation and other records onsite.