

CLINICAL RECORD DOCUMENTATION STANDARDS

This policy section defines the procedures and minimum standards for documentation of Medicare/OHC/Medi-Cal Specialty Mental Health Services at any site providing those services within Alameda County Behavioral Health Care Services and its Behavioral Health Plan's Provider Network.



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CONTENTS

Mental Health Policy & Documentation Standards

POLICY STATEMENT: MENTAL HEALTH

All service providers within the Alameda County Mental Health Services system shall follow the Clinical Record Documentation Standards Policy. This includes providers employed by BHCS and all contracted providers. Service providers may develop additional policies in order to adapt these standards to their specific needs. If variance from this policy is needed, approval must be obtained from the Quality Assurance Administrator.

PROCEDURE

This Section of the Quality Assurance Manual contains information about basic required chart management, informing materials, and the minimum requirements for clinical documentation. Most requirements are for all types of providers, as indicated; differences and exceptions for certain types of providers are so noted.

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Definitions of Commonly Used Terms

Specialty Mental Health Services: This is the broad umbrella of Medi-Cal services directed at the mental health needs of Medi-Cal beneficiaries. Specialty Mental Health Services include the smaller umbrella of Mental Health Services. ^(CCR09)

- **Mental Health Services:** Assessment, Plan Development, Psychotherapy, Rehabilitation, and Collateral. ^(CCR08)
- Medication Support
- Case Management/Brokerage
- Psychiatrist & Psychologist Services
- EPSDT Supplemental Specialty Mental Health Services
- Day Treatment Intensive & Day Treatment Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment Services & Crisis Residential Treatment Services
- Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services (PHF), and Psychiatric Nursing Facility Services

(Mental Health Rehabilitation Centers [MHRC's] follow the documentation standards established in the California Code of Regulations, Title 9, Chapter 3.5, Section 786.15.)
^(CCR02)

Long Term Care Beneficiary: A beneficiary who receives case management and/or multidisciplinary mental health services, for a period of 60 days or more. Case Management is defined as a system in which long term, high cost, and high-risk and/or complex beneficiary mental health needs are identified; monitored; and addressed, in order to maximize the mental health status of the beneficiary, utilizing available resources and multidisciplinary mental health providers.

This Policy addresses the documentation standards for all Specialty Mental Health Services except Psychiatric Inpatient, PHF and Nursing Facility Services.

Types of Providers: The type of provider contract determines the documentation standards and method of claiming for reimbursement of services. Each provider's contract specifies which specialty mental health services they may claim; *not all provider contracts authorize claiming for all possible services.*

Master Contract Providers (bill via INSYST or Clinician's Gateway):

- County-operated service providers of outpatient services (includes BHCS-identified Brief Service Programs, e.g., Crisis, Assessment Only)
- Organizational providers of outpatient services (CBO's)
- Full Service Partnerships (FSP's)
- HPAC providers

A Word about Terminology: ACBHCS providers and administrative offices have the intention to be inclusive in the language used to refer to beneficiaries of the Mental Health Plan (e.g., consumers, clients, families, children, youth, transition-age youth, etc.). Depending on the language used, it is possible that some beneficiaries could feel excluded or secondary in

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importance. While it is the goal of ACBHCS to honor each individual’s desire to be identified as they wish, this Section of the Quality Assurance Manual is bound by regulatory language that uses “beneficiary” and “client” in reference to documentation standards. Therefore, in the interest of clarity, inclusion, and consistency with regulatory language, all beneficiaries will be referred to as “clients” in this Section.

General Management of Clinical Records

(CFR2) (CC1) (CC2) (HS1) (CalOHI1) (DMHcontract2) (CCR23)

Applies to All Provider Contracts

For the purposes of these documentation standards, charts containing documentation of mental health services are referred to as Clinical Records or Records.

General Record Maintenance:

Per BHCS, the “best practices” outlined below should be followed:

- Records should be organized and divided into sections according to a consistent standard allowing for ease of location and referencing. (BHCSQA09)
- Records should be sequential and date ordered. (BHCSQA09)
- Records should be fastened together to avoid loss or being misplaced. No loose papers or sticky-sheets in the chart (may staple). (BHCSQA09)
- Progress Notes must be filed in clinical records. Psychotherapy notes (process notes) should be kept separately. (CalOHI1)
- All entries must be legible (including signatures). (See “Clinical Documentation Standards” section, “Signature Requirements.”) (CCR30) (DMHcontract3)
- Use only ink (black or blue recommended). (BHCSQA09)
- Every page must have some form of client identification (name or identification number, etc.). (BHCSQA09)
- Do not use names of other clients in the record (may use initials or similar method of preserving other clients’ identities). (BHCSQA09)
- Do not “rubber stamp” your record entries; tailor wording to the changing needs of each individual. (BHCSQA09)
- Correcting errors: Do not use correction tape/fluid, scribble over, etc. Instead, draw a single line through the error & initial, then enter correct material. (BHCSQA09)
 - Only original authors may make alterations.
 - Reviewers or supervisors may not edit original authors but may supply an addendum with dated signature.
- Acronyms & Abbreviations: Use only universal and County-designated acronyms and abbreviations. A list is available at www.acbhcs.org/providers under the QA tab. (BHCSQA09)

Record Storage:

Clinical records contain Protected Health Information (PHI) covered by both state and federal confidentiality laws. Providers are required to safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons. (CFR1) (CFR2) (CC1)

Alameda County BHCS requires that clinical records be stored in a “double locked” manner (e.g., in a locked filing cabinet located within a locked office). If records must be transported,

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maintain the “double locked” and safeguarding requirement (e.g., transported in a locked box in a locked vehicle trunk and not left in an unattended vehicle). Electronic Health Records (EHR) must be stored in a password-protected computer located within a locked room. ^(BHCSQA09)

The following record storage procedures are consistent with good clinical practice: ^{(HS2) (CC2) (CCR31) (CFR1) (CFR2)}

- A controlled record check-out or retrieval system for access, accountability and tracking.
- Safe and confidential retrieval system for records that may be stored off-site or archived.
- Secure filing system (both physical plant and electronic safeguards used, when applicable). (See above regarding “double locked” storage.)

Record Retention:

Clinical records must be preserved for a minimum of seven (7) years following discharge/termination of the client from services, with the following exceptions: ^{(HS3) (CCR31)}

- The records of un-emancipated minors must be kept for at least one (1) year after such minor has reached age 18, and in any case, not less than seven (7) years.
- For psychologists: Clinical records must be kept for seven (7) years from the client’s discharge/termination date; in the case of a minor, seven (7) years after the minor reaches age 18 ^(DMH02)
- Third party: If a provider uses a third party to perform work related to their BHCS contract, the provider must require the third party to follow these same standards. ^(BHCSQA09)
- Audit situations: Records shall be retained beyond the seven (7) year period if an audit involving those records is pending, until the audit findings are resolved. The obligation to insure the maintenance of records beyond the initial seven (7) year period exists only if the MHP notifies Contractor of the commencement of an audit prior to the expiration of the seven (7) year period. ^(BHCSQA09)
- Provider out of business: In the event a provider goes out of business or no longer provides mental health services, the provider is still obligated to make arrangements that will assure the accessibility, confidentiality, maintenance, and preservation of clinical records for the minimum retention time as described above. ^{(CCR29) (HS3)}

Record Destruction:

Clinical records are to be destroyed in a manner to preserve and assure client confidentiality. ^(CC1)

Medical Necessity: Providing the Rationale for Services

^{(CCR16) (CCR20)}

Applies to All Provider Contracts

The Mental Health Plan requires substantiation of the need for mental health services in order for those services to qualify for reimbursement. This is known as establishing Medical Necessity (MN). ^(CCR16)

All providers use the following documents to document medical necessity for services: Initial Assessment, Initial/Annual Client Plan (or Consumer Plan, Life Plan, Treatment Plan, etc.), and 6-Month Review/Update to the Client Plan.

