Documentation Manual
3rd Edition

Based Upon

Solano County MHP Quality Management Plan
Solano County MHP Contract with the State Department of Mental Health (DMH)
CA Code of Regulations, Title 9, Chapter 11, Sections 1810 through 1850
CA Business and Professions Code
CA Welfare and Institutions Code, Sections 5600, 5614, 5704, 5751, 5778, 5855
Code of Federal Regulations, Title 42, Subchapter C, Subpart D
Relevant State DMH Policy Letters and Information Notices

April 2012
Introduction to Documentation Manual
3rd Edition

We are pleased to be able to bring you the 3rd Edition of the Solano County Mental Health Plan (MHP) Documentation Manual. It is certainly our hope that this manual will be something that you more than just occasionally reference. We hope that it can act as a daily companion. We realize that, in order for the staff in our Mental Health Plan to be convinced that this document is worth referencing more than once a month (or for some, once a year), certain elements have to be present. It has been our endeavor over the past few months to attempt to identify and include those elements in this improved edition.

We welcome your feedback, questions or concerns. Please contact the Quality Improvement Unit at 707-784-8323 or by email at QualityImprovement@solanocounty.com

Thank you,

The Quality Improvement Staff
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The Purpose of Documentation

This Documentation Manual gives documentation standards for the Short Doyle/Medi-Cal mental health services managed by the Solano County MHP. It also provides a general description of services and service definitions and is presented as a day-to-day resource for clinical and administrative support staff. The Solano County MHP establishes documentation standards in order to help realize a core value of our system: commitment to clinical and service excellence. The importance of maintaining a comprehensive, detailed and uniform clinical record and documentation system cannot be overemphasized. The clinical record stores the information concerning the client and his/her care. The content of the clinical record is developed as a result of the interaction of the mental health care team which uses it as a communication tool.

To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, justify treatment, and record observations, plans, outcomes and interventions as well as the client’s response to treatment. It is necessary that there be prompt recording of observation, treatment and care by all who contribute to the care of a client.

Establishing uniform standards for the clinical record facilitates access to necessary client documentation and simplifies review of records. The clinical record is potentially one of the most important and persuasive items of evidence available counteracting a client’s allegations of medical negligence and can protect us from risk in legal proceedings. In addition, accurate, complete documentation helps us to comply with all legal requirements when we claim for services and enables professionals to discharge their legal and ethical duties.

The 2012 Documentation Manual, like previous editions of this manual, is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements and standards. In all cases, the reader should defer to California Code of Regulations, Title 9, State and Federal regulations, and Mental Health Plan (MHP) contractual requirements and applicable MHP policies and procedures.

If you have any questions about documentation or billing, please consult with your supervisor, and/or contact the Quality Improvement Unit directly. It is also recommended that you routinely review the Quality Improvement Documentation Manual, and ensure that your documentation is fully compliant with the guidelines set forth therein.
An Emphasis on Wellness and Recovery

Solano County Mental Health Mission

To provide mental health services and supports in Solano County that are person-centered, safe, effective, efficient, timely and equitable, that are supported by friends and community, that promote wellness and recovery, and that fully incorporate shared decision making between consumers, family members and providers.

SAMHSA Definition of Wellness and Recovery

The Federal Substance Abuse and Mental Health Services Administration recently released their official working definition of recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA has also delineated four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way
- **Home**: a stable and safe place to live
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society
- **Community**: relationships and social networks that provide support, friendship, love, and hope

Wellness and Recovery in Documentation

We want all Mental Health Plan staff to emphasize a focus on the wellness and recovery of the clients you serve in your documentation. We recommend that services and documentation focus on:

- Ensuring that all services are based on a shared belief, between Provider and the individual seeking treatment, that greater mental health wellness can be achieved
- Achieving the goals and aspirations of the individual as they relate to the client’s mental health wellness and recovery
- Involving the client and families in the planning and implementation of treatment
- Client self-determination and informed decision-making
- Achieving specific objectives to support the individual in accomplishing his/her desired goals
- Identifying and encouraging the use of strengths that assist individuals to overcome challenges and barriers to greater wellness
- Documenting services that are funded under the authority of Short Doyle/Medi-Cal (SD/MC) in a manner that meets Medi-Cal documentation requirements
BIRP...Because It’s the Right Protocol

The BIRP model for progress notation may not be “the best thing since sliced bread”, but in the auditing world it comes pretty close. In the past, there had been wide variation in documentation practices from provider to provider, or even from one program to another within the same agency. In March 2009, the Solano County Quality Improvement Unit adopted the BIRP standardized method of documenting a progress note for mental health clinicians, psychologists, and mental health specialists. The findings from Medi-Cal audits since that time were considered and a solution created to reduce disallowances and increase consistency within the Mental Health System as a whole.

Behavior/Presenting Problem

Identify the location of the service to justify travel time and indicate the type of service provided (i.e., “This writer provided an individual therapy session at Jesse Bethel High School.”) Refer to both the long-term presenting problems and client’s current presentation to document why the service is medically necessary:

- **Do not** repetitively restate the same Behavior/Presenting Problem from note to note. Provide a description of the long-term presenting problem as well as the client’s presentation on the day of treatment (the current presentation will differ from session to session).
- **Do not cut and paste** using the same “B” for every session.

Interventions

Use verbs to capture what you did in the session to address the treatment plan goals. Examples are:

- Processed
- Explored
- Contained
- Taught
- Identified
- Practiced
- Facilitated
- Reinforced
- Reviewed
- Reframed
- Encouraged
- Role-played
- Mirrored
- Supported
- Reflected
- Modeled
- Coached
- Clarified
- Contracted
- Normalized
- Prompted
- Challenged
- Prepared
- Redirected
- Reassured
- Demonstrated
- Compiled
- Counseled
- Explained
- Guided
- Offered
- Validated
- Recommended
Indicate the therapeutic modality from which the intervention came: i.e., cognitive behavioral, client-centered, DTQI, supportive counseling, art therapy, etc.

Response

Indicate how the client (or collateral support person) responded to your interventions. Ideally, if you document three interventions in the “I” section, you will describe responses to each in the “R” section.

Plan

Indicate which treatment goal(s) will be the focus of the next session. Document plan for follow-up appointment.

BIRP Progress Note Example:

B- Met with client in the Vallejo Adult Clinic. Per most recent clinical assessment, client has chronic symptoms of depression. Today she presented with flat affect and looked somewhat disheveled. She was tearful when she reported having had a terrible week and that she is no longer taking medication.

I- Using client-centered techniques, this writer validated and supported client, encouraging her to process her feelings of despair. Gently challenged client’s negative thinking, and discussed her non-compliance with medication. When client became non-responsive to the medication discussion, Clinician explored the client’s resistance, and normalized her feelings of ambivalence around medication use. Recommended that the client meet with her Psychiatrist as soon as possible to discuss concerns about medication.

R- When the Clinician confronted the client on lack of medication compliance, client responded to writer with “yes, but…” repeatedly. Client became silent, reduced eye contact, and displayed defensive body language (e.g. leaned back and folded her arms). The client revealed that she has concerns about mental illness stereotypes and being labeled “crazy” because she takes medication. At the end of the session, she agreed to make an appointment to discuss further with her Psychiatrist.

P- Next appointment scheduled for January 6th. Will continue to address client’s symptoms of depression and monitor medication compliance.
In addition to BIRP format, all notes must include:

**Start Time:** This is the specific start time when staff begins working with a client, collateral or case management contact in person or via telephone. This must be documented to the minute. (For instance, an individual session time begins at 2:03 p.m. The Clinician would document 2:03 p.m. in the “start time.”)

**End Time:** This is the specific end time when staff ends working with a client, collateral or case management contact in person or via telephone. This must be documented to the minute. (For instance, an individual session time ends at 3:01 p.m. the Clinician would document 3:01 p.m. in the “end time.”)

**Documentation Time:** This is the amount of time that it takes to write or dictate note or to document an assessment. Progress notes should be submitted within two (2) business days of the date of service.

**Travel Time:** If travel is required to provide services to a client or on behalf of a client, travel time can be billed as long as the service does not include travel from one Medi-Cal certified site to another Medi-Cal certified site. When documenting **travel from one Medi-Cal certified site to another**, staff can use a non-billable code.

**Total Time:** This is the “face-to-face time”, “documentation time”, and “travel time” added together.
Audits & Investigations

Utilization Review Audits

The Solano County Mental Health Plan requires an annual utilization review audit of each Provider Reporting Unit (RU) that bills Short-Doyle Medi-Cal, operating within the plan. Quality Improvement facilitates these audits using a standard technical and clinical review tool. Every provider will make some mistakes, but adhering to the documentation standards contained within this manual can help you lessen the amount of dollars recouped by the state of California for disallowed services.

Quality Improvement Memo (July 15, 2011): The Importance of Accurate Documentation

“At the Federal level, numerous actions have been taken to encourage external reviewers and auditors to aggressively seek out claiming errors by incentivizing these agencies and organizations, including the States themselves, for each instance of perceived fraud that is found in the course of an audit. Fines in the hundreds of thousands of dollars are not unusual and any failure to document compliantly puts the Mental Health Division and Health and Social Services at great risk...”

“Quality Improvement is charged by the State of California through Title 9 and the DMH-Mental Health Plan Contract to review and monitor documentation and claiming, to continuously take steps to improve standards, and to guard against and identify fraud and waste. Quality Improvement is committed to assisting you to assure that your documentation is compliant, and that you and this organization are free from untoward consequences that may result from documentation-related problems.”

Agency/Employee Investigations

A Quality Improvement investigation of an agency or employee’s documentation practices will occur only after a consistent and significant pattern of inappropriately documented services has been detected. This is a Quality Improvement and County Compliance mandate, as it is intended to protect clients from unethical providers and the Mental Health Plan from potential penalties levied by the state and federal government.

Please be aware, that Quality Improvement uses a Continuous Quality Improvement (CQI) approach to all such investigations. A series of Plan-Do-Study-Act (PDSA) cycles are used to examine a minimal amount of documentation. If one cycle suggests looking at more data, then additional records are examined. We realize that ALL clinicians make occasional mistakes in their documentation, and such investigations quickly separate the occasional mistake from consistent acts of fraud.

Please refer to the “Dos and Don’ts of Documentation” and the “Reasons for Recoupment” on the following pages for additional explanation.
The Dos and Don’ts of Documentation

The Dos - Progress notes should:

- Provide a clear, ongoing record of the client’s condition, the interventions attempted, the client’s response to the care provided, and the progress the client is making toward realizing his/her goals and objectives
- Facilitate the coordination of care and communication between team members
- Record a service for every billing activity
- Show evidence of collaboration with community resources including primary care
- Be legible and signed/dated appropriately by clinical staff
- Include the license, title, or degree of service provider
- Demonstrate ongoing medical necessity for each billable service
- Show that the amount of time billed is appropriate for the service provided
- Show that content within the note corresponds with the respective billing activity that is being claimed.
- Be unique and non-repetitive in each section (i.e. Behavior, Intervention, Response, and Plan) from the note before it
- Accurately document the use of a specific therapeutic modality whenever such interventions are utilized (e.g. Cognitive Behavioral Therapy, Depression Treatment Quality Improvement, Moral Reconciliation, Dialectical Behavioral Therapy, Solution Focused Therapy, etc.)

The Don’ts - Progress notes should not:

- Record start and stop times that overlap with other progress note activities (this includes any overlapping documented service activities involving a single provider and the same client or different clients).
- Bill for more hours than hours worked
- Bill for more than 60 minutes in one hour for a single provider (or claim for two services during the same time frame)
- Copy and paste notes from one progress note to the next, from one client to another, etc--- each note must be unique to the client
- Fall below industry standards for documenting service activities
- Be corrected with the use of “white-out” (All corrections must have a single strike through and be initialed)
- Combine multiple services under one procedure code/one progress note entry (i.e. do not combine Individual Therapy and Collateral, or Mental Health Rehab and Case Management)

Progress notes provide the funding source (i.e. Medi-Cal) with a clinical record of service that demonstrates medical necessity and provides justification for payment of service claims.
Common Reasons for Recoupment (Disallowances)

Documentation in the chart does not establish that the client meets medical necessity criteria terms of:

- Level of impairment
- Included diagnosis
- How the intervention(s) address the impairment

The Client Service Plan is insufficient or incomplete, such as:

- Not completed within the specified time period
- No documentation of client or legal guardian participation in the plan or written explanation of the client’s/guardian’s refusal or unavailability to sign
- No documentation of a plan for clients receiving TBS services

Progress Note Deficiencies (Disallowances):

- No note for the service claimed
- Time claimed in billing records was greater than the time documented
- The service was provided while the client resided in a lock-out setting – i.e. Institute for Mental Disease, jail, juvenile hall, and other similar settings
- The progress note describes a situation that is solely for:
  - Academic educational service
  - Vocational service that has work or work training as its actual purpose
  - Recreation
  - Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors
- The service activity was solely clerical, i.e. copying documents or completing a form or other document
- The service activity was solely payee-related
- For child/youth receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for the following reasons:
  - For the convenience of the family, caregivers, physician, or teacher
  - To provide supervision or to ensure compliance with terms and conditions of probation
  - To ensure the child’s/youth’s safety or the safety of others—i.e. suicide watch
  - To address conditions that are not a part of the child’s/youth’s mental health condition
- For child/youth receiving TBS, the progress note clearly indicates that TBS was provided to a child/youth in a hospital mental health unit, psychiatric health facility, or crisis residential facility
Medical Necessity is the key element of good clinical documentation as this justifies why we are providing services to the client. If there is no medical necessity clearly noted within an assessment, or an annual update of client information, then all services for that reporting period could be subject to disallowance during an audit. Likewise, each claimed service provided to a client should be medically necessary and the progress note should reflect this. In order to best support your clinical work and reduce audit disallowances, we have included the following formula from California Code of Regulations, Title 9, as to how Medical Necessity is determined:

To be eligible for Medi-Cal reimbursement for Outpatient/Specialty Mental Health Services, a service must meet all three criteria for medical necessity: Diagnostic, Impairment and Intervention criteria.

