Mental Health Managed Care
Outpatient Provider Manual

February 2014
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All attachments listed above can be found at:
http://solano.networkofcare.org/mh/content.aspx?id=293&parentID=290
I. Phone and Address Directory

Claims Submission ........................................................................................................ 800-547-0495, Option 4
Mail to:
   Solano County Mental Health Plan
   Managed Care Claims Division
   275 Beck Avenue MS 5-210
   Fairfield, CA 94533

Credentialing Updates ................................................................................................. 800-547-0495, Option 5
Mail to:
   Solano County Mental Health Plan
   Managed Care Credentialing
   275 Beck Avenue MS 5-235
   Fairfield, CA 94533

Screening, Referral and Customer Services Line ...................................................... 800-547-0495, Option 2

Solano County Mental Health Services

Crisis Stabilization Unit ............................................................................................ 707-428-1131
Managed Care Fax Number ..................................................................................... 707-425-4320
Mental Health Plan ................................................................................................. 800-547-0495

Provider Forms .......................................................................................................... http://solano.networkofcare.org/mh/content.aspx?id=293&parentId=290

Partnership HealthPlan of California

Information Line ........................................................................................................... 707-863-4100
Automated Eligibility Verification ........................................................................... 707-863-4120, Option 3
Or ..................................................................................................................... 800-863-4155, Option 3
Member Services (Medi-Cal & Healthy Kids) ......................................................... 707-863-4120
Or ..................................................................................................................... 800-863-4155
Member Services (Partnership Advantage) .............................................................. 866-264-3626
Care Coordination .................................................................................................. 707-863-4276
Or ..................................................................................................................... 800-809-1350
Fax Numbers
Main ..................................................................................................................... 707-863-4117
Member Services ................................................................................................. 707-863-4415
II. What role does Kaiser Foundation Health Plan play in providing Mental Health Services?

Kaiser Foundation Health Plan will provide covered Mental Health Services, including assessment, screening, crisis services, outpatient treatment, and medication support for Partnership Health Plan (PHC) Medi-Cal members assigned to Kaiser Foundation Health Plan.

Solano Mental Health Plan is responsible for provision of long-term care services; e.g., case management, residential treatment, crisis intervention and Institution for Mental Disease (IMD)/State Hospital care; for PHC Medi-Cal members assigned to Kaiser Foundation Health Plan who meet medical necessity criteria for coordinated services, including:

- Seriously emotionally disturbed children or adolescents;
- Adults and older adults who have a serious and/or persistent mental disability which interferes substantially with primary activities of daily living and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support and rehabilitation for a long or indefinite period of time;
- Adults or older adults who require, or are at risk of requiring, acute psychiatric treatment because of a mental disorder with symptoms of psychosis, suicidality, or danger to self or others.
III. **Definitions and Acronyms**
The following is a list of terms and their abbreviations as commonly used in this manual

**Access Line/Unit:** Access to the system of care is through a centralized 1-800 number for all Medi-Cal Beneficiaries seeking mental health treatment. In addition, by calling this number, Providers and Beneficiaries are able to ask questions from the clinical staff about authorization for mental health services, referrals, or express a concern or complaint. A Provider may also call this number to obtain information on claims, and/or contact Provider Relations and member services.

**Beneficiary:** Medi-Cal eligible individual (Solano County resident status) requesting mental health treatment. Parents or a legal guardian may also call to request services on behalf of the Beneficiary.

**Care Manager:** A mental health clinician or nurse who links Beneficiaries to mental health services. Other functions include screening/assessment, authorization, coordination, referral, providing information and education, reviewing ongoing care and making a decision about medical necessity. Primarily talks to Providers, and Beneficiaries regarding mental health services.

**Medical Necessity:** The justification for mental health specialty services. Medical necessity for access to the mental health system is provisionally determined by an initial phone screening by a Care Manager. Medical necessity for ongoing care is based upon the results of an evaluation or progress update, and the agreement of the Care Manager.