Relevance of Medical Necessity for Documentation

- Initial assessment documentation establishes Medical Necessity (MN).*
- Initial client plans are based on the Initial Assessment. A licensed signature on the Plan is attestation that MN is met.*
- Client plans serve as progress reports and support ongoing MN**.
- Progress Notes must contain evidence that the services claimed for reimbursement meet Medical Necessity. Claim submission is attestation that this requirement is met.

**If services other than for the purpose of assessment are provided prior to completion of the initial assessment document, the Medical Necessity rationale for those services must be provided in the corresponding progress notes.*

*** In the gap of time that may exist between the Initial Assessment's completion and while the Initial Client Plan is being developed, mental health services may be provided as long as the medical necessity for services is clearly identified in the Initial Assessment. If a clinical issue arises that is not identified in the Initial Assessment, each Progress Note addressing that issue must evidence medical necessity.*

Medical Necessity is determined by the following factors:

- The client has an “included” DSM or ICD-9 (current editions) diagnosis that is substantiated by chart documentation.) ^(CCR17)
 - A client's excluded diagnosis may be noted, but there must be an “included” diagnosis that is a primary focus of treatment. (An “excluded” diagnosis may not be noted as primary.)
 - Identify the DSM diagnostic criteria for each diagnosis that is a focus of treatment.

- As a result of the included diagnosis, it must be documented that the client meets at least one of the following criteria: ^(CCR18)
 - A significant impairment in an important area(s) of life functioning.
 - A probability of significant deterioration in an important area of life functioning.
 - A probability that the child will not progress developmentally as individually appropriate.
 - For full-scope M-C beneficiaries under age 21, a condition as a result of the included diagnosis that can be corrected or ameliorated with mental health services.

- Identify how the proposed service intervention(s) meets both of the following criteria: ^(CCR19)
 - The focus of the proposed intervention(s) is to address the condition identified in No. 2. (a-c) above; or for full-scope M-C beneficiaries under age 21, a condition identified in No. 2 (d) above.
 - The expectation that the proposed intervention(s) will do at least one of the following:
 - Significantly diminish the impairment
 - Prevent significant deterioration in an important area of life functioning
 - Allow the child to progress developmentally as appropriate
 - For full scope M-C beneficiaries under age 21, to correct or ameliorate the condition.

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- Documentation must support both of the following: ^(CCR19)
 - That the mental health condition could not be treated by lower level of care.
 - That the mental health condition would not be responsive to physical health care treatment.

- EPSDT ONLY - Medical Necessity Criteria ^(CCR20)

If a youth does not meet the functional impairment criteria for MN, the services provided **MUST** correct or ameliorate at least one of the following:

 - A documented mental illness or condition, and/or
 - The documented risk of developing a mental illness or condition, or of not progressing developmentally as expected.

(Note: EPSDT clients must still have an included DSM diagnosis that is a focus of treatment.)

Clinical Documentation Standards for Specialty Mental Health Services
[Citations noted under each subject.]

Applies to All Providers, per Type of Contract/Service

This section describes signature requirements for all providers, as noted. It also describes the required contents of the following clinical documents, per type of provider or service, as noted below:

All providers:

- 1. Initial and Annual Assessments**
- 2. Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.)**
- 3. Progress Notes**
- 4. Discharge/Termination/Transition Documentation**

Master Contract Providers (except FSP's):

- 5. Community Functioning Evaluation (or approved equivalent)**

TBS providers:

- 6. Therapeutic Behavioral Services (TBS): All Documentation**

1. Signature Requirements: All providers ^(DMHcontract2)

Applies to All Providers

Exceptions: TBS Providers (See #6)

- **Complete Signature:** Every clinical document must be followed by a “complete signature,” which includes the writer's signature, appropriate credential and date. ^(BHCSQA09)
- **Legibility:** Signatures should be legible: If signatures are illegible, the associated document may be subject to disallowance. Therefore, the MHP recommends that the name and appropriate credential (see below) be typed under signature lines. Providers

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may also have an administrative “signature page” containing staff signatures with their typed name and credential. ^{(CCR30) (DMHcontract3)}

- **Credentials:** Every provider signature must also include the provider’s credential that allows them to bill Medi-Cal: MD, DO, NP, CNS, PA, RN, LVN, Psych Tech; PhD-L or PsyD-L (licensed); PhD-W or PsyD-W (waivered); MFT, LCSW, LPCC, LPCC-F (includes family counseling), MFT-Intern, ASW, PCC-Intern; MHRS; Trainee (Student in Mental Health: MA/MS/MSW/PhD/PsyD program); or Adjunct staff (peer or family provider).
- **Dates:** All signatures require a date (00/00/00). Exception: If a Progress Note date of service and date the note was written are the same, the date of service is sufficient. ^(BHCSQA09)
- **Late entries:** *It is the expectation of the MHP that all entries be written within 1 working day.* Supervisory sign off must happen within 5 working days. If an entry is late, provide complete signature using the date the late entry was written, not the date of service. (See above and “Progress Notes” below for more information.) ^(BHCSQA09)
- **Completion Line:** Nothing may be added within a document after it is signed. To indicate the end of an entry, draw a line up to the signature (n/a for electronic signatures). If additional information must be added, write an addendum. ^(BHCSQA09)
- **Addendums:** Include complete signature (see above). ^(BHCSQA09)

2. Psychiatric Diagnostic Evals (Initial and Annual Assessments) ^(DMHcontract2)

Applies to All Providers

Exception: TBS Providers (See #6)

For providers of Medication Support Services, documentation standards for Assessments are forthcoming.

Definition: Assessments are a collection of information and clinical analysis of the history and the current status of a client’s mental, emotional and/or behavioral health. Documentation must support the Medical Necessity criteria defined above if the Initial Assessment determines that ongoing mental health services will be provided. ^(CCR04)

Assessment information must be in either a specific document or section of the clinical record, per MHP requirements. ^(BHCSQA09)

Master Contract Providers - County-Operated: must use BHCS Initial Assessment templates.

Master Contract Providers - CBO: Per the MHP requirements, organizational providers may develop their own Initial Assessment templates, as long as the BHCS minimum required content areas are addressed in the document. Note: The QA Office is unable to review and/or approve templates created by providers. ^(BHCSQA09)

❖ ***Timeliness & Frequency of Initial and Annual Assessments, per Type of Provider*** ^(BHCSQA09)

Initial Assessment

All Providers: Per the MHP requirements, a completed and filed Initial Assessment is required within 30 days of the opening episode date.

- If it is not possible to address all required elements due to issues of client participation or inability to obtain a full history, but medical necessity has been established, the Assessment should be completed within 30 days, with notations of when addendums with missing information are expected.
- If it is not possible to determine medical necessity within 30 days, the need for more time must be documented in a progress note and the deadline may be extended to 60 days.
- If the case is closed before 30 days, best practice is to complete the Initial Assessment as much as possible.
- Progress Notes for every billed Assessment service must be in the clinical record.