## Diagnostic Criteria

The service must be provided to a client assessed to have one or more of the following DSM IV diagnoses. The focus of the service should be directed to the reduction of functional impairments and/or symptoms related to the diagnosis(es).

### Included Diagnoses

- Pervasive Developmental Disorders, excluding Autistic Disorder
- Attention Deficit Disorder and Disruptive Behavior Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

### Excluded Diagnoses

- Mental Retardation
• Motor Skills Disorder
• Communication Disorders
• Autistic Disorder (Other Pervasive Developmental Disorders are included)
• Tic Disorders
• Delirium, Dementia, and Amnestic and Other Cognitive Disorders
• Mental Disorders Due to a General Medical Condition
• Substance-Related Disorders
• Sexual Disorders
• Sleep Disorders
• Antisocial Personality Disorder
• Other Conditions that May Be a Focus of Clinical Attention

Impairment Criteria

The client must have at least one of the following as a result of the mental disorder(s) identified in the diagnostic criteria:

• A significant impairment in an important area of life functioning, or
• A probability of significant deterioration in an important area of life functioning, or
• Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated

Intervention-Related Criteria

The client must have all three listed below:

• The focus of the proposed intervention is to address the condition identified in Impairment Criteria (B) above, and
• It is expected that the proposed intervention will benefit the consumer by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children, it is probable that the child will be enabled to progress developmentally as individually appropriate (or, if covered by EPSDT, the identified condition can be corrected or ameliorated), and
• The condition would not be responsive to physical healthcare-based treatment.

If, after completing an assessment, it is the assessor’s clinical determination that the client does not meet criteria for Medical Necessity, then a NOA-A should be sent to Quality Improvement (There is a description of the NOA process in the Provider Manual. Please refer to that document for details.)
Documentation for Medical Necessity

It is important to understand that while documentation rules include specific points at which medical necessity must be verified, these are not the only points at which the medical necessity criteria must be met.

Every claimed service must meet the test of medical necessity; i.e., the service must be directed toward an included diagnosis, and the impairments that are a result of that diagnosis have interventions aimed at maintaining, reducing, or minimizing the effect of the diagnostic symptoms or impairments on a client’s life. Each time a service is claimed, the staff person who delivered the service and submitted the claim is saying that he/she believes that the service met all medical necessity criteria.
**Medi-Cal Reimbursement Rules**

These rules apply to Mental Health Services, Medication Support Services, Crisis Intervention and Targeted Case Management:

- 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. In no case shall the units of time reported or claimed for any one person exceed the hours worked [CCR Title 9, §1840.316(b)(1)].

- A service is an individual service when one client is present or represented for the service and is a group when more than one client is present or represented at the same time for a service.

- When a person provides services to, or on behalf of, more than one client at the same time, the person’s time must be prorated to each client. When more than one person provides a service to more than one client 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 total time utilized for claimable services [CCR Title 9, §1840.3169b)(2)].

- The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not documentation time is on the same day as the reimbursable service activity [CCR Title 9, §1840.316 9b)(3)].

- Every claim must be supported by a note that must be present in the clinical record prior to the submission of the claim (SDMH Contract, Exhibit A, Attachment 1, Appendix C).

- Services shall be provided within the staff person’s scope of practice (CCR Title 9, §1840.314) and his/her employer’s job description/responsibility. The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.

- The time required for documentation and travel must be linked to the delivery of the reimbursable service. [CCR Title 9, §1840.316(a)(3)].
Non Medi-Cal Reimbursement Services

These rules apply to all Mental Health Services:

- Mental Health Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health or Nursing Facilities are reimbursed, except on the day of admission to either service [CCR Title 9, §1840.364 (a)].

- Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive Services are being provided [CCR Title 9, § 1840.36 (b)].

- Crisis Stabilization is a package program and no other specialty mental health services are reimbursable during the same period this service is reimbursed, except for Targeted Case Management [CCR Title 9, §1840.368(b)].

- Mental Health Services are not reimbursable when provided in a jail or prison setting. [CCR Title 22, § 50273 (a)(1-8)].

- Mental Health Services are not reimbursable when provided to persons aged 22 through 64 who are residents of an Institution for Mental Disease (IMD) [CCR Title 9, §1840.312(g)]. An IMD is defined as a hospital nursing facility, or other institution that has minimally more than 16 beds and is primarily engaged in providing diagnosis, treatment or care of persons with mental illness, including medical attention, and related services (CCR Title 9, §1810.222.1); [Title 42, CFR §435.1009(b)(2)]. As such, a free standing Psychiatric Hospital or a State Hospital qualifies as an IMD.

- A client under 21 years of age resides in an IMD other than a Psychiatric Health Facility (PHF) that is a hospital or an acute psychiatric hospital, except if the client under 21 years of age was receiving such services prior to his/her 21st birthday. If this client continues without interruption to require and receive such services, the eligibility for Federal Financial Participation (FFP) dollars continues to the date he/she no longer requires such services, or if earlier, to his/her 22nd birthday.

- Services of clerical support personnel are not reimbursable [CCR Title 9, §1830.205(b)(3)]. While it may be appropriate at times to record in the clinical record activities or observations of these personnel, their cost is included in overhead rates, for which the Department receives a percent of Medi-Cal reimbursement, so these services should not be separately claimed.

- Supervision time is not reimbursable. Supervision focuses on the supervisee’s clinical/educational growth (as when meeting to monitor his/her caseload or his/her understanding of the therapeutic process) and is NOT reimbursable time. Supervision time required by Department policy or State licensing boards always falls within this definition and thus, is never reimbursable.
• Personal care services performed for the client are not reimbursable (SDMH Letter No. 01-01). These would include examples such as grooming, personal hygiene, assisting with medication, child or respite care, housekeeping and the preparation of meals.

• Conservatorship investigations are not reimbursable.
The initial assessment is designed to provide a comprehensive clinical picture of the client, establish medical necessity, help treatment teams and clients define goals and objectives, and fulfill State and Federal requirements. California Code of Regulations, Title 9, states the following:

- The following areas shall be included as a part of a comprehensive client record:
  - Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate
  - Presenting problems and relevant conditions affecting the client’s physical health and mental health status shall be documented, for example: living situation, daily activities and social support
  - Documentation shall describe client strengths in achieving client plan goals or objectives
  - Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate
  - Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications
  - Client self report of allergies and adverse reactions to medications or lack of known allergies/sensitivities shall be clearly documented
  - A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab test and consultation reports
  - For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented
  - Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs
  - A relevant mental status examination shall be documented
  - A five-axis diagnosis from the most current DSM, or diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation, and/ or other assessment data
California Code of Regulations, Title 9, Mental Health Services:

“'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 and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.” (§ 1810.227)

Quality Improvement Additional Clarification

When providing services to seriously emotionally-disturbed children and adolescents or severely and persistently mentally ill adults, Mental Health Services provide a range of services to assist the client in achieving his or her goals.

Services shall be directed toward achieving the consumer/family’s goals and consistent with the current Client Service Plan. In this context, Mental Health Services is a term that includes the following services:

- Assessment
- Therapy
- Family Therapy
- Group Therapy
- Rehabilitation
- Group Rehabilitation
- Plan Development
- Collateral
- Collateral Group
- Psychological Testing

Mental Health Services, as well as other service categories (e.g., Medication Support Services, Targeted Case Management, Crisis Services, Brokerage and Placement and Therapeutic Behavioral Services) are reimbursed based on the time staff spend delivering the service. The following rules apply to services based on staff time:

- In no case shall more than 60 units of time (minutes) be reported or claimed for any one staff person during a one-hour period. Also, in no case shall the sum of the units of time reported or claimed for any one staff member exceed the hours worked in a given day.

- When a staff member provides services to, or on behalf of, more than one individual at the same time, the staff member’s time must be prorated to each consumer. When more than one staff person provides a service, the time utilized by all involved staff members shall be added together to yield the total billable services. The total time claimed shall not exceed the actual staff time utilized for billable services.
Assessment

California Code of Regulations, Title 9, Assessment:

“‘Assessment’ means 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.” (§ 1810.204)

Quality Improvement Additional Clarification

The clinical assessment is the foundation upon which medical necessity for providing mental health services to our clients is built. A clinical assessment should provide the basis for the answer to the question, “why should this individual receive the clinical services you are proposing?” Within the Solano County Mental Health Plan, a client shall receive an initial assessment (recorded on the Client Intake Assessment) completed within 2 months of opening to the system, and shall receive a re-assessment (documented on the Client Assessment Update) within one year of opening if the client continues to receive services in the system.

Additional use of the Assessment Code should occur when significant changes in the life or functioning of the client have occurred, OR when the previous assessment (that was meant to establish medical necessity for treatment during the current service authorization period) does not contain the required elements or was not completed in time to cover part or all of the current authorization period.

Assessment Services

Assessment is a service activity that typically includes:

- Gathering clinical information regarding a client’s presenting problems and symptoms
- A clinical analysis of the client’s mental health history
- A current status of a client’s mental, emotional and/or behavioral disorder
- A mental status determination
- An analysis of relevant cultural issues and history
- Identification of client’s strengths
- A five Axis included diagnosis
- Documentation of medical necessity via presenting problems, symptoms and impairments that meet DSM criteria for an included diagnosis

The Assessment code is not to be used as a catch-all category
Using the Assessment Code with the Intake Assessment:

The initial service provided for a new client in our MHP should be a **face-to-face meeting** with a licensed/license-eligible provider. During this meeting, the provider must review, explain, and have the client or authorized representative sign the following required paperwork:

- Acknowledgement of Receipt (Represents the following):
  - Mental Health Service Provider Notice of Privacy Practices
  - Solano County MHP “Guide to Medi-Cal Mental Health Services”
  - Advance Directive Fact Sheet (if applicable)
  - Solano County MHP Provider List
- Consent for Treatment
- Problem Resolution Process (Verbal explanation)
- Authorizations to Release Client Information (when applicable)

**Staff should also document evidence that:**

- Cultural issues were explored with the client and/or client system
- Linguistic needs were identified and documented either with the use of a bilingual certified staff or a contracted interpreter service, if applicable
- Coordination of care with the primary care physician was initiated (i.e. obtaining release, sending PCP letter, etc.)

The documentation of this evidence should be captured on the assessment forms. In the cases where a provider begins working with an already established client, this information can be gathered at the next appropriate client meeting and documented in the corresponding progress note. This can also be noted during the annual re-assessment in the Client Assessment Update.

Using the Assessment Code with the Client Assessment Updates:

- Complete annually, within the month prior to the Child/Adult episode opening month (the month the client was newly opened to the MHP system)
- Complete prior to the date the previous service authorization expires to avoid the risk of losing revenue for services provided
- Involve a **face-to-face** meeting between licensed, license eligible or waiver ed staff and the client
- Complete periodically throughout treatment when there is a need to revise the diagnosis or otherwise incorporate relevant new information that may affect treatment

**Billable Activities**

- Meeting with a client to complete intake paperwork and to gather information to complete assessment
- Completing the assessment and formulating the diagnosis
Non-billable Activities

- Completion of other authorization paperwork
- Services provided prior to the first face-to-face meeting, when the client is new in the MHP system
- Services provided before episode opening date, or after episode closing date

BIRP Note for Assessment:
Start Time: 9:05 a.m.
End Time: 11:11 a.m.
Doc Time: 12 min.
Total Time: 138 min.

B — Client was seen for initial evaluation at the Vallejo Children’s Clinic. Client is a 16 year old white English Speaking female referred by the client’s primary care physician for extreme shifts in mood, and inability to stabilize with current medication prescribed by the primary care physician. Client appears manic with pressured speech and inability to remain focused on one topic for an extended period. Client denies suicidal or homicidal ideation or plan. This is client’s first interaction with County mental health services.

I — The psychosocial assessment is the intervention. In addition, the following information was reviewed, explained and/or signed: Informing Materials, HIPAA Privacy Practices, Consent for Treatment, Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Provider List and Cultural/Linguistic Issues. Obtained a release of information for the primary care physician. Assessed for risk factors including suicidal ideation/plan and homicidal ideation/plan. Developed initial client service plan to address client’s mood instability.

R — Client and parents were cooperative with the assessment process. Client and parents provided information, provided informed consent and understood the risks and benefits of treatment. Client was able to identify several strengths. The parent was able to come up with at least one item she would like the client to work on in therapy.

P — Plan to complete written mental health assessment with client’s presenting issues, level of functioning, justification of medical necessity, and five axis clinical diagnosis. Assisted client to schedule an initial psychiatric evaluation.
BIRP Note for Assessment:
Start time: 3:04 p.m.
End Time: 5:30 p.m.
Doc Time: 14 min.
Total Time: 160 min.

B — Client was seen for intake in Fairfield Adult Clinic. Client presents with complaints of feeling anxious, appetite disturbance, problems with family, inability to keep employment and mood cycles which result in over-spending and inappropriate sexual behavior. Client appears depressed but denies any suicidal/homicidal ideation. Client denies drug use. Client is currently on unemployment, which will soon run out. Recently during an “upswing”, client was arrested in another county for causing a disturbance at a store. Has a history of five psychiatric hospitalizations during the last two years, the first at age 22.

Diagnostic Impressions:
Axis I: 296.4 Bipolar Disorder
Axis: V71.09: No diagnosis II
Axis III: 799.9 deferred
Axis IV: Primary, employment, legal, financial
Axis V: GAF = 50

I — Facilitated a face-to-face interview to begin the psychosocial assessment process. In addition, the following information was reviewed, explained and signed: Informing Materials, HIPAA Privacy Practices, Consent for Treatment (including a discussion around the risks, benefits, and alternatives to treatment); Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Provider List and Cultural/Linguistic Issues were also reviewed. Obtained an authorization to release information to the primary care physician.