**Medi-Cal:** California’s version of the Federal Medicaid program. This is a State and Federal funded health insurance for low-income individuals and families.

**Mental Health Plan (MHP):** An entity that enters into a contract with the California Department of Health Care Services to provide directly or arrange and pay for specialty mental health services to Beneficiaries in a county. A MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

**Pre-Authorization:** Providers must call a Care Manager to obtain authorization for mental health services prior to those services beginning. Outpatient pre-authorization is obtained by calling 800-547-0495. *Emergency services do not require pre-authorization.*

**Partnership HealthPlan of California (PHC):** A Medi-Cal countywide system, under contract to the State, designed to provide a more economical organization of health care resources on a case management basis and to improve continuity of care.

**Providers:** Licensed mental health professionals that have contracted with Solano County Mental Health Managed Care to provide evaluation and treatment to Medi-Cal Beneficiaries.

**Provider Relations Coordinator:** Managed Care staff member tasked to oversee Provider recruitment, retention and contractual activities and assisting with processing of complaints, concerns and grievances.

**Screening:** The process of triaging callers, checking eligibility, gathering demographic data, determining problem, assessing for emergency, and providing appropriate referral on intervention.
**Share of Cost (SOC):** The amount determined by Medi-Cal an individual or family can afford to pay towards medical expenses before Medi-Cal will pay for medical expenses. The individual must meet (pay) the share of cost amount to become Medi-Cal eligible. A person with an unmet SOC is not Medi-Cal eligible.
IV. Access Protocols

**Screening and Referral (Access) Line**
Assistance is available 24-hours a day, seven days a week by calling 1-800-547-0495.

**Note: All Routine Services Must Be Pre-Authorized**

**Access Assessment Procedures**
Pre-authorization is not required for emergency services. Most Beneficiaries will go to their local emergency room to be evaluated by the Solano County Crisis Stabilization Unit for urgent care; however, if any eligible Medi-Cal Beneficiary/consumer contacts a Provider for emergency services, pre-authorization for treatment is not required. The Provider must contact Solano MHP as soon as possible afterwards to receive retro-authorization for treatment provided.

Care Manager will verify eligibility.

Calls regarding non-Medi-Cal eligible individuals will be assessed and triaged to an appropriate resource.

Kaiser eligibles will be referred to closest Kaiser Behavioral Health Department.

Care Manager will obtain information necessary to establish need for assessment and appropriate referral:
- Determine eligibility
- Presenting problem
- Brief recent treatment history
- Current risk factors
- Geographic location
- Appropriate clinician and specialty areas
- Other clinician characteristics requested or deemed appropriate by the Care Manager i.e. gender, ethnicity, language, other cultural preferences, etc.

Emergency procedures will be utilized as needed, including telephone safety checks, emergency response services triage, child and elder abuse reporting, Tarasoff Warning, etc. Referral to the Solano County Crisis Stabilization Unit may also be facilitated for immediate risk assessment.

A referral will be made based upon level of care required to either an internal Provider or external Provider, or possibly to a community resource. When a referral is made to an external Provider, the caller will be provided with the clinician's name, address, phone number, an authorization number and be instructed to call the clinician for an appointment.

**Interpreter Services**
- The county will arrange interpreter services for Providers who need to utilize this service. Providers are encouraged to utilize professional interpreters rather than family members. To make arrangements for an interpreter, please call 800-547-0495, Option 5.
Access Standards and Monitoring
Access standards as defined below will be monitored for:

- **Urgent assessments**: the Provider will schedule appointments within three (3) days.
- Routine (non-urgent) outpatient evaluations: the Provider will respond to call from Beneficiary within five (5) business days and;
- The Provider will schedule an appointment within fourteen (14) business days of the Beneficiary’s call.