Exceptions:

Full Service Partnership Programs: Per the MHP requirements, a completed and filed Initial Assessment is due within 60 days of the opening episode date.

- If it is not possible to address all required elements due to issues of client participation or inability to obtain a full history, but medical necessity has been established, the Assessment should be completed within 60 days, with notations of when addendums with missing information are expected.
- If the case is closed before 60 days, best practice is to complete the Initial Assessment as much as possible.
- Progress Notes for every billed service must be in the clinical record.

Time-Limited Programs: The due dates for a completed and filed Initial Assessment varies based upon program length. Consult with your agency's MHP contracts for these timeframes.

Annual Assessments

All Providers: Per MHP requirements, a completed and filed Assessment is now required on an annual basis. The Initial Assessment is required 30 days after the Episode Opening Date (EOD), therefore, the 2nd Assessment is due 11 months after the Initial Assessment by the EOD. Every Assessment after that would be due on a 12 month cycle. History can be carried forward from a previous assessment, but all other items must be updated and a new Assessment form is required.

All Providers: Assessments shall be updated, as necessary, via addendums to the document.

Re. Returning Clients: If a beneficiary's episode is closed but he/she returns to the provider for additional services within 12 months of an Assessment's completion, that Assessment may be updated with new information and signatures and re-used for the new episode opening. If the beneficiary returns for services after 12 months of an Assessment's completion, the Assessment must be re-done.

❖ **Minimum Requirements for Initial and Annual Assessment Content**

Applies to All Providers

Exceptions: TBS Providers (See #6)

For providers of Medication Support Services, documentation standards for Assessments are forthcoming.

The following areas must be included in the Initial and Annual Assessment, as appropriate, as part of a comprehensive clinical record. ^(DMHcontract1)

- a. **Identifying information:** Unless included in another document in the record (e.g., a face sheet or admission note), the Assessment must include: ^(BHCSQA09)
 - The date of initial contact and admission date
 - The client's name and contact information (including address/phone and emergency contact information)
 - The client's age, self-identified gender & ethnicity, and marital status
 - Information about significant others in the client's life including guardian/conservator or other legal representatives
 - The client's school and/or employment information
 - Other identifying information, as applicable
- b. **Communication needs** are assessed for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter services, etc.). If required, indicate whether it was/will be provided, and document any linkage of the client to culture-specific and/or linguistic services in the community. Providers are required to offer linguistic services and document the offer was made; if the client prefers a family member as interpreter, document that preference. Service-related correspondence with the client must be in their preferred language/format. ^(BHCSQA09)
- c. **Relevant physical health conditions** reported by the client or by other report must be prominently identified and updated, as appropriate. ^(DMHcontract1)
- d. **Presenting problem/referral reason & relevant conditions** affecting the client's physical health, mental health status and psychosocial conditions (e.g. living situation, daily activities, social support, etc.). Includes problem definitions by the client, significant others and referral sources, as relevant. ^(DMHcontract1)
- e. **Special status situations** that present a risk to the client or to others must be prominently documented and updated, as appropriate. If a risk situation is identified, the Client Plan must include how it is being managed. ^(DMHcontract1)
- f. **Client's strengths** in achieving anticipated treatment goals (e.g., client's skills and interests, family involvement and resources, community and social supports, etc.). ^(DMHcontract1)
- g. **Medications:**
 - List medications prescribed by an MD employed by the provider, including dose/frequency of each, date of initial prescriptions & refills. Documentation of informed consent for medications is required and may be located in a different section of the record. ^(DMHcontract1)
 - Medications prescribed by an outside MD must be listed as above, per client or MD's report; provide the MD's name and telephone number. ^(BHCSQA09)
- h. **Allergies & adverse reactions/sensitivities**, per client or by report, to any substances or items, or the lack thereof, must be noted in the Initial Assessment ^(DMHcontract1) and prominently noted on the front of the chart, or in agency identified data field in their Electronic Health Record (EHR). ^(BHCSQA09)

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- i. **Substance use**, past & last use/current: Alcohol, caffeine, nicotine, illicit substances, and prescribed & over-the-counter drugs. (DMHcontract1)
- j. **Mental health history**, including previous treatment dates and providers; therapeutic interventions and responses; sources of clinical data; relevant family information; and results of relevant lab tests and consultation reports (as applicable to scope of practice). (DMHcontract1)
- k. **Other history**: As relevant, include developmental history; social history; histories of employment/work, living situation, etc. (BHCSQA09)
- l. **For clients under age 18**: Include (or document efforts to obtain) pre-natal/ perinatal events, and complete developmental history (physical, intellectual, psychological, social & academic). (DMHcontract1)
- m. **Relevant Mental Status Examination**: Includes signs and symptoms relevant to determine diagnosis and plan of treatment. (DMHcontract1)
- n. **Five-axis diagnosis** from the most current DSM (or ICD), consistent with presenting problem, history, mental status examination, and/or other assessment data. (DMHcontract1)
 - At least one diagnosis must be the focus of treatment and must be on the “included” Medical Necessity criteria list. (CCR16)
 - Per the MHP requirements, only a licensed clinician may assign a psychiatric diagnosis. (A waived or registered intern may only assign a diagnosis if it is co-signed by a Licensed LPHA.) The name and license credential of the person who made the diagnosis must be noted within this item, even if from a referral source; the signature is not required within this item. (BHCSQA09)
- o. **Complete signature** of the person completing the Initial Assessment and the signature of a licensed or registered/waivered LPHA. (CCR21) (CCR11) (BP1) (CCR01)

Note: History can be carried forward from a previous assessment, but all other items must be updated and a new Assessment form is required.

Clinical Analysis: “Best practice” is to also provide a clinical analysis (aka clinical impression or formulation) of how the client’s mental health issues impact life functioning, based on the Assessment information. This may be part of the Assessment document or the Initial Client Plan. (BHCSQA09)

4. Medication Consents

Applies to All Providers

Exceptions: TBS Providers (See #6)

For providers of Medication Support Services, documentation standards for Client Plans are forthcoming.

Medication Consents: Informed consent is part and parcel to the values of BHCS and the desire for active collaboration with our clients. Medication consents are required. They are also a valuable tool to assist the medical practitioner and the client in education and communication about new medications.

- Must be done when a new medication is being prescribed.
- Must be filled out completely, including dose started and possible maximum dose.

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- Must be signed and dated by the client (unless the client is willing to take the medication but unwilling to sign. In this case, this should be documented in the space available.)
- Must be signed and dated by the prescribing medical practitioner.
- Must be legible.

5. Client Plans ^{(DMHcontract2) (CCR12)}

Applies to All Providers

Exceptions: TBS Providers (See #6)

For providers of Medication Support Services, documentation standards for Client Plans are forthcoming.

Definition: Client Plans (aka Consumer/Life/Treatment/Recovery/Care Plans, etc.) are plans for the provision of mental health services to clients who meet the Medical Necessity criteria. Services must address identified mental health barriers to goals/objectives. Client Plans are developed from the Initial Assessment must substantiate ongoing Medical Necessity and be consistent with the diagnosis/diagnoses that is the focus of mental health treatment. Client Plans must be maintained in a specific section of clinical records and must be clearly evident and identifiable, per the MHP. ^{(CCR05) (BHCSQA09)}

Strength-based and recovery/resiliency oriented treatment planning is strongly encouraged. ^(BHCSQA09)

The minimum required content areas of any Client Plan may not be left blank; instead, indicate the plan to complete those elements or indicate when they are not applicable. ^(BHCSQA09)

Master Contract Providers- County-Operated: must use BHCS Client Plan templates.