R — Client understands this session is an assessment and approval for services is still pending. During intake, client answered questions with one-word answers, and fidgeted frequently in her chair. Approx. halfway through the assessment, client asked “how much longer is this thing going to take?” and rolled her eyes when this writer informed client that there were several question still needing to be answered. Despite the client’s apparent lack of interest in the process, she was willing to review all information the provider presented/explained, and demonstrated her acceptance/agreement with each request for consent, acknowledgement or authorization verbally and with a written signature.

P — Will present to supervisor for disposition of services. Subsequent to authorization for ongoing outpatient mental health services, client will return to develop client plan.
Therapy

California Code of Regulations, Title 9, Therapy:

“Therapy’ means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.” (§ 1810.250)

Quality Improvement Additional Clarification

Individual and group therapy codes are used to document therapeutic interventions consistent with the client’s goals. Therapy services can only be provided by clinicians consistent with their scope of practice. These services include various treatment modalities, utilized within a professional relationship, to assist the client to achieve better psychosocial adaptation. Therapy may also be used to help the client modify internal and external conditions to allow the client to improve functioning in terms of behavior, emotions and thinking. This improvement in functioning may occur with respect to self, significant interpersonal relationships, the larger community, or in all of these domains.

<table>
<thead>
<tr>
<th>Individual Therapy</th>
<th>Code: 341</th>
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</table>

**Individual Therapy** - A service activity that is:

- A therapeutic intervention
- Focused primarily on symptom reduction and improved wellness
- Utilized to reduce the severity of functional impairments

**Billable Activities** (Therapy services represented in progress notes must target the client’s diagnosis, symptoms and impairments, and adhere to treatment plan goals and objectives.)

- Assisting client to process thoughts and feelings regarding a certain event
- Utilizing a therapeutic modality to assist a client with a specific problem area
- Identifying obstacles and helping a client see, and make a plan for, how they might be overcome
- Helping strategize with client about what they can accomplish
- Education regarding how symptoms/problem behaviors are impeding functioning

Medi-Cal only reimburses for services to or on behalf of an identified client. Services to collaterals of identified clients should be claimed as collateral services to the appropriate client.
Non-Billable Activities

- Assisting a client with coursework or teaching job functions
- Providing therapy to a client’s significant support person. This would NOT be billed as individual therapy (see Chapter Four, Collateral Code definition for billable services to clients’ support persons)
- Taking a client on a “reward” outing without demonstrating therapeutic interventions and client’s response to those interventions throughout the activity

**BIRP Note for Therapy:**

| Start Time | 1:58 p.m.  
| End Time   | 3:03 p.m.  
| Doc Time   | 11 min.   
| Travel     | 22 min.   
| Total Time | 98 min.   

B — Round trip travel from Vacaville clinic to Jepson Middle School to meet with client. Client was seen at a school site and she reports that she is having intrusive thoughts and nightmares related to a sexual assault she endured while homeless last year. She has not told anyone about this assault due to her blaming self about the attack.

I — Provided a safe therapeutic container for client to express fears. Utilized cognitive behavioral strategies, including psychoeducation around the connection between negative thoughts and feelings. Helped client test her thinking around her expressed feelings of guilt, to help her understand that she was the victim and did not cause the attack. In addition, this writer explained PTSD manifestation. Provided the client with a take-home assignment to improve strategies to replace negative thoughts with more healthy thoughts.

R — Client expressed that she felt some relief in discussing the attack; however, she was initially resistant to replacing her thoughts that she may have provoked the attack. Client participated in and appeared receptive to discussion about PTSD symptoms. Client said she is afraid to go to sleep tonight and experience a nightmare. Client agreed to work on the take-home assignment over the next week.

P — Will continue to use cognitive techniques and will consult with psychiatrist regarding possible need for medication changes. Will plan to monitor client closely to ensure she has sufficient support to prevent decompensation.
**Family Therapy** - A service activity which is a therapeutic intervention that focuses on assisting the client and his or her family/primary support system to meet identify service plan goals as a means to reduce functional impairments.

A group log does not need to be completed for family therapy services; however, identifies all the individuals in the session by their relationship to the client (mother, sister, etc.)

<table>
<thead>
<tr>
<th>BIRP Note for Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Time: 3:30 p.m.</td>
</tr>
<tr>
<td>End Time: 4:47 p.m.</td>
</tr>
<tr>
<td>Doc Time: 17 min.</td>
</tr>
<tr>
<td>Travel: 20 min.</td>
</tr>
<tr>
<td>Total Time: 114 min.</td>
</tr>
</tbody>
</table>

**B** — Travelled to client’s home in Fairfield to provide family therapy to client and client’s mother because of ongoing issues with aggressive behavior connected with mood instability. Client appeared sullen at beginning of session. Client said he did not want to participate in therapy and said family therapy sessions were “stupid.” Mother of client told this writer that client has had a “bad attitude” in recent days, with an increase in defiant behavior and mood instability.

**I** — Attempted to engage client through a Structural Family therapeutic process by urging client to communicate further with this writer and his mother about apparent resistance to session today. When client raised his voice, this writer redirected client to communicate in an appropriate manner with a reasonable tone of voice. Supported mother when she also redirected client in the same way. Facilitated discussion between client and mother regarding house rules, and helped client understand consequences and loss of privileges that are imposed by mother when client engages in unacceptable behavior. Assessed client’s mood and medication compliance, and urged client to report increase in symptoms to his psychiatrist.

**R** — Client continued to state that he was angry about having to participate in family therapy and client spoke to this writer in a rude and defiant manner. Client ceased this behavior when confronted and redirected by this writer and client’s mother. Client and mother were then able to engage in a discussion about expectations around client’s behavior. Client agreed to try to comply
more with house rules. Client said he has felt more irritable lately but has been compliant with taking medications as prescribed. Mother said that a psychiatric consultation is scheduled for next week.

**P** — Continue to assist client and mother to communicate more effectively with each other, with the aim of increasing client’s mood stability and reducing verbal aggression.

**Group Therapy** - A therapeutic intervention provided in a group setting that focuses primarily on symptom reduction as a means to reduce functional impairments.

**Psychotherapeutic Groups** are groups with the following components:

- Personal and group dynamics that are discussed and explored in a setting that allows for emotional catharsis, instruction, peer reinforcement and support
- Utilization of psychotherapeutic theories to assist clients in meeting goals
- Structure in terms of attendance policy, number of clients present, and format of the group
- Specific curriculum and interventions

**Billable Activities**

- Groups with a focus on processing thoughts and feelings that significantly impair functioning
- Groups with a focus on skill building to increase coping strategies and overcome obstacles to mental health wellness and recovery

**Non-Billable Activities**

- Teaching a remedial English class
- Assisting with coursework or a study group
- Teaching job functions
- Teaching a group of youth publishing a newsletter
- Facilitating drop-in groups
- Facilitating a Life Skills group without a curriculum or guidelines
- Attending a group outing and watching a movie

**BIRP Note for Group Therapy:**
*(Must complete a Group Log for Data Entry)*

There were four group members

Dual diagnosis group therapy session at the Fairfield Clinic:
The topic of the group was triggers that lead to substance use and how these factors complicate a person’s mental health wellness and recovery.

**B** — Client participated in group due to his history of severe depression with psychotic features and multiple substance dependence. Client appeared sad, with flat affect, avoided eye contact, and was occasionally tearful during today’s group session.

**I** — Using an informal mood scale from 1-10, requested a self-report from each group member. Allowed the client to process feelings and thoughts associated with his depressive and psychotic symptoms and how these symptoms were triggers for multiple instances of alcohol use. Utilizing cognitive behavioral techniques, helped client to begin to create a plan to avoid triggering situations- i.e. identify ways to replace negative thoughts with more helpful thoughts.

**R** — Client reported feeling sad and despondent due to increased psychotic symptoms. He is discouraged by the continuation of hearing voices despite his medication compliance. Client reported he was surprised by the amount of support he received from the group. Client expressed a commitment to maintaining sobriety. Client agreed to complete a take-home assignment to identify five negative thoughts that lead to increased substance use.

**P** — Client agreed to utilize peer support, community resources, or to call this clinician if he feels his condition is deteriorating. Continue to work with client to replace negative thinking with more constructive thoughts that support his wellness and recovery. Clinician will consult with psychiatrist regarding client hearing voices.

### Common Problems with Group Notes and Logs

- For Group Therapy and Group Rehab, the group log does not list the total number of participants in the group regardless of Medi-Cal status
  - This error can be corrected by writing the full name of Medi-Cal clients, along with initials of non-Medi-Cal clients. For this group service to be billed properly, the log must reflect the total number of people that received treatment in the group
  - For Collateral Group notes and logs, refer to section on Collateral Group in this manual
- Group log is not signed
- Group log date does not correspond with group note date
- Group note is not in the BIRP format
- Group note is identical for each client/group participant note. (The theme may be the same for each note, but the behavior of the client should be individualized along with the client’s response to the intervention)
- Use of incorrect billing code
- More than two providers billing for group
Rehabilitation

California Code of Regulations, Title 9, Rehabilitation:

“‘Rehabilitation’ means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.” (§ 1810.250)

Quality Improvement Additional Clarification

There are many Rehabilitation activities that can be built into a beneficial, reimbursable service when the provider demonstrates how these activities link back to the client’s diagnosis and impairments in functioning, and how such service activities can help to improve functioning and reduce impairments and lead to greater wellness and recovery.

For claiming and reimbursement, rehabilitation service activities are categorized into the following two types:

<table>
<thead>
<tr>
<th>Individual Rehab</th>
<th>Code: 345</th>
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<tbody>
<tr>
<td>Group Rehabilitation</td>
<td>Code: 355</td>
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</tbody>
</table>

**Billable Activities**

- Assisting with a specific problem area related to such activities as Activities of Daily Living (ADLs)
- Showing client how some obstacle might be overcome (i.e., how to obtain a bus pass when client has difficulty making decisions)
- Identifying obstacles (i.e., client wishes to attend Junior College but has difficulty getting up in the morning, does not know how to use public transportation, and has not gotten necessary hearing aids)
- Helping strategize with client about what he or she can accomplish (i.e. prioritizing household chores)
- Education regarding how problem behaviors are getting in the way of meeting goals
- Education about how symptoms/problem behaviors might be managed (i.e. diet changed, medication)

**Non-Billable Activities**

- Assisting a client with coursework/homework/tutoring or learning job functions
- Performing a task for a client without a clear connection to teaching client an independent living skill or helping client to improve functional skills
B — Traveled to community center in Suisun City to meet with client, 30 minutes round trip travel. Client was distracted as he appeared to be responding to internal stimuli. He avoided eye contact and muttered to himself occasionally. His behaviors were consistent with his baseline for the past six months.

I — Provider assisted the client to identify methods to learn the bus system so that he could attend community college. Continued to assist client to practice coping with internal stimuli and interacting with others in a socially appropriate manner. Focus of activity was to role-play eye contact, and teach basic reciprocal communication skills required for education participation goal on his service plan.

R — Client was able to sustain more eye contact. He was able to verbalize that his voices were telling him not to look at this writer, but he knew that this writer was trying to help him so he could keep going to school. He was able to read the bus schedule and identify what time he should be at the bus stop in order to be on time for class. He was able to make eye contact on several occasions and muttered less often to internal stimuli in comparison to six sessions ago.

P — Follow-up appointment set in one week to build upon current skills. Plan to role play with client on how to advocate for self with school staff.
BIRP Note Individual Rehab:
Start Time: 3:00 p.m.
End Time: 4:05 p.m.
Travel 48 min.
Doc Time: 9 min.
Total Time: 122 min.

B — Met with client at her home in Vacaville today to work on listening and focusing skills. This skill-building relates to client’s goal of remaining focused on the present moment as a way to decrease impulsivity.

I — Worked with client to identify distractions in the room, and role played with client on how to decrease distractions by turning off background noises.

R — Client was able to independently identify two additional distractions in the room without guidance, and was able to identify ways to decrease distractions to increase her ability to focus. She was able to focus for 5 out of 10 minutes on the task at hand, and client expressed that she was very pleased with her improvement.

P — Follow-up appointment set in one week. The plan is to work on how to identify and decrease distractions at school.
Plan Development

California Code of Regulations, Title 9, Plan Development:

“‘Plan Development’ means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.”  (§ 1810.232)

Quality Improvement Additional Clarification

Plan Development is a service activity that typically consists of:

- Development of Client Service Plans with client participation. This is the primary use for this code
- Monitoring and reviewing a client’s progress with the client
- Adjusting or changing goals, when appropriate
- Plan Development includes collaboration with mental health staff or other professionals involved in the client’s care when the interaction involves communicating about or evaluating the client’s clinical response to the plan

Plan Development Progress Note: Progress notes should refer to Client Service Plan Goals and Objectives when documenting the service activities listed above.

Billable Activities

- Creating an initial or annual treatment plan with a client
- Completing the 6-month Client Service Plan Update by reviewing the client’s progress on each goal
- Completing an addendum to an existing Client Service Plan, with client participation
- Discharge planning
- Taking information from evaluations or assessments and developing a written plan when client is unable or unavailable to participate in the treatment planning process (Please be sure to document on the Client Service plan and in the progress note the reasons why the client did not participate)

Non-Billable Activities

- Reviewing client service plan of a transfer case prior to first session with client
- Supervision
- Discussing/processing a case with a colleague who does not have a specific role on the case
- Completing reports for client’s lawyers or representatives
B — Met with client and parent in the Vacaville Children’s Clinic to review client’s progress on previous year’s client service plan and to develop new treatment goals based on client’s current level of functioning and clinical diagnostic impressions of Bipolar Disorder currently Depressed.

I — Collaboratively developed client service plan with client and client’s parent. Identified client’s overall goal from the mental health system, along with strengths and barriers to growth. Identified two treatment objectives: 1) decrease frequency and intensity of depressive symptoms from current baseline of one depressive episode every three months, lasting two weeks, to one depressive episode a year lasting no more than three days. 2) increase wellness and treatment ownership by recognizing symptoms and triggers for depression and implementing coping strategies, agreed upon by client and provider. Client is currently able to identify one trigger (irregular sleep routine) and strategies to stabilize sleep pattern 5 days of the week. Objective is to identify four additional triggers and coping strategies in the next six months.