Outpatient Authorization
Beneficiaries must call the Provider within 30 days from the Authorization Start Date. The Provider has a total of forty-five (45) days from the Authorization Start Date in which to see the Beneficiary or the initial authorization will be invalid. In addition, all other authorizations that have not been used within 12-months from approval date will be invalid.

This policy does not apply to medication management. Authorizations for medication management may be used over a period of 12-months from initial approval date. However, the initial authorization must be used within forty-five (45) days from the authorization start date to remain valid.

Service Authorization Letters
A letter will automatically be sent to the Beneficiary, unless Beneficiary requests letter not be sent, which will confirm that an authorization has been made. (See Attachment A for sample)

An authorization letter will also be sent to the Provider confirming the authorization. (See Attachment B for sample)

V. Getting Ready for Referrals

Outgoing Voicemail Message
As a Provider in Solano MHP Network, you must ensure you have an after-hour message when you are unavailable. All Providers are required to include the following for their outgoing message:

- Name of Provider (including licensure status i.e. MFT, LCSW, etc.) or Agency
- Identify whether the voice mail is confidential/private (or not)
- Emergency contact information including instructions to call 911, or to the nearest ER, or call the Solano County Crisis Services Unit at 707-428-1131.

An example may be:

“You have reached the confidential voice mail for John Smith, Licensed Clinical Social Worker. I am unable to take your call at this moment. Please leave your name and phone number with a good time to return your call. If you are experiencing a life threatening emergency, please call 9-1-1 or go to the nearest Emergency Room. If you are a Solano County Medi-Cal Beneficiary and feel you are in crisis, please call their Crisis Stabilization Unit at 707-428-1131.”

If you speak more than one language in your practice, you must duplicate the message in all of those languages.
Forms you will need when meeting a client for the first time:

- **Acknowledgement of Receipt** (Attachment C, refer to VII. Chart Forms/Requirements on page 11)
- **Client Services Information Sheet** (Attachment G, refer to VII. Chart Forms/Requirements on page 11)
- **Biopsychosocial Assessment** (Attachment D, refer to VII. Chart Forms/Requirements on page 11)
- **Progress Note** (Attachment K, refer to VII. Chart Forms/Requirements on page 12)

All of these can be found under Chart Forms at: [http://solano.networkofcare.org/mh/content.aspx?id=293&parentId=290](http://solano.networkofcare.org/mh/content.aspx?id=293&parentId=290).

You will soon receive an informational packet in the mail similar to the one our Beneficiaries receive upon their authorization for services. These forms can also be found at [http://solano.networkofcare.org/mh/content.aspx?id=293&parentId=290](http://solano.networkofcare.org/mh/content.aspx?id=293&parentId=290) under Informing Materials. Please keep this packet on hand for your reference, or in the event that the Beneficiary may ask for a form such as the Grievance Form. Please refer to Section X. Provider Responsibilities on page 16.

**Who to Contact**

Call the Access Line at **800-547-0495** and select the appropriate option for any of your needs.

- Option 3: To request additional sessions for a client
- Option 4: For claims or payment inquiries
- Option 5: To update your contact information, change status of accepting referrals, or for general inquiries.

You can also send an e-mail to: providerrelations@solanocounty.com for updating your contact information, changing status of accepting referrals, or for general inquiries.

**VI. Authorization Criteria and Guidelines**

**Authorization Criteria**

**Medi-Cal Medical Necessity Criteria: Outpatient**

Consumers must meet the following criteria for medical necessity and be Medi-Cal eligible in order for services to be reimbursable. **All three criteria – 1, 2, and 3 – must be met.**

1) **Diagnosis:**

   **Included Diagnosis:**
   - Pervasive Developmental Disorders, Excluding Autistic Disorder
   - Attention Deficit and Disruptive Behavior Disorders
   - Feeding and Eating Disorders of Infancy or Early Childhood
   - Elimination Disorders
   - Other Disorders of Infancy, Childhood, or Adolescence
   - Schizophrenia and Other Psychotic Disorders
   - Mood Disorders
   - Anxiety Disorders
   - Somatoform Disorders
• Factitious Disorders
• Dissociative Disorders
• Paraphilia
• Gender Identity Disorders
• Eating Disorders
• Impulse-Control Disorders Not Elsewhere Classified
• Adjustment Disorders
• Personality Disorders, Excluding Antisocial Personality Disorder
• Medication-Induced Movement Disorder
• An Included Diagnosis when an Excluded Diagnosis is also Present