Master Contract Providers- CBO: Per the MHP requirements, Master Contract organizational providers may develop their own Client Plan templates as long as the BHCS minimum required content areas are addressed in the document. Note: The QA Office is unable to review and/or approve templates created by providers. ^(BHCSQA09)

❖ ***Timeliness & Frequency of Client Plans, applies to all providers except FSP & Time-Limited Programs***

Initial Client Plan:

A completed and filed Initial Client Plan is required within 60 days of the opening episode date. If the case is closed before 60 days, a completed Plan is not required. The Initial Client Plan may be completed before the deadline. ^(BHCSQA09)

- Until 11/1/10, the BHCS requirement was a 30-day deadline (higher than the DHCS standard of 60 days) and there was no need to count actual calendar days. However, providers must now adhere to the BHCS and DHCS 60-day deadline; therefore it is prudent to utilize the InSyst system prompt of the 60 day deadline that is sent automatically to providers. The following is an example of the 60 day count: An open episode date of 9/13/10 requires the Initial Client Plan to be completed by 11/11/10.

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- In the gap of time that may exist between the Initial Assessment's completion and while the Initial Client Plan is being developed, mental health services may be provided as long as the medical necessity for services is clearly identified in the Initial Assessment. If a clinical issue arises that is not identified in the Initial Assessment, each Progress Note addressing that issue must evidence medical necessity.
- **Time-Limited Programs:** The due dates for a completed Initial Client Plan vary for Time-limited programs. They are based upon program length. Consult with your agency's MHP contract for these timeframes.

Annual Client Plan:

A completed and filed Annual Client Plan is required. The cycle should be kept in sync with the Episode Opening Date (EOD). Initial Client Plans are due at 60 days. Therefore the 2nd Client Plan is due 10 months after the first Client Plan during the month prior to the EOD. Every Treatment Plan after that would be on a 12 month cycle (e.g., opened in March, so due every February); in other words, it must be completed in the month prior to the next authorization/utilization review period. If the case is closed before that month, a completed Plan is not required. (DMHcontract1) (BHCSQA09)

Providers MUST be attentive to the need to update changes in the treatment plan throughout the year. DHCS (and QA) will disallow notes if the treatment plan has not been updated to reflect new goals and events in the client's life. Examples of events requiring a change to the Client Plan include, but are not limited to, hospitalization, new thoughts or behaviors of self-harm or dangerousness to others, additions of new treatment modalities i.e. case management or groups. It would be expected that there would be a new MSE, new goals, interventions, etc.

In addition, internal Continuous Quality Review Team (CQRT) should be done at 60 days after the EOD. This ensures that the Assessment and the Treatment Plan have been thoroughly completed with all signatures, on time. If you skip this CQRT and only do it annually and one of these items is missing, the financial repercussions are heavy.

- Other Updates to the Client Plan:
 - HPAC: It is extremely important that a goal and progress towards referral back to the PCP be documented in the client plan.
- If unable to fully address each component of a Client Plan within the specified timeframe, the Plan must be finalized by the deadline date and indicate when the missing information will be added. (BHCSQA09)
- Note for Day Treatment Intensive Programs: Though these programs are authorized for services every 3 months, Client Plans follow the above schedule.

❖ ***Minimum Requirements for the Initial/Annual Client Plan and Updates***

Applies to All Providers

Exceptions: TBS Providers (See #6)

For providers of Medication Support Services, documentation standards for Client Plans are forthcoming.

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The following elements must be fully addressed in the Initial and Annual Client Plans, as appropriate, as part of the clinical record.

Client Plan Updates must provide updated information, as applicable, for each element.

- a. **Client's goals** (stated in own words, when possible) ^{(DMHcontract1) (BHCSQA09)}
- b. **Mental health goals/objectives** that are specific and observable or measurable, and that are linked to the Assessment's clinical analysis and diagnosis (i.e. must be related to mental health barriers to reaching client's goals). Provide estimated timeframes for attainment of goals/objective. ^{(DMHcontract1) (BHCSQA09)}

Note for Day Treatment (Intensive or Rehabilitation) and Minors in Group Home Programs: These Client Plans must identify the goal(s) that Day Treatment will assist the client to achieve, as well as the proposed duration of the Day Treatment Program. ^(DMH04)

- c. **Interventions and their focus** must be consistent with the mental health goals/objectives and must meet the medical necessity requirement that the proposed intervention(s) will have a positive impact on the identified impairments (Item 3.b. in the Medical Necessity section of this Policy). ^{(DMHcontract1) (BHCSQA09)}

Indicate:

- Service Interventions, which are the planned mental health services (e.g., Family Psychotherapy).
 - "Best practice" to also indicate Clinician Interventions, which are the provider's actions during services to support the client's progress toward goals/objectives (e.g., "Offer stress reduction techniques to reduce anxiety" or "Support client to express unresolved grief to reduce depression").
- d. **Duration and Frequency** of the service interventions. ^{(DMHcontract1) (BHCSQA09)}
 - e. **Key Assessment Items:** The following four key assessment items (included in the BHCS Client Plan template) shall be reviewed and updated every time the Client Plan is reviewed or renewed: 1) Diagnosis, 2) Risk situations, 3) Client strengths & resources, and 4) Special needs ^(BHCSQA09)
 - f. **Coordination of care:** If applicable, it is "best practice" to include an objective in the Client Plan regarding coordination of a client's care with other identified providers. ^(BHCSQA09) For minors receiving Therapeutic Behavioral Services, the Client Plan must indicate coordination of services with the TBS provider. ^(DMH03)
 - g. **Tentative Discharge Plan** (termination/transition plan). ^(BHCSQA09)
 - h. **"Complete Signature"** (see also "Clinical Documentation Standards" section, "Signature Requirements") or the electronic equivalent by at least one of the following: ^(CCR13)
 - Person providing the service(s).
 - If psychiatric medication is prescribed by an organizational provider's Psychiatrist, that Psychiatrist must also sign the Client Plan. ^(BHCSQA09)

If the above person providing the service(s) is not licensed or registered/waivered, a complete co-signature is required by at least one of the following:

- Physician
 - Licensed/registered/waivered psychologist
 - Licensed/registered social worker
 - Licensed/registered marriage and family therapist, or
 - Registered nurse
- i. **Evidence of the client's degree of participation and agreement** with the Client Plan must be addressed in the following ways: ^{(CCR14) (BHCSQA09)}
 - The client's (or legal representative's) dated signature on the Client Plan is required.

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- If the client (or legal representative) is unavailable or refuses to sign the Client Plan, the Plan must include the provider’s dated/initialed explanation of why the signature could not be obtained, or refer to a specific Progress Note that explains why. In either case, include evidence on the Plan or in Progress Notes of follow-up efforts to obtain the signature.
 - If the provider believes that including the client in treatment planning would be clinically contraindicated, the Plan must include the provider’s dated/initialed explanation or refer to a specific Progress Note that explains why, and the reason must be supported by the clinical record’s documentation.
- j. **A copy of the Client Plan** must be provided to the client (or legal representative) upon request and a statement to that effect must be either on the Plan or within informing materials signed by the client. ^{(DMHcontract1) (BHCSQA09)}

6. Progress Notes

Applies to All Providers, per Type of Service ^(DMHcontract2)

For providers billing Medicare, see “Special Situations: Progress Note Documentation Requirements” following this section.