R — The client said, “I want to do this. I don’t like feeling depressed.” Mother said, “It is hard to see her going through this. I want to see her feeling better.” Both felt the goals and objectives were achievable. Client and parent were responsive to referral for continued psychiatric evaluation and medication management. Client was open to discussion of long-term discharge planning to community services and primary care when stabilized. The parent was able to describe what that might look like when the goals were met. Client and parent signed the treatment plan. A copy was offered; they accepted the copy.

P — Client has a psychiatry appointment scheduled in two days. A follow-up appointment was scheduled with this writer in one week. Client continues to deny suicidal ideation or plan; denies homicidal ideation or plan. Client and parent have contact number for emergency crisis services.
B — Met with client in Vallejo Clinic to formulate the Client Service Plan that was specific, medically necessary, measurable, observable, specified frequency and duration, and identified client strengths. Client identified frequent hospitalizations due to extreme mania and depressive symptoms as the major issues to address.

I — Clinician and client were able to agree on the following as a focus of the treatment plan: reducing the number of hospitalizations and finding a healthier support system. Goals that were identified and agreed upon by the client were: 1) Identifying and implementing at least 3 coping skills, including medication compliance, in the next six months as evidenced by reducing hospitalizations from once every two months to zero hospitalizations in 6 months and 2) Attending two bipolar support groups per month.

R — Client appeared pleased with the goals decided upon. Client expressed that he could honestly commit to maintaining medication compliance with support from community, family and this agency. Client signed completed treatment plan, but declined a copy.

P — The clinician will be following this client to assist him in achieving the above-named goals. Will work closely with psychiatrist in monitoring medication compliance in order to reduce hospitalizations. Will give client schedule for the Bipolar Support Group.

B — Clinician and MH Specialist met at the Fairfield Children’s Clinic to plan for tomorrow’s session with client and mother. During the week, client had been extremely agitated and got suspended from school for fighting. Mother did not follow through on implementing strategies discussed in previous sessions with MH Specialist to address client’s behavior.
I - Clinician and MH Specialist discussed case and agreed that clinician will work with mom one-on-one this upcoming session to encourage her to follow the service plan goals and objectives. Clinician will explore mom’s reluctance to enforce consequences for negative behaviors or to issue praise for positive behaviors. Clinician will also address mom’s inconsistency in giving client his medication for ADHD. MH Specialist will provide a Rehab session for client to work on following rules at school, and increasing attention and concentration.

R - Clinician and MH Specialist agreed to the plan, with aim of reducing client’s aggression and defiance, and improving attention.

P — Will meet again before next week’s session to assess whether the plan was effective.
Collateral

California Code of Regulations, Title 9, Collateral:

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

Quality Improvement Additional Clarification

Collateral is defined as contact with one or more significant support persons in the life of the client with the intent of improving or maintaining the client’s mental health wellness and recovery.

Collateral - A service activity that:

- Helps significant support persons to understand and accept the client’s condition
- Involves identified significant support person/people in planning of and implementation of client plan(s)
- Focuses on benefiting the client by working with the client’s significant family members, with or without the client present. (The family members should be identified as significant support persons for the client.)

Collateral sessions (with one or more clients represented) can only be billed for working on issues pertaining to the client, not issues specific to the collateral support person.

Billable Collateral Activities

- Obtaining information relevant to the client from an important person in client’s life
- Discussing (with Release of Information) with an important person in client’s life how to collaborate and help client to overcome obstacles, or how they might support (and not hinder) some area of improvement in functioning in client’s life
- Helping family members who are part of the client’s significant support team implement supportive strategies that will help the client meet his/her service plan goals and objectives and a greater degree of wellness and recovery

Sessions must always relate to improving or maintaining the mental health status of the client. Client may or may not be present.
• Providing psycho-education around the client’s symptoms, strengths, barriers, and paths to wellness and recovery, providing family coping strategies, intervention strategies, and support, or otherwise advising them on how to assist the client

**Activities Not Billable as Collateral**

• Coordinating/linking with other providers, for example: Working with outside/adjunct agency staff, school teachers, board and care operators, residential treatment/group home staff (use Case Management Code 384)
• Providing individual therapy for a client’s parent or significant other (NOT an approved service)
• Working with anyone else not perceived by the client as a member of the client’s immediate family/support system (use Case Management Code 384)

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**BIRP Note for Collateral:**
Providing psychoeducation to a client’s caregiver

- **Start Time:** 10:02 a.m.
- **End Time:** 10:20 a.m.
- **Doc Time:** 8 min.
- **Total Time:** 26 min.

---

**B** — Telephone contact from client’s mother regarding status of behavior modification strategy to increase client’s ability to complete chores with two prompts or re-direction (Client Service Plan Objective #2). Mother reported that she was “so frustrated” and that “it doesn’t work.” Mother indicated that the client “only did half of what I told her to do then went to her room and ignored me.” Mother indicated that client has been following directions at school but “just won’t listen to me at home.”

**I** — Provided reflective listening and validated mother’s feelings of frustration. Identified strategies to address the client’s resistance to mother’s parenting (e.g. loss of privileges). Discussed positive reinforcers and the importance of consistency. Reviewed use of oral praise and token economy when desired task had been completed.

**R** — Mother said that she “felt so tired last night it was all I could do to not get upset.” Mother indicated that she had not used oral praise and instead had focused on the negative behaviors and then got in a cycle of negative feedback. Mother agreed to use oral praise and token economy as positive reinforcers three times daily leading up to our next session.

**P** — Plan to continue referring parent to parenting classes and support groups for parenting. Plan to meet with client and parent at next scheduled appointment to explore the client’s goal for behavior and continue use of rewards for improved behavior at home.
BIRP Note for Collateral:
Planning and Implementing
Client’s Plan
Start Time: 1:17 p.m.
End Time: 1:40 p.m.
Doc Time: 11 min.
Total Time: 34 min.

B — Telephone contact from client’s girlfriend regarding client’s status. Client has a release of information on file. Girlfriend says that the client has been more agitated lately. He has had a decreased need for sleep, seems manic on task completion, and his hygiene is deteriorating. Overall her impression is that he is decompensating. She is uncertain if he has been taking his medications lately “or if they aren’t working anymore.”

I — Obtained her observations of the client. He has previously identified her as a key support person in his recovery and wellness in his Wellness and Recovery Action Plan. Developed plan for collaborative intervention to include face-to-face brief assessment of client for mental status, and referral for psychiatric evaluation.

R — Girlfriend indicated that, during periods when the client has deteriorated in the past, he has been responsive to his girlfriend’s prompts for mental health intervention. Past decompensation was four months ago when he lost his job at the community center. During periods of stress, the client has had a history of checking medications. Girlfriend indicated her willingness to approach the client about making contact with his provider to discuss a face-to-face meeting.

P — Plan to meet with client for face to face brief assessment of current functioning and to mutually develop plan for coping. Plan to schedule client a psychiatric appointment.

Collateral Group is a meeting with a group of significant support persons (i.e. family, alternative caregivers), of more than one client, with the specific intent of improving or developing the support person’s skills necessary to support clients in achieving their treatment goals.

Collateral Group Code: 315
The successful mental health treatment of clients with mental illness or serious emotional disturbances frequently requires contact with persons who play an integral part in assisting the beneficiary in achieving the goals of their client plan.

Collateral contacts may include, but are not limited to, consultation and training of the significant support persons to assist in better utilization of specialty mental health services by the beneficiary, promoting a better understanding of the client’s mental illness, and assisting the beneficiary in meeting their client plan goals. Collateral may also include family counseling with significant support persons. It should be noted that the beneficiary is not required to be present when the collateral contact occurs.

The collateral contacts provided in a group setting must be clearly documented in each client’s mental health client plan and chart. In addition, the provision of the service must be carefully coordinated with the other specialty mental health services being provided.

For Collateral Group, the group log is somewhat different than for other groups:

- Enter the number of clients represented by the people in the group, whether or not the client is actually present. For example, in a parent support group some clients may be represented by two parents and others by just one
- The log should reflect each client just once irrespective of the client’s number of representatives
- When families meet together, some with multiple siblings of the client in attendance, again, only the client should be counted once
- If there are multiple clients in a family participating in the group, each client will be counted

In terms of progress notes, all of the different kinds of groups—Group Psychotherapy, Group Rehab and Collateral Group—are documented in the same way. There may be similar or exactly replicated statements describing the group purpose in each participant’s progress note, but that note must also include a significant description of the participant’s unique participation, presentation and response to the group intervention. For Collateral Groups, the note should be clear in tying the group service and participants’ responses to the client’s Service Plan goals and objectives.

**BIRP Note for Collateral Group:**

There were 5 clients represented by the group participants.

Parent Support Group for Children with Mental Illness at Vallejo Children’s Clinic.
The topic was “Understanding Bipolar Disorder in Children”
**B** — Client’s mother attended the group due to client’s history of bipolar disorder, and her difficulty accepting his diagnosis. Client has been having severe and rapid mood swings, and mother is distraught.

**I** — Group facilitator led the group in a discussion of bipolar disorder, providing education about the disorder and its treatment. Facilitator challenged the group to compile a list of “red flag” symptoms that might lead to inpatient psychiatric hospitalization. Facilitator then allowed each participant to process issues regarding their child, as well as offer support and suggestions to others in the group.

**R** — Client’s mother expressed relief at being with others experiencing similar problems as she does with client. She talked about other family members and friends making her feel like a bad parent because client gets so out of control. Mother was receptive to suggestions by other group members regarding trying medication. Client has never been on medication due to mother’s fears about side effects and her denial about his bipolar diagnosis. Mother agreed to set up an appointment with the psychiatrist to discuss the possibility of trying meds.

**P** — Facilitator will inform client’s clinician about mother’s change of heart regarding having client try medication. Group to meet again in two (2) weeks when ADHD will be the topic.
Medication Support

California Code of Regulations, Title 9, Medication Support Services

“ ’Medication Support Services’ means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.” (§ 1810.250)

Medication Support Services include:

- Prescribing
- Administering
- Dispensing
- Monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness

Service Activities may include but are not limited to:

Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- Obtaining informed consent
- Medication education
- Instruction in the use, risks and benefits of and alternatives to medication
- Collateral and plan development related to the delivery of the service and/or assessment of the client
- Prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals

Allowable Costs - May include drugs and laboratory tests related to the delivery of this service.

Scope of Practice - Medication Support Services must be provided within the scope of practice by:

- Physician
- Registered Nurse
- Licensed Vocational Nurse
• Psychiatric Technician
• Pharmacist
• Physician Assistant

**Medication Support Service Documentation**

• Supports the need for medication
• Evaluation of clinical effectiveness and side effects
• Obtaining of informed consent
• Instruction in the use, risks and benefits of and alternatives to medications
• Collateral and plan development related to the delivery of the Medication Support Service

**Lockouts**

Medication Support Services are not reimbursable on days when Psychiatric Inpatient Services [CCR Title 9, §1840.215(d)] or Psychiatric Health Facility Services [CCR Title 9, §1840.370] are reimbursed, except for the day of admission to either service.

**Psychiatric Assessment** - Initial face-to-face services provided to a client with the express purpose of evaluating the need for medication to relieve the symptoms of mental illness. If medications are prescribed, includes time spent on medication education, obtaining informed consent, and plan development during the initial session.

![Psychiatric Assessment](#)

**Medication Refills without Face-To-Face Contact** - Non-client contact services provided to authorize refills of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. Includes time spent reviewing the medical record.

![Medication Refills without Face-To-Face Contact](#)

**Medication Support Services** - Those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, obtaining informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.
Medication Support Services

**Nursing Assessment** - A service provided to a client with the express purpose of obtaining information pertinent to diagnoses and treatment, including obtaining biological specimens for analysis, obtaining and reviewing records from other treatment providers or collateral contacts, and consultation with physicians regarding client response to treatment and/or case history.

**Nursing Assessment**

**Code: 369**

**Nursing Services** - Those services which include administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

**Nursing Services**

**Code: 367**
Medication Support General Guidelines

Informed Consent

A voluntary client shall be treated with psychotropic medications only after s/he has been informed by the physician of his/her right to accept or refuse such medications (CCR Title 9, §851)

The Information received by the client and documented by the physician shall include, but need not be limited to (CCR Title 9, §851):

- Nature of the client’s mental condition
- Reason(s) for taking the medication(s), including the likelihood of improving or not improving without the recommended medication
- Type, range of frequency and amount, and method and duration of taking medication(s)
- Probable side effects which commonly occur and any possible additional side effects which are likely to occur if medication is taken beyond three (3) months; the client shall be advised in accord with the medication(s) prescribed that the symptoms of tardive dyskinesia are potentially irreversible and may continue or appear after medications have been discontinued.

Additional Elements to Include in Medication Support Documentation

- Reasons for changes in medication and/or dosage shall be clearly documented by the psychiatrist
- A description of what was attempted and/or accomplished at the time the service was provided is to be included in the progress note

Medication Prescribing/Dispensing/Administration – Must be facilitated by an appropriately licensed provider. The note shall contain the following information:

- Name, dosage, and quantity of medication(s)
- Frequency and route of administration

Non-Physician Providers – When a non-physician provides medication support services (within their scope of practice), the documentation is to include:

- Description of the client’s response to the medication
- Side effects
- Compliance with medication

Outside Providers - If outside physicians prescribe psychotropic medications, complete information about such medications shall be documented in the chart.
Crisis Services

California Code of Regulations, Title 9, Crisis Intervention:

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

“’Crisis Intervention’ may either be face-to-face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.” (§ 1840.336)

Quality Improvement Additional Clarification

Crisis Intervention is an unplanned service involving actual or potential threats of danger to self, danger to others, or grave disability. The acute nature of the condition requires a more timely response than a regularly scheduled visit. This service is delivered at a site other than a Crisis Stabilization program. Crisis intervention services may either be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community.