Excluded Diagnosis:
• Autistic Disorder
• Learning Disorders
• Motor Skills Disorder
• Communication Disorders
• Tic Disorders
• Delirium, Dementia, Amnesic, and Other Cognitive Disorders
• Mental Disorders Due to a General Medical Condition
• Substance-Related Disorder
• Sexual Dysfunction
• Sleep Disorders
• Antisocial Personality Disorder
• Other Conditions That May be a Focus of Clinical Attention, Except Medication Induced Movement Disorders Which are Included
• Mental Retardation

2) Impairment Criteria:
Must have 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.
• A probability of significant deterioration in an important area of life functioning.
• Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.

3) Intervention-Related Criteria:
Must have all of the following:
• The focus of proposed intervention is to address the condition identified in impairment criteria
• It is expected the Beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of
life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate.

- The condition would not be solely responsive to physical healthcare-based treatment

**Authorization Guidelines – Psychologist, LCSW, LMFT Providers**

- Emergency or urgent assessments require immediate phone report by Provider. Complete *Biopsychosocial Assessment* [(Attachment D)](attachment).

- **Sessions may be authorized for a frequency of once per week or other frequency as appropriate and medically necessary.** If frequency of more than once per week is required, Provider must obtain prior authorization. The request may be done in writing or by calling 1-800-547-0495 for verbal authorization.

- Beneficiaries must call the Provider within thirty (30) days of the Authorization Start Date.

- Provider has a total of forty-five (45) days from the Authorization Start Date in which to see the Beneficiary or the authorization will be invalid.

- For Adult Beneficiaries (18 years or older), authorization is limited to a maximum of eighteen (18) sessions for the first year and sixteen (16) sessions for subsequent years.

- For Child and Adolescent Beneficiaries (17 years or younger), authorization is limited to a maximum of twenty-four (24) sessions for the first year and twenty-two (22) sessions for subsequent years.

**Initial Authorization**

- Four sessions will be authorized by Access based on the Beneficiary’s provisional diagnosis and impairments.

- Provider submits *Biopsychosocial Assessment* within four weeks of the Initial Authorization Start Date.

**Re-Authorization #1 – First Year of Service**

- Provider is responsible for requesting additional treatment for the Beneficiary.

- Adult Beneficiary: Up to seven (7) additional sessions may be authorized upon submission of the *Biopsychosocial Assessment* provided sufficient medical necessity criteria are documented.

- Child or Adolescent Beneficiary: Up to ten (10) additional sessions may be authorized upon submission of the *Biopsychosocial Assessment* provided sufficient medical necessity criteria are documented.

**Re-Authorization #2 – First Year of Service**

- To request additional treatment for the Beneficiary, Provider submits *Outpatient Treatment Progress Report* [(Attachment J)](attachment).

- Adult Beneficiaries: Up to seven (7) additional sessions may be authorized upon submission of the *Outpatient Treatment Progress Report* provided sufficient medical necessity criteria are documented.

- Child and Adolescent Beneficiaries: Up to ten (10) additional sessions may be authorized upon submission of the *Outpatient Treatment Progress Report* provided sufficient medical necessity criteria are documented.
Providers are encouraged to send the *Outpatient Treatment Progress* prior to the end of the currently authorized group of sessions to avoid the risk of non-authorization and non-payment of services.

The standard time for processing an *Outpatient Treatment Progress Report* is fourteen (14) calendar days after receipt.