Definition: Progress Notes are the evidence of a provider’s services to or on behalf of a client and relate to the client’s progress in treatment. Notes are filed in the clinical record and must contain the clinical details to support the medical necessity of each claimed service and its relevance to the Client Plan. ^(BHCSQA09)

In order to submit a service for reimbursement, there must be a complete and filed Progress Note for that service. Reimbursement submission is attestation that these criteria are met:

- Progress Notes must clearly relate to the mental health objectives & goals of the client as established in the Client Plan (versus, for example, a Progress Note that focuses on the mental health needs of a depressed mother in a family session, without addressing how her depression impacts the client/child’s mental health needs). ^(CCR23)
- Each Progress Note must “stand on its own” regarding Medical Necessity; identifying a clear link to the Client Plan helps meet this rule. ^(BHCSQA09)

❖ **Progress Notes vs. Psychotherapy/Process Notes** ^(CFR3)

Alameda County BHCS expects that all providers will understand the content difference between Progress Notes and Psychotherapy Notes (also known as Process Notes) and the differences in privacy protection as described below. If a provider chooses to write Psychotherapy Notes, they should maintain them in a separate file to protect the privacy of those notes.

Progress Notes, as noted generally above, relate to the client’s progress in treatment and include only the information required by the MHP (described later in this Progress Note section). Progress Notes become part of the clinical record, which may be requested by the client at any time.

Psychotherapy Notes are defined by CFR 45, Part 164.501 as: “...notes recorded (in any medium) by a health care provider who is a mental health professional documenting or

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analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.” (CFR4)

Examples of Psychotherapy Notes are a description of dream content, specific memories of child abuse, a clinician’s thought process about the client’s issues, a clinician’s personal feelings or counter-transference, etc.

Psychotherapy Notes differ from regular clinical records and receive special protection under HIPAA (CFR 45, Part 164.524) from other clinical records which may be exchanged between providers and the MHP without specific permission from the client. Physically integrating the excluded information and protected information into one document does not make the excluded information protected. (CFR5)

Psychotherapy Notes that are not filed separately from the clinical record, or that contain excluded information, no longer receive special protection under HIPAA. Those notes are subject to review by the MHP and would be seen by the client if he/she so requested. Psychotherapy Notes that are maintained separately and do not contain excluded information would only be disclosed via legal action or with the client’s release.

❖ ***Timeliness & Frequency of Progress Notes, per Type of Provider & Service***

Timeliness

Applies to All Providers

All providers must complete/finalize and sign their progress notes within three (3) working days of the Date of Service (DOS). This provides sufficient time for supervisors to review and sign notes which require the signature of a Licensed Practitioner of the Healing Arts (LPHA). ACBHCS considers this a standard clinical practice.

Exceptions:

- Inpatient Units: Notes must be entered every third day, nursing notes are required for each shift. (DMHcontract1) (BHCSQA09)
- The After-Hours Program progress notes will be completed, finalized and emailed to the supervisor and to the consumer’s primary case manager the next business day. (After hours P&P Adult SOC)

Late Entries: As a general rule, late progress notes are not billable. There may be some exceptions for staff illness/emergency with supervisor approval. If this should become a pattern (more than 5% of the notes fall into this pattern, either individually or as a program) than these notes will be disallowed by ACBHCS.

Progress notes written after three (3) working days must be documented as a “late entry” and signed the day of that entry. The beginning of the note must clearly identify itself as a late entry for the date of service (e.g. “Late entry for date of service.”). The note must be filed chronologically in the clinical record per the date it was written, not per the date of service. (BHCSQA09)

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Even though a late note is not billable, it is imperative that the note be written and in the record in a timely manner for clinical continuity.

The DOS and the Date of the Signature are required on all electronic and paper progress notes.

Late Notes are a Loss of Revenue and Must be Avoided.

Frequency: Applies per Type of Service

Every service contact for: Mental Health Services (see page 4)
Medication Support Service
Crisis Intervention
Case Management/Brokerage
Therapeutic Behavioral Services (TBS)

Daily for: Crisis Residential
Crisis Stabilization (one per 23-hr. period)
Day Treatment Intensive

Weekly for: Day Rehabilitation
Adult Residential
Day Treatment Intensive Weekly Summary (Must be co-signed by one of the following: Licensed/Registered Social Worker or Marriage & Family Therapist, Licensed/Waivered Psychologist, Physician, or Registered Nurse.)

❖ ***Minimum Requirements for Progress Note Contents***

Applies to All Providers

Exception: TBS Providers (See #6)

For providers billing Medicare, see “Special Situations: Progress Note Documentation Requirements” following this section.

Progress notes are documentation of services provided to or on behalf of clients. Services may or may not include direct contact with clients. *Not all providers are contracted to provide all of the services described in this section.* (BHCSQA09)

➤ ***Minimum requirements for Progress Notes:***

- a. ***Date of service*** (00/00/00). If the date of service and the date on which the note is written are the same, the date of service is sufficient. (See “Timeliness” section above, “Late Entries” paragraph.) (DMHcontract1)
- b. ***Service intervention*** or service code (e.g. psychotherapy, collateral, rehabilitation, medication support, etc.). (DMHcontract1)
- c. ***Location*** of the service provided. (BHCSQA09)
- d. ***Time*** spent providing a *billable* service. Varies per provider type, as below: (CCR26)
 - **Master Contract Providers:** Enter claims only by the minute. Add the length of service time to documentation time. Include time spent travelling to/from a location (other than home) to provide service. If travel time

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exceeds service time, indicate face-to-face time with the client, per Federal guidelines. ^(CCR26)

Exception: Providers of full-day, half-day or hourly services only claim for those portions of time (e.g., day treatment and crisis stabilization). These contracts do not provide for reimbursement of documentation or travel time.

- e. **Documentation of specific services/interventions:** Succinct description of clinically relevant information. ^{(BHCSQA09) (DMHcontract1)}

In general:

- When a service includes client contact, minimum requirements are description of the following, as applicable:
 - Reason for the contact.
 - Assessment of client’s current clinical presentation.
 - Relevant history.
 - Specific mental health/clinical interventions by provider, per type of service and scope of practice.
 - Client’s response to interventions.
 - Unresolved issues from previous contacts.
 - Plans, next steps, and/or clinical decisions. If little or no progress toward goals/objectives is being made, describe why. Include date of next planned contact and/or next clinician action. Indicate referrals made. Address any issues of risk.
 - When a service does not include client contact, minimum requirements are description of:
 - Specific interventions by provider, per type of service and scope of practice.
 - Unresolved issues from previous contacts, if applicable.
 - Address any issues of risk.
 - Plans, next steps, and/or clinical decisions. Include date of next planned contact, clinician actions and referrals made, if applicable.
- f. **Signature:** The person who provided the service must write and sign all notes; and co-signature, if required (see **Staff Qualifications for Service Delivery and Documentation** in this Policy). (See also “Clinical Documentation Standards” section, “Signature Requirements.”) ^(DMHcontract1)
- g. **HPAC:** It is extremely important that a goal and progress towards referral back to the PCP be documented in each progress note.

❖ **Special Situations: Progress Note Documentation Requirements** ^{(BHCSQA09) [Other citations noted at specific lines]}

Applies to All Providers

Medicare Billable Services: Progress notes must contain the minimum requirements above, *as well as the following* in order to be potentially billable to Medicare:

- Medicare CPT code of the service provided.
- Face-to-Face Time and Total time to provide the service.
- ICD-9 Diagnosis.
- Physical exam findings & Prior test results, if applicable.
- Patient’s progress: Response to treatment and changes in treatment, patient’s level of compliance, revision of diagnosis.