While a client might state that s/he is in crisis, it is the responsibility of the provider to determine if the situation is a crisis. If the provider determines that the client is not in crisis, the appropriate non-crisis code must be billed for the service. If it is in fact a crisis intervention, be sure to indicate “yes” on the drop-down box at the top of the progress note, that it is an “emergency psychiatric condition”.

Crisis Intervention

Code: 371
Code CONREP: 374

Crisis Intervention is an unplanned need for immediate service to assess whether or not the client meets the criteria for:
- Danger to Self
- Danger to Others
- Grave Disability due to a mental disorder
**Billable Activities**

The service activities that fall within the scope of crisis intervention may include but are not limited to:

- **Assessment** (must document crisis—i.e. threats to self/others, risk behaviors, severe symptoms...etc.)
- **Collateral** (exchanging information about the crisis with those perceived by the client to be members of his or her immediate family/support system)
- **Therapy** (supportive services as the situation dictates, to assist the client to navigate the crisis as safely as possible)
- **Case Management** (interfacing with other providers or agencies to facilitate the crisis intervention)

**Medi-Cal Lockouts (CCR Title 9, §1840.366)**

- Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facilities Services, Psychiatric Nursing Facility Services, or Inpatient Services are reimbursed, except for the day of admission to those services
- The maximum amount billable for Crisis Intervention within a 24-hour period is 8 hours

**BIRP Note for Crisis Intervention:**

| Start Time | 11:00 a.m. |
| End Time   | 1:00 p.m. |
| Travel     | 40 min.   |
| Doc Time   | 10 min.   |
| Total Time | 170 min.  |

**B** — Received a telephone call from school principal requesting immediate response due to client throwing a chair at her teacher and destroying property at school. This writer arrived at the school site in Vallejo to find client in a quiet room yelling obscenities and threatening to kill her peers if she got out. Upon seeing this writer, client angrily yelled and cursed at this writer, and accused her peers of “setting her up.”

**I** — Client calmed down after about 15 minutes and agreed to speak with this writer about the incident. Assessed client for risk to herself and to others.

**R** — After calming down, client was assessed to be at low risk for hurting herself or others. Client was willing to discuss the incident, and reported that she was outside playing with her peers when she was told to “hide” and they would come get her when recess was over. Her peers did not follow through, resulting in her teacher advising client that she will receive a demerit for being late.
to class. At this point, client admitted accusing the teacher of being “unfair” and throwing a chair at him.

**P** — Was informed that mother had been called and that client would be going home from school today because client has been suspended for two days for this incident. Will plan to continue to work with client on better anger management techniques and impulse control.

**BIRP Note for Crisis**

<table>
<thead>
<tr>
<th>Intervention:</th>
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<tbody>
<tr>
<td><strong>Start time:</strong> 11:03 a.m.</td>
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<tr>
<td><strong>End Time:</strong> 12:01 p.m.</td>
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<tr>
<td><strong>Doc Time:</strong> 10 min.</td>
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<tr>
<td><strong>Travel</strong> 25 min.</td>
</tr>
<tr>
<td><strong>Total Time:</strong> 99 min.</td>
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**B** — Client has been treated, over the last six months, for signs and symptoms of mood instability that have led to impaired interpersonal, family and occupational functioning. When this writer arrived at client’s home in Fairfield for scheduled individual session, client answered the door crying and said she was going to take a bottle of aspirin because her boyfriend just broke up with her. She has never threatened suicide before.

**I** — This writer urged client to try to calm down and contract for safety. Attempted to provide options for client to problem-solve through the immediate emotional crisis in an attempt to de-escalate client’s emotional reactivity. When client continued to sound despondent and hopeless and said she wanted to die, this writer evaluated suicidality further and determined that client appeared to be at risk for self-harm. This writer called 911 and asked for a health and safety check from the local police department. This writer also called the psychiatric emergency team and asked that a team member meet client at the hospital for evaluation.

**R** — Client continued crying and reported thoughts of suicide that escalated as session progressed. Client said she was feeling extremely hopeless and saw no reason to live. Client demonstrated that she was unable to consider any other options and appeared unable to think reasonably or rationally. When this writer called 911, client agreed to be taken to the ER by police, who arrived shortly. Client understood that she would be met by a psychiatric emergency team member at the hospital for further evaluation.
P — If client is hospitalized, this writer will negotiate discharge planning and provide feedback to hospital staff regarding observations made during this writer’s crisis assessment. Will work with client to devise a safety plan in the event of another crisis.

Crisis Evaluation for Jail or Juvenile Hall Client - Clinical assessment of clients housed in jail or juvenile hall to evaluate the appropriateness of instituting an involuntary hold under Welfare and Institutions Code § 5150.

Crisis Residential Treatment Services - Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for beneficiaries, as an alternative to hospitalization, for clients experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports clients in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral and crisis intervention.
Targeted Case Management/Brokerage and Placement

California Code of Regulations, Title 9, Targeted Case Management:

“ ‘Targeted Case Management’ means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development.” (§ 1810.249)

Quality Improvement Additional Clarification

Targeted Case Management is utilized when:

- Linking clients to necessary services
- Consulting with other necessary professional entities (who are not identified as the client’s support person/people) when linking client to other necessary services
- Gathering information that will benefit client in receiving necessary services from sources (who are not identified as the client’s support person/people) such as medical providers, social workers and educators
- Making referrals to providers for needed services
- Monitoring activities for necessary follow-up
- Establishing contacts necessary to ensure client’s treatment plan is being effectively implemented and that progress toward goals is being made

Targeted Case Management is NOT skill development, assistance in daily living, or training a client to access services himself/herself. (These activities may be billable under Rehabilitation.)

Crisis Stabilization Units: Targeted Case Management is reimbursable during the same time crisis stabilization is provided. (No other specialty mental health service is reimbursable during the same period Crisis Stabilization is reimbursed.) [§1840.368(b)]

Crisis Residential Services: Billing Targeted Case Management services is permissible any time during a client’s stay in a Crisis Residential facility, as are Medication services. However, Mental Health Services, such as assessment, collateral, psychotherapy or rehabilitation can only be billed on day of admission.

Fee-for-Service Hospitals: Targeted Case Management cannot be billed except for day of admission and discharge planning 30 days prior to scheduled discharge. Medication services and mental health services can continue to be billed.
Short Doyle/Medi-Cal Hospitals: Targeted Case Management cannot be billed except for the day of admission and discharge planning 30 days prior to scheduled discharge. Medication services and mental health services can only be billed on day of admission.

Targeted Case Management  
Code: 384

Billable Activities

- Communication, coordination, and referral service activities. (Referral services activities do not include solely clerical tasks of “copying and completing paperwork for referral”)
- Monitoring client’s access to services
- Monitoring client’s progress (i.e. providing verbal report to non-treatment providers Child Welfare Services Social Workers, educational staff, lawyers for foster care clients, etc.
- Relaying information that is medically necessary from client, therapist, case manager, or psychiatrist to another person
- Placement Services including:
  - Assessment regarding appropriateness of placement
  - Clinical needs determination
  - Locating and securing an appropriate living environment
  - Pre-placement visit(s)
  - Placement and placement follow-up—see below for more on this function
  - Accessing services necessary to secure placement

Non-Billable Activities

There will be services that a case manager performs that should be documented but are not billable; these are coded under 381.

- Any activity that is clerical in nature, e.g. filling out SSI paperwork for/or with a client
- Faxing
- Emailing
- Compiling packets for residential placements
- Composing letters
- Writing court reports
- Providing transportation (without a simultaneous clinical activity/intervention)
- Receiving and leaving voice mail messages
- Completing Adult Protective Services (APS) or Child Welfare Services (CWS) reports
- Grocery shopping for a client
- Accompanying a client to a 12-step meeting
- Providing a case management service to a member of the client’s support system that has no direct link to the client’s treatment goals, objectives, diagnosis, impairment, etc.
**B** — Travelled to Jesse Bethel High School in Vallejo to meet with client’s parents and teacher. The client’s mental health symptoms have been escalating despite increases in outpatient treatment services of individual therapy, case management, rehab services, and more frequent psychiatry services to stabilize client. Client reports frequent depressed mood and continues to experience suicidal ideation. Client has utilized crisis services twice this month but did not meet criteria for 5150. The client’s parents and school staff feel that client may “need more.”

**I** — Met with parents and teacher to review client’s current presentation in comparison to baseline established six months ago. Frequency of suicidal ideation has increased from once or twice a month to once weekly. Noted client’s increased use of intensive services and her continued instability at home and at school. Agreed to complete referral packet to facilitate client’s access to more intensive mental health services, including day treatment and residential treatment.

**R** — At the current level of services, client’s presenting issues have not been stabilized. Client has met with the psychiatrist three times this month to adjust medications with no improvement.

**P** — Complete referral packet. Case will be presented at the Interagency meeting next week.

**B** — Adult consumer was brought into the clinic for an appointment. During the appointment, the consumer and mother reported that the consumer has been meeting with his medical doctor for issues not related to his mental health treatment.
I — Discussed the value of communicating with client’s primary care physician in order to coordinate care and rule out medical conditions that may affect mental health symptoms or treatment. Further explained the importance of obtaining client’s medical records for the psychiatrist to review to determine whether psych meds are appropriate and safe in conjunction with other medications the client’s primary care physician is currently prescribing.

R— Consumer agreed to have coordination of care by mental health and medical care providers. Consumer signed a release to allow verbal exchange of information with his doctor, as well as permission for his doctor to send client’s medical records. The consumer accepted the offer to have a copy of the release for his records.

P — Writer to follow up with a letter to the consumer’s medical provider requesting consultation and coordination of services, and to submit the release for medical records. Plan to wait for receipt of requested documents from medical provider.

Placement Visits - Intensive case management clinicians who do placement visits face a special set of circumstances that need to be documented. Placement visits are typically billed as 384, Targeted Case Management, for the purpose of monitoring the client’s progress at his/her current placement. The progress note should state where the visit is occurring, and name the program and location. Clinicians should not provide therapy services during placement visits, as placement staff are charged with providing therapy. Placement visits should not be billed as Assessment or Plan Development, unless the Client Assessment Update or Client Service Plan is being completed with the client. During some placement visits, clinicians may take the client out in the community as a reward. This outing should be written up separately from the case management note as a non-billable service.

| BIRP note for Placement Visit: |
| Start Time: 2:15 p.m. |
| End Time: 3:20 p.m. |
| Travel: 125 min. |
| Doc Time: 12 min. |
| Total Time: 3 hrs., 22 min. |

B — Travelled to Edgewood Center in San Francisco for initial monthly placement visit. Client presented as depressed and tearful, stating that she wanted to go home.

I — Met with client and staff to monitor how client has been adjusting to her new placement. Validated client’s feelings of homesickness. Inquired specifically with staff about client progress on
client’s treatment plan objective #1 to reduce self-injurious behavior. Explored ways with staff to make client feel more comfortable and less isolated. Encouraged client to use her social skills and take part in activities that are offered. Reviewed treatment plan goals, and discussed plan for a family session next month.

**R** — Staff were very responsive, making positive comments about client’s progress and offering suggestions on how to reduce some of her anxiety and depression. Staff indicated that the client surrendered voluntarily a sharp object after she indicated that she wants to begin coping with her depression in more healthy ways. Client was skeptical about her overall progress and about her ability to adjust to this setting, but agreed to make an effort to be more social. She was more animated by the end of the session.

**P** — Will visit again next month to continue to monitor client’s adjustment to placement, depressive symptoms and self-injurious behaviors. Will coordinate visit with parents.

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**Lockouts**

Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, with the exception of the day of admission or for placement services as provided below (§ 1840.374):

- Psychiatric Inpatient Hospital Services
- Psychiatric Health Facility Services
- Psychiatric Nursing Facility Services
- Juvenile Hall

| Lockout Case Management | Code: 303 |

This new procedure code is to be used when a provider is claiming for a service that would otherwise be billable to Medi-Cal, but cannot be claimed because the client is in a “lock-out” setting such as a Crisis Residential, inpatient psychiatric hospital, Juvenile Hall or jail. The utility of this procedure code has been expanded from its original “Targeted Case Management” focus to include other Title 9 Mental Health Services, so please be aware of the expanded parameters listed below.
When writing a progress note using this code:

- Craft the progress note using the Documentation Manual guidelines that guide service documentation for that service (e.g. Assessment, Collateral, Rehab, Therapy, Case Management, etc.)
- Indicate at the beginning of the note what service is being billed under the Lockout code—i.e. Targeted Case Management, Individual Rehab, Collateral, Assessment...etc.
- Create the progress note using B.I.R.P format, and be sure to demonstrate the connection between the client’s “included” diagnosis, their functional impairments, and the service being provided
- Do not use this code when Brokerage and Placement can be used instead—i.e. when writing a progress note focused on discharge planning for a client within 30 days of the client’s discharge from a hospital
- Do not use this code for a service that would normally be non-billable (such as leaving a voice mail, completing a clerical task, completing tasks without a link to diagnosis and/or impairment, writing a court report, supervision, etc.) For these tasks use the 381 Non-Billable Code

Please make every effort to deliver billable services when a client is NOT in a Lockout setting, to generate revenue for your program. However, if clinically indicated, deliver the service to the client in the Lockout setting and utilize this procedure code as described above.
Brokerage and Placement

**Brokerage and Placement** - Targeted Case Management Services solely for the purpose of coordinating placement of the client upon discharge from a psychiatric inpatient hospital, psychiatric health facility, or psychiatric nursing facility may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less, per continuous stay in the facility. Brokerage and Placement provides linkage to community resources for the purpose of coordinating placement following discharge from a psychiatric inpatient facility, psychiatric health facility (PHF), or Institute of Mental Disease (IMD).