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- Plan of care: Treatments, medication, patient/family education, follow up instructions and discharge plan.

Group Services: A note must be written for each beneficiary client participating or represented in a therapy or rehabilitation group. These notes must include the minimum requirements above, as well as: ^(CCR25)

- Summary of the group’s behavioral health goals/purpose.
- Primary focus on the client’s group interaction & involvement, as relevant to their Client Plan.
- The total number of clients served (regardless of insurance plan/status).
- Total service time: The addition of group time to the time it takes to write progress notes for all clients served (regardless of insurance plan/status).

Crisis Services: Crisis services may be necessary when a client is in a mental health crisis requiring more intensive services to prevent the necessity of a higher level of care. Providers must document the need for such services in the clinical record. These services may be Crisis Therapy or Crisis Stabilization services, or an increased number/duration of services, per type of provider, as described below:

- Only Master Contract Provider’s may claim for Crisis Therapy services.
- Crisis Stabilization Programs are the only providers who may utilize Crisis Stabilization services.

➤ Progress Notes for crisis services must include the minimum requirements already described, as well as:

- Relevant clinical details leading to the crisis
- The identified crisis must be the client’s crisis, not a significant support person’s crisis. ^(CCR24)
- The urgency & immediacy of the situation must be clearly documented and describe each of the following medical necessity requirements: ^{(CCR06) (CCR10) (CCR15)}
 - How the crisis is related to a mental health condition
 - How the client is imminently or currently a danger to self or to others or is gravely disabled
 - Why the client either requires psychiatric inpatient hospitalization or psychiatric health facility services or that without timely intervention, why the client is highly likely to develop an immediate emergency psychiatric condition.
- Interventions done to decrease or eliminate or alleviate danger, reduce trauma and/or ameliorate the crisis.
- The aftercare safety plan.
- Collateral and community contacts that will participate in follow-up. ^{(CCR06) (CCR10) (CCR15)}

******Due to changes in the Medicare CPT codes, crisis “intervention” is now called “Crisis Therapy”. Who can provide the service has not changed despite the name change.

Documenting Missed Appointments: It is not permissible to submit a claim or charge clients for missed appointments; however, the missed appointment should be noted in the clinical record. The MHP suggests that providers follow up in a timely manner with clients when appointments are missed and document the findings. ^{(DMH05) (BHCSQA09)}

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Documenting Lockout Situations: If a mental health service is provided to a client in a lockout situation (when Medi-Cal is suspended or when a client is in a facility that provides “bundled” mental health services), a Progress Note for that service should still be written and noted to be “non-billable” so that the clinical record documents all services provided. *(CCR22) (CCR28) (DMH01)*

Note: If a minor client is residing in Juvenile Hall, services are not billable to Medi-Cal **unless** the client has been adjudicated (client is only awaiting placement in a group home or other non-institutional setting). Due to risk of disallowance, evidence of a placement order must be obtained and filed in the clinical record prior to providing services. A copy of the court ordered placement or another document indicating the date of adjudication will serve as proof. If that proof is not available prior to providing necessary services, the clinician may use a Progress Note to document a client’s adjudication status as reported by a reliable source who is identified in the Note. “Best practice” is to make ongoing efforts to obtain paper evidence of adjudication. *(BHCSQA09)*

Documenting the Creation of Clinical Documents (Master Contract Providers only): When claiming for the time spent writing clinical documents, a Progress Note must be written to substantiate the claim. Examples of such documents are: Assessment, Client Plan, a clinical summary to Social Services/court that is required for treatment purposes, psychological testing report, etc. A copy of the dated clinical document must be filed in the record as evidence of the activity. Progress Notes for these claimed activities must briefly describe the purpose/mental health relevance of creating the clinical document, the time it took to complete, and reference where the copy is located in the clinical record.

7. Discharge / Termination / Transition Documentation

Applies to All Providers (DMHcontract2)

Exception: TBS Providers (See #6)

Definitions: Discharge documentation describes the termination and/or transition of services. It provides closure for a service episode and referrals, as appropriate. There are two (2) types of clinical discharge documentation – one (1) of the following must be completed, per type of provider: *(BHCSQA09)*

Master Contract Providers:

- Discharge Note: A brief Progress Note to indicate that the case is closed, per the Minimum Requirements below. (This is considered an administrative activity and is not billable to Medi-Cal, *unless it is part of a final billable service with the client present.*)
- Discharge Summary: A comprehensive document that is **clinically necessary** in order to provide continuity of care for the next service provider, per the Minimum Requirements below. The MHP considers this to be a billable Plan Development service. *(BHCSQA09)*

❖ **Timeliness of Discharge Summary & Discharge Note**

Cases/episodes must be closed within 90 days (3 months) after the client's last service, unless the rationale for maintaining an open case is written in the clinical record. A quarterly

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written rationale must be provided if the case will be kept open during continued non-contact. ^(BHCSQA09)

Discharge documentation must be entered into the clinical record within one (1) working day of the discharge decision, but prior to closing the episode, and must be clearly labeled as either “Discharge Summary” or “Discharge Note”. ^(BHCSQA09)

❖ **Minimum Requirements**

Discharge Note: A Progress Note that includes brief documentation of the following: ^{(DMHcontract1) (BHCSQA09)}

- a. Reason for discharge/transfer.
- b. Date of discharge/transfer.
- c. Referrals made, if applicable.
- d. Follow-up care plan.

(Reminder for Master Contract providers: This is considered an administrative activity and is not billable to Medi-Cal, *unless it is part of a final billable service with the client present.*)

Discharge Summary: A document that must meet the requirements of a Discharge Note plus a summary of the following: ^(BHCSQA09)

- a. Treatment provided.
- b. Overall efficacy of interventions (including medications, their side effects/sensitivities and dosage schedules).
- c. Progress made toward the mental health goals/objectives.
- d. Clinical decisions/interventions:
 - Treatment planning recommendations for future services relevant to the final Client Plan; and
 - Referral(s) for aftercare services/community support services.

(Reminder for Master Contract providers: The MHP considers this a billable Plan Development service when **clinically necessary for continuity of care.**)

8. Community Functioning Evaluation or Equivalent

Applies to Master Contract Providers Only ^{(BHCS1) (BHCSQA09)}

Exception: Full Service Partnership programs & TBS providers

Definition: The Community Functioning Evaluation (CFE) is a tool developed by BHCS to quantify levels of functioning in common domains in the community for child and adult clients. (Child & Adult versions are available at www.acbhcs.org/providers under the QA tab.)

- ❖ **Timeliness:** The CFE is completed at the time of admission for services and annually thereafter. (It is best practice to complete the CFE within 30 days, and must be completed within 60 days, of the first date of service.)

School-Aged Children and Youth Version: This form must be completed and submitted by the clinician during the following periods in which a child/youth is receiving services: 1) at intake, 2) at the end of the school year (school-based services) or at 6 months review (community-based services), and 3) at discharge. If the client is discharged prior to 6 month review or the end of the school year, the form need only be completed at intake and discharge.

11. Therapeutic Behavioral Services (TBS) Documentation

Applies to TBS Providers Only ^(DMHcontract2) ^(CCR07) ^(BHCS2) ^(TBS1)

All providers of Therapeutic Behavioral Services (TBS) must comply with:

- The documentation standards noted as relevant to “All Providers” in this Policy document;
- The documentation standards noted in the “TBS Documentation Manual” published by the Department of Health Care Services (DHCS); **and**
- The BHCS items noted below:

In addition to the “TBS Manual” documentation standards, BHCS requires the following:

Evidence of Adjudication for Clients in Juvenile Detention Facilities:

Prior to providing TBS services to a client residing at Juvenile Hall but who is only there awaiting placement in a group home or other non-institutional setting (client has been adjudicated), evidence of adjudication must be obtained and filed in the clinical record. A copy of the court ordered placement or another document indicating the date of adjudication will serve as proof. If that proof is not available prior to providing billable TBS services, the clinician may use a Progress Note to document a client’s adjudicated status as reported by a reliable source who is identified in the Note. “Best practice” is to make ongoing efforts to obtain paper evidence of adjudication.

Initial Assessments:

- Initial Assessments for TBS are due within 30 days of the TBS episode opening date.
 - If it is not possible to complete the Assessment within 30 days, the need for more time must be documented in a progress note and the deadline may be extended to 60 days.
- Initial Assessments must address the following, in addition to TBS Documentation Manual description:
 - ***Communication needs*** are assessed for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter services, etc.). If required, indicate whether it was/will be provided, and document any linkage of the client to culture-specific and/or linguistic services in the community. Providers are required to offer linguistic services and document the offer was made; if the client prefers a family member as interpreter, document that preference. Service-related correspondence with the client must be in their preferred language/format. ^(BHCSQA09)
 - ***Allergies & adverse reactions/sensitivities***, per client or by report, to any substances or items (especially medications), or the lack thereof, must be noted in the Assessment ^(DMHcontract1) and prominently noted on the front of the chart. ^(BHCSQA09)

Client Plans:

- Initial Client Plans for TBS are due within 60 days of the episode opening date and must be completed and reviewed before services are authorized.
- Monthly Summaries of the Client Plan are required (function as Client Plan Updates).
- Interventions in the Client Plan and Monthly Summary must utilize the standard behavioral measurement known as Frequency, Intensity, and Duration (FID).

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Progress Notes:

- Progress Notes must also utilize the standard behavioral measurement known as Frequency, Intensity, and Duration (FID).

Staff Qualifications for Service Delivery and Documentation

(EPSDT1)

Applies to All Providers, per Type of Contract

Staff qualifications for delivery of Medi-Cal Specialty Mental Health Services are dictated in general by the following standards and scope of practice as defined by California Code of Regulations Title 9, and BHCS.

In addition, the “Guidelines for Scope of Practice” handout is available on the ACBHCS Provider Website as a resource.

****Providers must ensure, on an ongoing basis that all staff credentials are up-to-date and meet the criteria of the BHCS Credentialing Policy.**

Providers must also maintain documentation of all staff persons’ qualifications to support their level of service provision.

The following staff qualifications are described in this section:

Licensed Practitioner of the Healing Arts (LPHA)

Waivered/Registered LPHA

Graduate Student Intern/Trainee

Mental Health Rehabilitation Specialist (MHRS)

Adjunct Mental Health Staff & Other Staff Not Meeting Above Category Qualifications

Licensed Practitioner of the Healing Arts (LPHA)

A Licensed Practitioner of the Healing Arts (LPHA) possesses a valid California clinical licensure in one of the following professional categories:

- a. Medical Providers: Psychiatrist, NP, CNS, or PA
- b. Licensed Clinical Psychologist
- c. Licensed Clinical Social Worker
- d. Licensed Marriage and Family Therapist
- e. Licensed Professional Clinical Counselor

Approved Activities

- Can function as a “Head of Service” on agency application;
- Can authorize services as directed by BHCS;
- Can conduct comprehensive assessments and provide a diagnosis without co-signature. (Note re. RN Staff: In order to provide a diagnosis without co-signature, RN staff must possess a Masters degree in Psychiatric or Public Health Nursing *and* two years of nursing experience in a mental health setting. Additional post-baccalaureate nursing experience in a mental health setting may be substituted on a year-for-year basis for the educational requirement.)
- Can co-sign the work of other staff members, within their scope of practice; and
- Can provide all service categories within their scope of practice.

Waivered/Registered LPHA

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“Licensed waived staff” members includes the following:

- a. Registered Psychologists and Psychological Assistants:

Each psychologist candidate must obtain a waiver—even if he/she is registered with his/her licensing board.

In order to be eligible for such a waiver, the psychologist candidate must have successfully completed 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.

There is no statutory provision for extension of psychologist candidate waivers beyond the five-year limit.

Psychologist interns are individuals registered with the Board of Psychology as “Registered Psychologists” or “Registered Psychological Assistants” that possess an earned doctorate degree in psychology or educational psychology, or in education with specialization in counseling psychology or educational psychology. These interns must obtain supervised post-doctoral clinical hours towards licensure as a psychologist. The waiver for Registered Psychologists or Psychological Assistants is issued by DHCS and is granted up to five years from the initial date of registration with the Department. The waiver allows these staff to function as an LPHA while acquiring experience towards clinical licensure. Please see the Waiver Policy and Procedures in the QA Manual for further instructions.

Note: Registered Psychologist/Psychological Assistants are granted waiver by DHCS. Registered MFT & PCC Interns and ASWs are over seen and monitored by the hiring provider and the BBSE.

Approved Activities

Registered Psychologists, Psychological Assistants, Registered Marriage Family Therapist Interns, and Associate Social Workers may perform the following activities under the supervision of a licensed professional within their scope of practice:

- Can function as a LPHA staff for the time dictated by their respective Boards and DHCS;
- Cannot function as the Head of Service unless they meet qualifications dictated by the California Code of Regulations;
- Can authorize services as directed by BHCS;
- Can conduct/create comprehensive assessments and sign them. Per BHCS, may not provide a diagnosis without co-signature while under waiver (see Assessment section);
- Can create Client Plans but require co-signature by licensed LPHA;
- Can co-sign the work of other staff members within their scope of practice, except for other staff in their same category and graduate students performing psychotherapy;
- Can claim for all Mental Health Services, Unplanned Services, and Case Management within their scope of practice; and
- Cannot hold themselves out as independent practitioners and claim as a Fee-for-Service provider. (May be employed by a Fee-for-Service organization/agency with appropriate supervision, but may not be employed by an individual/group private practice provider.)

Graduate Student Intern/Trainee

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A “Graduate Student Intern/Trainee” is an individual participating in a field intern/trainee placement while enrolled in an accredited Masters in Social Work (MSW), Masters of Art (MA), Masters of Science (MS), or clinical/educational psychology doctorate degree program that will prepare the student for licensure within his/her professional field. There is no minimum experience required for graduate students.

Some graduate students may qualify as “Mental Health Rehabilitation Specialists,” if employed by the provider and if their experience permits. (Individuals enrolled in other degree programs may qualify as “Adjunct Mental Health Staff,” as described below.)

Approved Activities

Graduate students may perform the following activities under the supervision of a licensed or waived professional within their scope of practice:

- Can conduct/create comprehensive Assessments and Client Plans, but require a co-signature by a licensed LPHA;
- Can write Progress Notes but require a co-signature by a licensed LPHA;
- Can claim for individual and group psychotherapy but require oversight and co-signature of a licensed LPHA staff member; and
- Can claim for any service within the scope of practice of the discipline of his/her graduate program.

Note: Waivered/Registered Professional staff cannot co-sign for a graduate student’s psychotherapy progress notes. Those notes must be co-signed by a licensed LPHA.