<table>
<thead>
<tr>
<th>Brokerage and Placement</th>
<th>Code: 380</th>
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Day Treatment Services

California Code of Regulations, Title 9, Day Treatment Intensive:

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

Quality Improvement Additional Clarification

For seriously emotionally disturbed children and adolescents, Day Treatment Intensive provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration. Interventions are intended to prevent hospitalization, placement in a more restrictive facility, or out of home placement. This service may be integrated with an education program. A key component of this service is contact with the families/caregivers of these clients.

Day Treatment ½ day: Codes: 286
Day Treatment full day: Codes: 281

Medication Support Services are billed separately from Day Treatment Intensive.

DMH Letter 03-03: Please see DMH Letter 03-03 for more detailed information visit www.dmh.ca.gov/dmhdocs/2003_Letters.asp.

California Code of Regulations, Title 9, Day Rehabilitation:

“‘Day Rehabilitation’ means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.” (§ 1810.213)

Quality Improvement Additional Clarification

For seriously emotionally disturbed children and adolescents, Day Rehabilitation focuses on maintaining individuals in their community and school setting, consistent with their requirements
for learning, development and enhanced self-sufficiency. Services emphasize delayed or impaired personal growth and development and ways to improve functioning in these areas, and may be integrated with an education program. A key component of this service is contact with the families of clients.

<table>
<thead>
<tr>
<th>Day Rehab ½ day:</th>
<th>Codes: 295</th>
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<tbody>
<tr>
<td>Day Rehab full day:</td>
<td>Codes: 291</td>
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**Non-Billable Activities**

Two half-day programs may not be provided to the same client on the same day.

**DMH Letter 03-03:** Please see DMH Letter 03-03 for more detailed information visit [www.dmh.ca.gov/dmhdocs/2003_Letters.asp](http://www.dmh.ca.gov/dmhdocs/2003_Letters.asp).
Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Service (TBS)

TBS services are one-to-one therapeutic contacts between a mental health provider and a client, completed within a specified short-term period of time, and designed to maintain the child/youth’s residential placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals.

Therapeutic Behavioral Services:  Code: 347

A contact is considered TBS if intended to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that is the barrier to achieving or maintaining residence at the lowest appropriate level.

Important components of delivering TBS include the following:

- Making collateral contacts with family members, caregivers and other significant support persons in the client’s life
- Developing a TBS plan that clearly identifies specific target behaviors and interventions

Use this code only if TBS has been pre-approved

Therapeutic Behavioral Services (TBS) must be provided face-to-face with the client and may be provided anywhere in the community. Services can be provided to clients up until their 21st birthday.
Psychological Testing

MFT, LCSW and Unlicensed Providers

The Administration of Psychological Testing – This procedure code would be used when an MFT, LCSW or unlicensed provider administers the testing.

| Psychological Testing Administration Technician | Code: 386 |

Ph. D Providers

The Administration of Psychological Testing – This procedure code would be used only when a Ph.D. Provider administers the testing.

| Psychological Testing Administration Psychologist | Code: 388 |

Progress Note Documentation: When using these codes, the activity is to be documented in the BIRP format.
Intake Assessment

Assessment Timelines - Assessments are to be completed fully within two (2) months of initial contact with the client.

The majority of the clinical information is meant to be captured on the clinical assessment document. The assessment needs to be considered as a “stand alone” document in terms of describing symptoms to support the diagnosis, functional impairment(s), and justification for medical necessity. It is this document that is carried forward when referrals are made, or when a chart is split.

Necessary elements of the assessment include:
- Establishment of medical necessity
- Description of functional impairment(s)
- Description of how intervention criteria are met
- Description of symptoms to justify diagnosis
- Included Title 9 diagnosis
- Complete five-axis Diagnosis
- Legible signature, and co-signature when applicable
- Date Assessment completed (next to signature)

Audit Alert: If the assessment in the chart is not completed within 2 months or does not have the necessary elements, then the entire period covered by the assessment may be disallowed.

Correct Immediately: In a case like the Audit Alert listed above, the Primary Service Coordinator (or the service provider receiving the case) should complete a Client Assessment Update immediately (as a re-assessment of the client’s functioning) but this will only “save” the services that are provided from that period forward until the annual Client Assessment Update is due.
Client Assessment Update

Assessment or re-assessment of a client to establish medical necessity is required at least on an annual basis within the Solano County Mental Health Plan. This process serves to re-evaluate the client’s level of functioning or impairment, symptoms to justify clinical impressions, and to re-establish justification for medical necessity. The annual assessment should contain elements that are required for the initial assessment in terms of Title 9 requirements. (Please refer to Chapter Two for further details.) This form is also used to report changes in the client’s address, phone number and significant others.

When to Complete the Client Assessment Update

- When there is a significant change in the client’s level of functioning or diagnostic impressions
- Annually, prior to the expiration of the previous period of authorization
- When an initial assessment has not sufficiently addressed the required elements to justify medical necessity (e.g. level of impairment, needed interventions, and an included diagnosis)
- To report a change in the client’s phone number, address or to add or delete a significant other contact person. (A release of information should always be obtained when assigning a new significant person)

Audit Alert: The Client Assessment Update in the chart must be completed prior to the expiration of the previous period of authorization. If this does not occur, all services provided after the service authorization has expired will be disallowed, until such time that the Client Assessment Update is completed. If the Client Assessment Update does not have the necessary elements, then the entire period covered by the Client Assessment Update may be disallowed.

Correct Immediately: In the case like the Audit Alert listed above, the Primary Service Coordinator (or the service provider receiving the case) should complete a Client Assessment Update immediately (as a re-assessment of the client’s functioning) but this will only “save” the services that are provided from that period forward until the annual Client Assessment Update is due.
Client Service Plan (CSP)

Client Service Plans are to be completed within 2 months of initial client opening or within one (1) month of the plan’s expiration. The plan does not begin until the date on which it was signed and ends the last day of the month prior to the annual system episode opening date. Plans cannot be “back dated” to cover lost services that were not covered under the current plan.

Requirements of the Client Service Plan include: Client’s strengths, barriers to the client’s movement towards goals and objectives, and treatment objectives that are observable, measurable and/or quantifiable. It can be helpful to include a baseline observation of frequency and intensity of problem behaviors, and a specific target for intended behavioral changes. These objectives should be related to the client’s diagnosis and functional impairments and/or symptoms.

If none of the treatment objectives is a behavioral/mental health objective, during an audit there is the risk that all services covered by the client service plan will be disallowed.

This form must be signed by the client. (In the case of a child or dependent adult, it must be signed by their parent/legal representative.) If it is not signed, there should be written documentation on the Client Service Plan as to the reason why it was not signed, and how the client participated in the development of the plan.

If the form is not signed initially, document why both in the content of a progress note and on the Plan. Continue to document ongoing efforts to obtain the signature—i.e. sending a letter (to be filed in the correspondence section of the chart.) If there is no signature present at the time of an audit AND there is no evidence of ongoing efforts to obtain it, all services covered by the plan could be subject to disallowance.

Offer a copy of the Client Service Plan to the client and/or the legal representative and document if a copy of the Plan was accepted or declined.

The Psychiatric Service Plan does not have a line that says “plan was offered to the client.” Staff should use a stamp or a handwritten statement on their Plan.

Audit Alert: If the client is “meds only”, then an auditor will look for the Psychiatric Service Plan. If the client receives additional services, then the Client Service Plan would be completed. This is the document that an auditor reviews.
Psychiatric Service Plan and Target Symptom Inventory (TSI)

Solano County Mental Health Psychiatrists are required to participate in the planning of treatment and service authorization in ways that are unique to their role in our MHP system. The role our Psychiatrists play in these areas is governed by the following principles:

1. All services need to establish medical necessity which, in our system, occurs through a Client Assessment or Client Assessment Update.
2. All services need to be governed by a Client treatment plan. This can be accomplished in our system by completing the Client Services Plan (purple form), the Psychiatric Services Plan (side one of grey form) with the Target Symptom Inventory (side two of grey form).
3. All services need an official mechanism of authorization. This is accomplished by either a Licensed/License-eligible clinician on the Service Authorization form (pink) or a Physician on the Psychiatric Service Plan (side one of grey form).

**Psychiatrist Service Plan/Authorization Matrix:** Here is a list of specific circumstances, what form would be completed, and who would complete it:

<table>
<thead>
<tr>
<th>Forms to Complete</th>
<th>Providers on the Case</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Target Symptoms Inventory (TSI)</td>
<td>- Physician (Medication Only)</td>
<td>- Both of these forms are completed by the Physician</td>
</tr>
<tr>
<td>- Psychiatric Service Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Target Symptoms Inventory (TSI)</td>
<td>- Physician</td>
<td>- TSI and Psychiatric Service Plan is completed by Physician</td>
</tr>
<tr>
<td>- Psychiatric Service Plan</td>
<td>- Mental Health Specialist</td>
<td>- Client Service Plan completed by MH Specialist</td>
</tr>
<tr>
<td>- Client Service Plan</td>
<td></td>
<td></td>
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<tr>
<td>- Target Symptoms Inventory (TSI)</td>
<td>- Physician</td>
<td>- TSI ONLY is completed by Physician</td>
</tr>
<tr>
<td>- Client Service Plan</td>
<td>- Mental Health Clinician (licensed or license eligible)</td>
<td>- Client Service Plan and Service Authorization are completed by MH Clinician</td>
</tr>
<tr>
<td>- Service Authorization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Service Authorization Form**

This form is used to authorize mental health services, targeted case management and medication services. It is also used for changing the primary service coordinator (PSC).

When authorizing a service for a particular service provider, **list the provider’s program name and contact number** instead of the provider’s name e.g. list “Fairfield Children’s Outpatient Clinic” rather than “Sally Smith, LCSW”.

The **start date** is the first date that you authorized the service.
The “end date” should not be a date beyond when the client plan expires. It is best to match the end date of the Client Service Plan.

The “Mental Health Services” box (1st box on page) for authorizing services is separated from “Targeted Case Management” (2nd box on page).

- If you plan to provide any type of case management, be certain to authorize your program’s service in the “targeted case management” box.
- If you plan to provide therapy, rehab services, collateral, assessment, plan development, then your program’s service will need to be authorized in the “mental health services” box.

The PSC will need to initial and date when there are additions to the authorizations.

If a non-physician clinical staff is the PSC, then the authorization for medication management listed in the “medication management” box (3rd box on page), with name of program, should be utilized.

AB 3632 status remains on the form, but is likely no longer relevant for most MHP providers.

**Group Service Log**

- There are no more than two (2) staff members per group
- Each note needs to be unique to the client in terms of the client’s behavior at onset of the group and their response to the intervention
  - The group intervention may be the same because the intervention was presented in a group format
- A group log must be completed and signed
  - Billing is generated from the group log and not the progress notes when there is a group note

**Common mistakes from group notes are:**

- The group log does not list the total number of participants in the group regardless of Medi-Cal status.
  - This error can be corrected by writing the full name of Medi-Cal clients, along with initials of non Medi-Cal Clients. *The log must adequately reflect the total number of people that had received treatment in the group for proper billing.*
- Group log is not signed.
- Group log date does not correspond with group note
- Use of incorrect billing code (i.e. use of AB 3632 code when client does not have AB 3632)
• Clinical staff fails to notify clerical staff when a service was provided at a lock-out site, an attendee is a resident of a lock-out site (i.e. Laurel Creek) or fails to notify clerical of which clients to not bill.
• More than two staff persons billing for group.

**LOCUS and CALOCUS**

The “Levels of Care Utilization System” (LOCUS) and “Child and Adolescent Levels of Care Utilization System (CALOCUS) are used by our system as treatment planning and utilization management tools. Scores on the CALOCUS are based on the clinical need of clients and help ensure that clients receive the types and amount of services that correspond to the clinical need. These tools are an important part of our system and have been integrated into the timeline structure for other important clinical documents. In addition, the CALOCUS has been useful in authorizing day treatment services.

**Who completes the CA/LOCUS?**

The CA/LOCUS should be completed by clinicians who have been trained in its use and who can direct the client plan as defined by their Scope of Practice. In order to ensure inter-rater reliability, clinicians are urged to complete the form using the scoring grid by the authors of the form.

The form should be completed by the clinic or team assigned as the care coordinator for the case. Adjunct providers are not expected to complete the CA/LOCUS.

**Timelines**

For new clients, the team has two months to complete the initial CA/LOCUS. For clients continuing in care, the CA/LOCUS must be completed in the window period (one month) prior to the anniversary date. This means the CA/LOCUS is completed on the same schedule as the Client Service Plan (CSP) and the Client Assessment Update.

**Consent for Treatment (Revised January 2010)**

This informed consent for mental health services replaces the previous consent to treat form. It should be completed at time of initial contact for all clients. The form should be explained to the client by the treating staff member and the signature of the client should be obtained to indicate consent. The “Signature of Authorized Representative” must be obtained for children, adolescents and conserved clients.

This form should be filed in the consent section of the client chart.

**Acknowledgment of Receipt (Revised January 2010)**

This form replaces the Acknowledgment of Privacy Practices form and the Advance Directive Acknowledgement Form. It must be completed at initial contact or at first follow up visit after a crisis visit or hospitalization. By signing the form the client acknowledges receipt of informing materials mandated by the State: Notice of Privacy Practices (NOPP), MHP Guide to Medi-Cal
Mental Health Services, Advance Directives and the receipt or offer of receipt of the Provider List. All clients must be offered these informing materials at first contact and upon request thereafter.

This form should be filed in the legal section of the client chart.
Question 1: How do I write up a progress note for opening an episode?

As part of opening a case to a program, a provider must evaluate a client and complete agency approved documentation commonly known as an “episode opening.” This task is a function of an assessment for a client that is new to the mental health system or is new to a reporting unit to which it is opened. As part of the episode opening, it is good clinical practice, to include in the body of the progress note the purpose of the referral to the particular program and symptoms to support the diagnostic impressions to support the diagnosis. This description can be brief but it demonstrates how the activity is more than a clerical function of completing paperwork. If a provider simply writes “completed opening paperwork” or “opened episode to program ‘x’”, as a stand alone phrase then it will not contain the needed information to justify the use of an assessment code; the provider should instead use a non-billable code.