Mental Health Rehabilitation Specialists (MHRS)

A “Mental Health Rehabilitation Specialist” (MHRS) is an individual who meets one of the following requirements:

- MHRS staff must have 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 (AA degree) clinical experience may be substituted for the required educational experience, in addition to the requirement of four years’ experience in a mental health setting.

Approved Activities

MHRS staff may perform the following activities:

- Can function as a “Head of Service” on agency/provider application with BHCS approval. (Note: Does not qualify as “Director of Local Mental Health Services” unless approved by DHCS);
- Can provide and collect information for Assessments;
- Can create Client Plans (require co-signature by licensed LPHA) and Progress Notes; and
- Can claim for all Mental Health Services (except Psychotherapy), Unplanned Services, and Case Management within their scope of practice.

Adjunct Mental Health Staff & Other Staff Not Meeting Above Category Qualifications

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Master Contract Providers have the prerogative and program flexibility to integrate and define other staff who can provide direct or supportive specialty mental health services, as determined by their BHCS contract. Bachelor's level staff may qualify for this designation.

It should be noted that it is not a requirement that staff are paid for services provided and claimed to Medi-Cal (i.e., staff may include unpaid graduate students/trainees/interns, volunteers or advocates), as long these unpaid persons meet Medi-Cal rules and regulations regarding claiming and scope of practice.

Approved Activities

Adjunct mental health staff and other staff not meeting the above category qualifications may provide services (except Psychotherapy) and follow the same clinical documentation rules as for MHRS staff (above), with evidence of on-going supervision, within the scope of the staff member's ability. *BHCS strongly advises that all adjunct mental health staff documentation be co-signed by a licensed LPHA.*

Note: Mental Health Services, Day Rehabilitation Services, Day Treatment Intensive Services, Crisis Intervention Services, Case Management, and Adult Residential Treatment Services may be provided by any person determined by the hiring provider to be qualified to provide the service, consistent with state law and their scope of practice. The hiring provider must retain personnel materials that justify their determination.

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Citations

Citations for documentation standards and requirements are included with each subject heading, and for specific items, if warranted:

BHCS Behavioral Health Care Services
BHCS1 BHCS Requirement
BHCS2 BHCS Office of the Medical Director, Guidelines for Psychotropic Medication Practices can be found at, <http://www.acbhcs.org>, under tab “Office of the Medical Director”

BHCSQA Behavioral Health Care Services, Quality Assurance can be found at <http://www.acbhcs.org>, in tab “Quality Assurance”
BHCSQA09 BHCS/QA Requirement, 2009 or earlier
BHCSQA10 BHCS/QA Requirement, 2010

BP Business and Professions Code can be found at <http://www.leginfo.ca.gov>
BP1 BP, Section 4996.9, Section 4996.15, Section 4996.18(e)

CalOHI California Office of HIPAA Implementation can be found at <http://www.ohi.ca.gov> under California Implementation
CalOHI1 CalOHI Chapter 4

CC California Civil Code can be found at <http://www.leginfo.ca.gov>
CC1 CC 56.10
CC2 CC 1798.48

CCR California Code of Regulations, Title 9 and Title 22 can be found at the DHCS (Department of Mental Health) website <http://www.dmh.ca.gov>

CCR01 CCR, Title 9, Chapter 3, Section 550
CCR02 CCR, Title 9, Chapter 3.5, Section 786.15
CCR03 CCR, Title 9, Chapter 4.0, Sections 851 & 852
CCR04 CCR, Title 9, Chapter 11, Section 1810.204
CCR05 CCR, Title 9, Chapter 11, Section 1810.205.2
CCR06 CCR, Title 9, Chapter 11, Section 1810.216
CCR07 CCR, Title 9, Chapter 11, Section 1810.225
CCR08 CCR, Title 9, Chapter 11, Section 1810.227
CCR09 CCR, Title 9, Chapter 11, Section 1810.247
CCR10 CCR, Title 9, Chapter 11, Section 1810.253
CCR11 CCR, Title 9, Chapter 11, Section 1810.254
CCR12 CCR, Title 9, Chapter 11, Section 1810.440
CCR13 CCR, Title 9, Chapter 11, Section 1810.440(c)(1)
CCR14 CCR, Title 9, Chapter 11, Section 1810.440(c)(2)
CCR15 CCR, Title 9, Chapter 11, Section 1820.205
CCR16 CCR, Title 9, Chapter 11, Section 1830.205
CCR17 CCR, Title 9, Chapter 11, Section 1830.205(b)(1)
CCR18 CCR, Title 9, Chapter 11, Section 1830.205(b)(2)
CCR19 CCR, Title 9, Chapter 11, Section 1830.205(b)(3)
CCR20 CCR, Title 9, Chapter 11, Section 1830.210
CCR21 CCR, Title 9, Chapter 11, Section 1830.215
CCR22 CCR, Title 9, Chapter 11, Section 1840.312

Citations

CCR23	CCR, Title 9, Chapter 11, Section 1840.314
CCR24	CCR, Title 9, Chapter 11, Section 1840.314(b)
CCR25	CCR, Title 9, Chapter 11, Section 1840.314(c)
CCR26	CCR, Title 9, Chapter 11, Section 1840.316
CCR27	CCR, Title 9, Chapter 11, Section 1840.346
CCR28	CCR, Title 9, Chapter 11, Section 1840.360 - 374
CCR29	CCR, Title 22, Chapter 2, Section 71551(c)
CCR30	CCR, Title 22, Chapter 7.2, Section 75343
CCR31	CCR, Title 22, Chapter 9, Section 77143

CFR **Code of Federal Regulations** can be found at <http://www.gpoaccess.gov/cfr>

CFR1	CFR, Title 45, Parts 160 and 164 (HIPAA)
CFR2	CFR, Title 45, Parts 160, 162 and 164 (HIPAA)
CFR3	CFR, Title 45, Part 164
CFR4	CFR, Title 45, Part 164.501
CFR5	CFR, Title 45, Part 164.524

DMH **Department of Mental Health** Information Notices & Letters can be found at <http://www.dmh.ca.gov>

DMH01	DMH Information Notice No. 02-06, page 3
DMH02	DMH Information Notice No. 06-07
DMH03	DMH Information Notice No. 02-08
DMH04	DMH Letter No. 02-01
DMH05	DMH Letter No. 02-07

DMH contract **Department of Mental Health Contract** with the Mental Health Plan; the boilerplate contract with DMH can be found at <http://www.dmh.ca.gov>

DMHcontract1	DMH Contract with MHP
DMHcontract2	DMH Contract with MHP, Exhibit A, Attachment 1, Appendix C
DMHcontract3	DMH Contract with MHP, Exhibit A, Attachment 1, Appendix C, page 39

EPSDT **Early and Periodic Screening Diagnosis and Treatment (EPSDT)** Chart Documentation Manual, 2007 can be found at <http://www.cimh.org>

EPSDT1	EPSDT Chart Documentation Manual, 2007
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HS **Health and Safety Code** can be found at <http://www.leginfo.ca.gov>

HS1	H&S, 123105, 123145 and 123149
HS2	H&S, 123105(b) and 123149
HS3	H&S, 123145

RMS **Risk Management Services**

RMS1	Risk Management Services 2010
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TBS **Therapeutic Behavioral Services Documentation Manual**, first published online in October 2009; can be found, along with future updates, at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp.

TBS1	TBS Documentation Manual
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Citations