Sample Note:
Start Time: 9:00 a.m.
End Time: 11:30 a.m.
Doc Time: 15 min.
Total Time: 205 min.

B — Client is an English-speaking, while 16 year old male. He was referred to the Fairfield Children’s Outpatient Clinic for issues relating to mood instability and difficulty maintaining current academic placement. Client has had elevated mood for approximately two weeks with decreased need for sleep, hyperactivity, irritability, and denies use of substances. Prior to the elevated mood he had increased need for sleep, was irritable, and lost interest in “hanging out with his friends.” He has been suspended again for the third time due to fighting and the parent indicates the school wants “to get him out of here.”

I — Met with client and parent for assessment. Reviewed limits of confidentiality, HIPPA, consent for treatment, risks and benefits of treatment, explored client’s linguistic and cultural needs. An Advance Directive was not needed as client is under 18 years of age and is not legally emancipated from his parents. Explored psycho-social treatment with client and formulated clinical impressions on intake assessment to allow client’s access for treatment services, including out-patient therapy, and referral for psychiatric evaluation.
R — Client and client’s parent were open to meeting with this writer for evaluation. They reported onset and duration of symptoms which will be described in the mental health assessment along with strengths within the client and family system. The client was initially hesitant to develop goals for the client service plan “because he was hungry and wanted to go.” He agreed to complete the goals at a future appointment.

P — Plan to meet with client and parent next week to collaboratively develop a service plan based on client’s presenting issues and strengths. Plan to complete written assessment.

Question 2: How do I write a progress note for discharge planning?
Discharge summaries can be billed as an assessment when documented properly. The documentation of the evaluation can be done by providing an overview of treatment history, events leading to client’s discharge, client’s benefit or lack of benefit to treatment interventions, diagnostic impressions, referrals at time of discharge, and recommendations for future treatment if client were to return or resume treatment services in the future. One must be mindful to that if the discharge service is solely clerical in nature, i.e. completing closing paperwork, then that in itself may not justify the use of the assessment code for discharge planning. Notes that read: “completed closing paperwork” as a stand-alone statement will be considered clerical in nature, therefore, a non-billable activity.

Question 3: How do I write up a progress note for closing an episode?
If the activity is written as discharge planning, then this can be a billable service as plan development.

If the task if solely clerical and it includes completing the episode closing paperwork to close the client “out of the system” then this is a non-billable task.

Question 4: On the Service Authorization Form, where are medication support services (nurse) authorized?
This is documented under the Medication Management Section. List the reporting unit of the nurse and the name of the program.

Question 5: Does the BIRP format relate to notes on parent support services?
Yes, it does.

Question 6: When the therapist and doctors consult on a mutual client, and both use the same code (343/346) why can we not use one note with a “co-staff time” instead of writing two separate notes with the same code, same time, and same information?
You can use a plan development to co-staff a “plan development” service activity between two providers with unique, ongoing roles on a case. Please do not refer to it as a “consultation”.

**Question 7:** Could there be a separate form for a change of address and phone number instead of using the three-page Update of Client Information?

Yes. This is a future project for the Quality Improvement Unit.

**Question 8:** Does the PSC sign for medication management on the Service Authorization sheet when a client is not meds only?

Yes.

**Question 9:** Can the social worker authorize foster parent to sign the treatment plan?

Please contact the Foster Care Treatment Unit Supervisor for current practices and protocols.

**Question 10:** Can the foster parent get a copy of the treatment plan if the children are dependent of the courts with approval of the social worker?

Refer to answer in question #9.

**Question 11:** Are contract agencies “required” or “encouraged” to do BIRP notes?

Contract providers are encouraged to use BIRP notes and may be required in future contracts to use BIRP notes.

**Question 12:** Is billing for case management permissible prior to completion of the assessment.

Yes, it is permissible.

**Question 13:** Is completing the Service Authorization Form billable?

Per the state auditors, you cannot bill for simply filling out a form. The progress note must tie the service to the client’s goals and objectives, and demonstrate that it is a medically necessary service.
# Common Abbreviations for Chart Documentation

<table>
<thead>
<tr>
<th>People and Relationships</th>
<th>Abbrev</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td>Adol</td>
</tr>
<tr>
<td>African-American</td>
<td>Af-Am</td>
</tr>
<tr>
<td>Also Known As</td>
<td>AKA</td>
</tr>
<tr>
<td>Asian-American</td>
<td>As-Am</td>
</tr>
<tr>
<td>Black</td>
<td>B</td>
</tr>
<tr>
<td>Boyfriend</td>
<td>BFr</td>
</tr>
<tr>
<td>Case Manager</td>
<td>C/M</td>
</tr>
<tr>
<td>Caucasian</td>
<td>Cauc</td>
</tr>
<tr>
<td>Client</td>
<td>Ct or Clt</td>
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<tr>
<td>Divorced</td>
<td>Div</td>
</tr>
<tr>
<td>Family of Origin</td>
<td>FOO</td>
</tr>
<tr>
<td>Father</td>
<td>Fa</td>
</tr>
<tr>
<td>Fee-for-Service</td>
<td>FFS</td>
</tr>
<tr>
<td>Female</td>
<td>♀ or F</td>
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<tr>
<td>Girlfriend</td>
<td>GFr</td>
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<tr>
<td>Grandfather</td>
<td>GFa</td>
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<td>Grandmother</td>
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<td>Hispanic-American</td>
<td>Hisp-Am</td>
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<td>Juvenile Hall</td>
<td>JV</td>
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<tr>
<td>Lanterman-Petris-Short</td>
<td>LPS</td>
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<tr>
<td>Male</td>
<td>♂ or M</td>
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<tr>
<td>Married</td>
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<tr>
<td>Mother</td>
<td>Mo</td>
</tr>
<tr>
<td>Patient</td>
<td>Pt</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>PCP</td>
</tr>
<tr>
<td>Primary Service Coordinator</td>
<td>PSC</td>
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<tr>
<td>Probation/Parole Officer</td>
<td>PO</td>
</tr>
<tr>
<td>Psych-iatric, -iatrist, -ologist</td>
<td>Ψiatric…</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>PHN</td>
</tr>
<tr>
<td>Sibling/s</td>
<td>Sib/s</td>
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<tr>
<td>Significant Other</td>
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<td>Single</td>
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<td>Sister</td>
<td>Sis</td>
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<tr>
<td>Spanish-Speaking</td>
<td>Sp-Spkg</td>
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<tr>
<td>System of Care</td>
<td>SOC</td>
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<tr>
<td>Temporary Conservatorship</td>
<td>T-Con</td>
</tr>
<tr>
<td>White</td>
<td>W</td>
</tr>
<tr>
<td>Years Old</td>
<td>Yo</td>
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</table>

<table>
<thead>
<tr>
<th>Activities, Cities, General Terms</th>
<th>Abbrev</th>
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</thead>
<tbody>
<tr>
<td>Against Medical Advice</td>
<td>AMA</td>
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<tr>
<td>Appointment</td>
<td>Appt</td>
</tr>
<tr>
<td>As Needed</td>
<td>PRN</td>
</tr>
<tr>
<td>As soon as possible</td>
<td>ASAP</td>
</tr>
<tr>
<td>Away without leave</td>
<td>AWOL</td>
</tr>
<tr>
<td>Brought in by</td>
<td>BIB</td>
</tr>
<tr>
<td>Change</td>
<td>Δ</td>
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<td>Complains of</td>
<td>C/O</td>
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<td>Day</td>
<td>D</td>
</tr>
<tr>
<td>Decrease</td>
<td>↓</td>
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<tr>
<td>Discontinue, Discharge</td>
<td>D/C</td>
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<td>Fairfield</td>
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<tr>
<td>Follow up</td>
<td>F/U</td>
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<td>Fourteen Day Cert</td>
<td>5250</td>
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<tr>
<td>Greater Than</td>
<td>&gt;</td>
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<tr>
<td>Increase</td>
<td>↑</td>
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<tr>
<td>Left message</td>
<td>L/M</td>
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<tr>
<td>Less than</td>
<td>&lt;</td>
</tr>
<tr>
<td>Night</td>
<td>Noc</td>
</tr>
<tr>
<td>No, None</td>
<td>0, Ø</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>NA</td>
</tr>
<tr>
<td>Phone call</td>
<td>PC</td>
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<tr>
<td>Received</td>
<td>Rec’d</td>
</tr>
<tr>
<td>Returned</td>
<td>Ret’d</td>
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<tr>
<td>Seventy-two Hour Hold</td>
<td>5150</td>
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<tr>
<td>Telephone call</td>
<td>TC</td>
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<tr>
<td>Therefore</td>
<td>.</td>
</tr>
<tr>
<td>Voicemail/Voice message</td>
<td>VM</td>
</tr>
<tr>
<td>With (cum)</td>
<td>W, c</td>
</tr>
<tr>
<td>Without (sine)</td>
<td>W/O, s</td>
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</tbody>
</table>
### Common Abbreviations for Chart Documentation

<table>
<thead>
<tr>
<th>Agencies, Clinics, Facilities, Services</th>
<th>Medical &amp; Medication Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Word</strong></td>
<td><strong>Abbrev</strong></td>
</tr>
<tr>
<td>Adult Protective Services</td>
<td>APS</td>
</tr>
<tr>
<td>Aging &amp; Adult Services</td>
<td>AAS</td>
</tr>
<tr>
<td>Board &amp; Care</td>
<td>B&amp;C</td>
</tr>
<tr>
<td>Child Protective Services</td>
<td>CPS</td>
</tr>
<tr>
<td>Christian Help Center (VJO)</td>
<td>CHC</td>
</tr>
<tr>
<td>Community Based Organization</td>
<td>CBO</td>
</tr>
<tr>
<td>Hospital</td>
<td>Hosp</td>
</tr>
<tr>
<td>Institute for Mental Disease</td>
<td>IMD</td>
</tr>
<tr>
<td>Mental Health Plan</td>
<td>MHP</td>
</tr>
<tr>
<td>Mental Health Rehab Center</td>
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<td>Psychiatric Emergency Services</td>
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<td>Psychiatric Health Facility</td>
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<td>School-Based Mental Health</td>
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<td>Skilled Nursing Facility</td>
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<td>Social Security Administration</td>
<td>SSA</td>
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<tr>
<td>Social Security Disability</td>
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<td>St. Helena Center for Behavioral Health (Vallejo)</td>
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<tr>
<td>St. Helena Hospital (Deerpark)</td>
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<td>State Disability Insurance</td>
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<td>Supplemental Security Income</td>
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<td>Therapeutic Behavioral Services</td>
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<tr>
<td>Transitional Aged Youth</td>
<td>TAY</td>
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<tr>
<td>Vocational Services</td>
<td>VOC</td>
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<td>YCM</td>
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<td>MHP</td>
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<td>Skilled Nursing Facility</td>
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<td>St. Helena Center for Behavioral Health (Vallejo)</td>
<td>SHCBH</td>
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<tr>
<td>St. Helena Hospital (Deerpark)</td>
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<td>State Disability Insurance</td>
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<td>Supplemental Security Income</td>
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<tr>
<td>After (post)</td>
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<tr>
<td>After meals</td>
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</tr>
<tr>
<td>Activities of Daily Living</td>
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</tr>
<tr>
<td>As needed</td>
<td>PRN</td>
</tr>
<tr>
<td>Bedtime (hour of sleep)</td>
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<tr>
<td>Before meals</td>
<td>ac</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>BP</td>
</tr>
<tr>
<td>By month (peros)</td>
<td>po</td>
</tr>
<tr>
<td>Chronic</td>
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<tr>
<td>Cubic centimeter</td>
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</tr>
<tr>
<td>Delirium Tremens</td>
<td>DTs</td>
</tr>
<tr>
<td>Electroconvulsive Treatment</td>
<td>ECT</td>
</tr>
<tr>
<td>Every</td>
<td>q</td>
</tr>
<tr>
<td>Every day</td>
<td>qi</td>
</tr>
<tr>
<td>Every other day</td>
<td>qod</td>
</tr>
<tr>
<td>Extra-Pyramidal Symptoms</td>
<td>EPS</td>
</tr>
<tr>
<td>Four times a day</td>
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<tr>
<td>High Blood Pressure</td>
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<td>Hypertension</td>
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<tr>
<td>Medication/s</td>
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<tr>
<td>Milligram</td>
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<tr>
<td>Milliliter</td>
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<tr>
<td>No Known (drug) Allergies</td>
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</tr>
<tr>
<td>Organic Brain Disorder</td>
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<tr>
<td>Out of Bed</td>
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<tr>
<td>Over the Counter (meds)</td>
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<tr>
<td>Prescription</td>
<td>Rx</td>
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<tr>
<td>Return to Clinic</td>
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<tr>
<td>Secondary</td>
<td>2°</td>
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<tr>
<td>Shortness of Breath</td>
<td>SOB</td>
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<tr>
<td>Status post</td>
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<tr>
<td>Tardive Dyskinesia</td>
<td>TD</td>
</tr>
<tr>
<td>Temperature-Pulse-Respiration</td>
<td>TPR</td>
</tr>
<tr>
<td>Three times a day</td>
<td>TID</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>TB</td>
</tr>
<tr>
<td>Within Normal Limits</td>
<td>WNL</td>
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</table>
# Common Abbreviations for Chart Documentation

<table>
<thead>
<tr>
<th>Clinical, Diagnostic, Treatment</th>
<th>Abbrev</th>
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<tbody>
<tr>
<td>Alcohol</td>
<td>Alc, etoh</td>
</tr>
<tr>
<td>Alcohol on Board</td>
<td>AOB</td>
</tr>
<tr>
<td>Alcohol and Other Drugs</td>
<td>AOD</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder</td>
<td>ADHD</td>
</tr>
<tr>
<td>Auditory Hallucinations</td>
<td>AH</td>
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<tr>
<td>Chemical Dependency</td>
<td>CD</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>COPD</td>
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<tr>
<td>Danger to Others</td>
<td>DP</td>
</tr>
<tr>
<td>Danger to Self</td>
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</tr>
<tr>
<td>Disease</td>
<td>D, Dis</td>
</tr>
<tr>
<td>Disorder</td>
<td>DO</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>DV</td>
</tr>
<tr>
<td>Function</td>
<td>Fn, Fctn</td>
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<tr>
<td>Grave Disability</td>
<td>GD</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>Grp Trt</td>
</tr>
<tr>
<td>History</td>
<td>Hx</td>
</tr>
<tr>
<td>Homicidal Ideation</td>
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<tr>
<td>Individualized Education Plan</td>
<td>IEP</td>
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<td>Major Depressive Disorder</td>
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<td>Mental Status Examination</td>
<td>MSE</td>
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<tr>
<td>Not Otherwise Specified</td>
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<td>Obsessive Compulsive Disorder</td>
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<td>Post-Traumatic Stress Disorder</td>
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<td>Psychiatric/Psychosocial</td>
<td>Ψ</td>
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<tr>
<td>Rehabilitation</td>
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<tr>
<td>Rule Out</td>
<td>R/O</td>
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<tr>
<td>Schizophrenia</td>
<td>Schiz</td>
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<tr>
<td>Seclusion &amp; Restraint</td>
<td>S&amp;R</td>
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<tr>
<td>Sever Emotional Disorder (AB27.5)</td>
<td>SED</td>
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<td>Substance Abuse</td>
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<td>Substance Use Disorder</td>
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<td>Suicidal Ideation</td>
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<td>Suicidal Attempt</td>
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<td>Symptoms</td>
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<td>Therapy, Treatment</td>
<td>Tx, Trt</td>
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<tr>
<td>Visual Hallucinations</td>
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## Lockouts, Overrides & Other Limitations

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<th>Mental Health Services</th>
<th>Medication Support Services</th>
<th>Case Mgmt/ Brokerage</th>
<th>Day Rehabilitation Full Day</th>
<th>Day Tx Intensive Full Day</th>
<th>Therapeutic Behavioral Services</th>
<th>Adult Residential Treatment</th>
<th>Crisis Residential Treatment</th>
<th>Crisis Intervention**</th>
<th>Crisis Stabilization ER***</th>
<th>Inpatient</th>
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<tr>
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<td>Day Rehabilitation, Full Day</td>
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<td>Crisis Intervention**</td>
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<tr>
<td>Crisis Stabilization – ER***</td>
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<tr>
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</tbody>
</table>

**Institutional Limitations-Audit**

- L: Lockout
- OR: Override
- A: Lockout except for day of admission
- T: Lockout during actual time service is provided-audit, not a computer edit

- * Maximum of 4 hours per day
- ** Maximum per 24 hour period is eight hours
- *** Maximum per 24 hour period is 20 hours

Providers may not allocate the same staff time under two cost centers for the same time period.
# Required Documentation Matrix

<table>
<thead>
<tr>
<th>Form</th>
<th>Purpose</th>
<th>Timeline</th>
<th>How Often Do I complete it?</th>
<th>Where Can I Find It?</th>
<th>Helpful Hints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode Opening</td>
<td>To open a client to the SCMH system.</td>
<td>Must be completed before any services can be billed via Medi-Cal or AB 3632.</td>
<td>Any time a client is opened to an RU</td>
<td>Intranet Electronic Document</td>
<td>Any services provided prior to episode opening of an non-open client might be billable to MAACode 807 (SPMPM) or 812 (non SPMP)</td>
</tr>
<tr>
<td>Confidential Client Information</td>
<td>To obtain data for SCMH system (i.e. DOB, Address, phone, etc)</td>
<td>Client/family completes upon intake into the system</td>
<td>One Time</td>
<td>Clinic: White Paper Form</td>
<td>Have the client/family complete in the waiting room at initial assessment.</td>
</tr>
<tr>
<td>Consent for Mental Health Services</td>
<td>To obtain legal/ethical consent to provide mental health services.</td>
<td>This form, and a thorough verbal explanation of services, should be completed during the initial assessment, prior to service provision.</td>
<td>Completed at Intake. Not required again unless closed to the system and opened again</td>
<td>Clinic: White Paper Form</td>
<td>Providing and documenting a verbal explanation of risks and benefits, alternative to treatment, anticipated gains, etc is recommended.</td>
</tr>
<tr>
<td>Client Service Plan (CSP): Intake/Annual</td>
<td>To co-author with the client what treatment services, goals and objectives, and discharge planning will be targeted for an annual service period.</td>
<td>Must be completed within 2 months of the episode opening. Requires client signature or documenting why there is no signature, how client was involved, and a follow up to obtain signature in subsequent progress notes. Medicare clients require an MD signature on the CSP, whether or not they are receiving meds.</td>
<td>Within 2 months of initial opening, and at month of intake annually thereafter</td>
<td>Clinic: Purple Paper Form</td>
<td>Complete this during the initial assessment by identifying at least one overall client goal and at least one objective through an addendum as needed so that the 2 months do not lapse w/out an active CSP. If client has Medicare, get MD signature to avoid all services for the CSP time period to be disallowed.</td>
</tr>
<tr>
<td>Form</td>
<td>Purpose</td>
<td>Timeline</td>
<td>How Often Do I complete it?</td>
<td>Where Can I Find It?</td>
<td>Helpful Hints</td>
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</tr>
<tr>
<td>Client Service Plan (CSP): Six Month Review of CSP</td>
<td>To briefly address, in writing, progress on each goal/objective of treatment listed on the CSP, after reviewing with the client and any adjunct service providers.</td>
<td>To be completed within the 6th month of opening, prior to the beginning of the 2nd month (i.e., if treatment began 01/01/09, the Review should take place/be dated between 5/01/09 &amp; 5/30/09).</td>
<td>At six months after each Annual Review date.</td>
<td>Clinic: Purple Paper Form (pg 2 of Annual CSP, bottom of page).</td>
<td>Schedule a meeting with client (and family members if client is a minor), review treatment progress, make adjustments to services, objectives, discharge plan as needed, complete written review, submit the form to clerical staff for data entry.</td>
</tr>
<tr>
<td>Service Authorization Form</td>
<td>To authorize mental health services</td>
<td>Within 2 months of intake and annually</td>
<td>Annually</td>
<td>Clinic: Pink Paper Form</td>
<td>This form goes “hand-in-hand” with the CSP and must be completed by an LMHP.</td>
</tr>
<tr>
<td>CSP Addendum</td>
<td>To add an additional service/provider, to change PSC, or to add additional objectives.</td>
<td>Prior to the client being opened to another unit for service provision or billing. Prior to a new PSC becoming responsible for service authorization. Prior to addressing new treatment goals in documented treatment</td>
<td>As needed (see Timeline)</td>
<td>Clinic: Purple Paper Form</td>
<td>Be sure this is completed and dated by the PSC before another provider attempts to provide services. Services provided before the date of authorization will be blocked.</td>
</tr>
</tbody>
</table>
## Required Documentation Matrix

<table>
<thead>
<tr>
<th>Form</th>
<th>Purpose</th>
<th>Timeline</th>
<th>How Often Do I Complete It?</th>
<th>Where Can I Find It?</th>
<th>Helpful Hints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization to Release Medical Information</td>
<td>To obtain legal/ethical written consent to disclose Mental Health info about the client to a party outside of SCMH.</td>
<td>Prior to disclosing the fact that the client receives services from SCMH, any personal identifying information about the client, or engaging in disclosure of assessment, diagnosis, psychological testing, progress notes, psychiatric evaluation, or consultation w/ a party outside of SCMH.</td>
<td>Whenever disclosure of SCMH medical information is requested by the client or the client’s legal representative</td>
<td>Clinic and MH Intranet: White, 3-page Paper Form</td>
<td>Individuals and Mental health systems can build solid clinical reputations by following these regulations, and they can also get into a lot of trouble by disclosing information without authorization from the legal representative involved in the case (i.e., the client, a minor's parent, legal rep for conservor or dependent adults, legal rep of a minor dependent of the county, etc)</td>
</tr>
<tr>
<td>Acknowledgement of Receipt</td>
<td>To obtain a written record of whether a client chose to receive a written copy of SCMH informing Materials and Advance Directive</td>
<td>To be completed during an initial assessment.</td>
<td>One Time.</td>
<td>Clinic and MH Intranet: White, one-page form</td>
<td>Obtain signature and offer client a copy of the form, and if they so indicate, a copy of the forms.</td>
</tr>
</tbody>
</table>
| Outpatient Services Adult Intake Assessment    | To Obtain Psychosocial assessment information from the client. Also, to record initial treating dx and medical necessity. | Complete within 2 months of Episode opening date. | One time per opening to the SCMH system. | Clinic: Blue, four-page form.                                                      | Be sure to provide clear working MH diagnosis and Medical Necessity for MH Treatment. This form establishes Diagnosis and Medical Necessity for all services provided during the upcoming annual treatment period. **If not correctly established, all services provided in the new annual treatment period could technically be disallowed.**  

*Don't forget to sign and date it!* |
## Required Documentation Matrix

<table>
<thead>
<tr>
<th>Form</th>
<th>Purpose</th>
<th>Timeline</th>
<th>How Often Do I complete it?</th>
<th>Where Can I Find it?</th>
<th>Helpful Hints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Intake Assessment</td>
<td>To Obtain Psychosocial assessment information from the client/parent. Also, to record initial treating diagnosis and medical necessity.</td>
<td>Complete within 2 months of Episode opening date.</td>
<td>One time per opening to the SCMH system.</td>
<td>Clinic: Blue, six-page form</td>
<td>Be sure to provide clear wording. MH diagnosis and Medical Necessity for MH Treatment. This form establishes Diagnosis and Medical Necessity for all services provided during the upcoming annual treatment period. <strong>If not correctly established, all services provided in the new annual treatment period could technically be disallowed.</strong> <em>Don’t forget to sign and date it!</em></td>
</tr>
<tr>
<td>Client Self Report of Substance Use (formerly Child and Adolescent Substance Abuse Inventory)</td>
<td>To obtain screening data for client Substance Use problems.</td>
<td>Complete during initial intake assessment.</td>
<td>Upon opening the case or when substance use is suspected.</td>
<td>Clinic: White, one-page form</td>
<td>There are times when these questions might be asked of parent and child in separate individual interviews.</td>
</tr>
<tr>
<td>Crisis Evaluation (formerly Brief Assessment-Referral)</td>
<td>To obtain assessment info for Short-term, brief interventions.</td>
<td>Upon opening a client for crisis intervention.</td>
<td>One time per opening of a case.</td>
<td>Clinic: Yellow, two-page form</td>
<td>Typically only used for “one-shot” interventions by psychiatric emergency staff.</td>
</tr>
<tr>
<td>Form</td>
<td>Purpose</td>
<td>Timeline</td>
<td>How Often Do I complete it?</td>
<td>Where Can I Find it?</td>
<td>Helpful Hints</td>
</tr>
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</tr>
</tbody>
</table>
| Client Assessment Update (formerly Update of Client Information) | To reassess and to record an up-to-date treating diagnosis, client functioning, and medical necessity. Also to update address, phone, living situation. | Prior to the client's Annual authorization expiring, or when diagnosis or living situation data changes during the annual authorization period. | See Timeline           | Clinic: Tan, 4-page form.                                                                                                                   | This form establishes Diagnosis and Medical Necessity for all services provided during the upcoming annual treatment period. **If not correctly established, all services provided in the new annual treatment period could technically be disallowed.**  
**Don't forget to sign and date it!**                                                                                                     |
| Payor Financial Information               | To determine the client’s Annual financial liability for receiving services, by obtaining monthly income, Medical status, private insurance information | To be completed during first service          |                            | Clinic: White, 2-side form.                                                                                                                  | Verify Medical eligibility prior to meeting with client, when possible.  
**Must obtain copy of all insurance cards to send to Billing and Collections.**                                                                 |


<table>
<thead>
<tr>
<th>DIRECT SERVICES</th>
<th>CONREP</th>
<th>MAA Services</th>
<th>INDIRECT SERVICES</th>
<th>Gen</th>
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<tbody>
<tr>
<td>Crisis Services</td>
<td></td>
<td>Med-Cal Outreach (Not Discounted)</td>
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<tr>
<td>Crisis Intervention</td>
<td>371</td>
<td>Med-Cal Outreach (Discounted)</td>
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<tr>
<td>5150 Evaluation for Jail or Juvenile Hall Client</td>
<td>377</td>
<td>Med-Cal Eligibility Intake</td>
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<td>Day Treatment Services</td>
<td>Gen</td>
<td>Referral in Crisis Situation for Non-Open Case</td>
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<tr>
<td>Day Intensive – ½ Day</td>
<td>266</td>
<td>Med-Cal Mental Health Service Contract Administration (Not Discounted)</td>
<td>803</td>
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</tr>
<tr>
<td>Day Intensive – Full Day</td>
<td>251</td>
<td>Med-Cal Mental Health Service Contract Administration (Discounted)</td>
<td>804</td>
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</tr>
<tr>
<td>Day Rehab – ½ Day</td>
<td>255</td>
<td>SPMP Program Planning and Policy Development (PP&amp;PD)</td>
<td>805</td>
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</tr>
<tr>
<td>Day Rehab – Full Day</td>
<td>251</td>
<td>Non-SPMP Program Planning and Policy Development (PP&amp;PD)</td>
<td>806</td>
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</table>
This Documentation Manual is a product of Solano County Health and Social Services, Mental Health Division, Quality Improvement Unit.

Please direct questions regarding this manual or documentation to qualityimprovement@solanocounty.com or 707-784-8323.

This Documentation Manual and any updates will be posted on the Mental Health Intranet Site and on Networkofcare.org.