**Yearly Update**

- If the Beneficiary requires further treatment, Provider contacts Care Manager and justifies ongoing medical necessity.
- Two (2) sessions will be authorized by Care Manager.
- Provider submits *Biopsychosocial Assessment Update* (Attachment F) within two (2) weeks of the Yearly Update Authorization Start Date.

**Re-Authorization #1 – Subsequent Year of Service**

- Provider is responsible for requesting additional treatment for the Beneficiary.
- Adult Beneficiary: Up to seven (7) additional sessions may be authorized upon submission of the *Biopsychosocial Assessment Update* provided sufficient medical necessity criteria are documented.
- Child or Adolescent Beneficiary: Up to ten (10) additional sessions may be authorized upon submission of the *Biopsychosocial Assessment Update* provided sufficient medical necessity criteria are documented.

**Re-Authorization #2 – Subsequent Year of Service**

- To request additional treatment for the Beneficiary, Provider submits *Outpatient Treatment Progress Report*.
- Adult Beneficiaries: Up to seven (7) additional sessions may be authorized upon submission of the *Outpatient Treatment Progress Report* provided sufficient medical necessity criteria are documented.
- Child and Adolescent Beneficiaries: Up to ten (10) additional sessions may be authorized upon submission of the *Outpatient Treatment Progress Report* provided sufficient medical necessity criteria are documented.

**Authorization Guidelines – Psychiatrist Provider**

- One Medication Evaluation session plus up to eleven Medication Management sessions may be authorized by Access or Care Manager.
- To request additional treatment for the Beneficiary, Provider submits *Psychiatric Medication Evaluation/Progress Report* (Attachment L).
- Provider has a total of forty-five (45) days from the Authorization Start Date in which to see the Beneficiary or the authorization will be invalid.

**VII. Chart Forms/Requirements**

**Acknowledgement of Receipt**

A packet is sent to client upon their authorization for services. In addition to the Initial Authorization for Services Letter (Attachment A), clients are sent an informative packet including an Advance Directives Fact...
Sheet, Notice of Privacy Practices, Provider Directory and Guide to Medical Mental Health Services, Grievance Form, Appeal Form, Beneficiary Rights & Problem Resolution Guide, Compliment/Suggestion Form, and Request to Change Service Provider Form. (Some of these forms can be found at: http://solano.networkofcare.org/mh/content.aspx?id=293&parentId=290.) Those forms not posted on the Network of Care Managed Care web page can be requested by calling 800-547-0495, Option 5 or by e-mailing: providerrelations@solanocounty.com.

We require that you have a signed copy of the Acknowledgement of Receipt Form (Attachment C) in each client’s file. By signing this form, our client is acknowledging that they received the information sent in the packet. Please, ask your client to sign it at their first session, and retain it in their file in the event of a future audit.

**Biopsychosocial Assessment**
The Biopsychosocial Assessment (Attachment D) is to be completed (legibly) for any new Beneficiary. Please submit to the Care Manager prior to the end of the initial four (4) sessions.

*Helpful Hint:*
Refer to Attachment E, which is an excellent example of how you would complete pages 4-6 of the Biopsychosocial Assessment.

**Biopsychosocial Assessment Update**
The Biopsychosocial Assessment Update (Attachment F) is to be completed (legibly) and submitted to the Care Manager within two (2) weeks of the yearly update authorization start date.

**Client Services Information Sheet (CSI)**
The Client Services Information Sheet (CSI) (Attachment G) is to be completed (legibly) for any new Beneficiary, or if the Beneficiary’s information needs to be updated. Please submit to the Care Manager prior to the end of the initial four (4) sessions or when information needs to be updated.

**Closing Summary**
Providers must complete (legibly) and send a Closing Summary Report (Attachment H) to the Care Managers when treatment is completed, or if member drops out of treatment.

*Note:*
The standard time for submitting a Closing Summary Report is fourteen (14) calendar days after last session.

**Outpatient Treatment Progress Report**
The Outpatient Treatment Progress Report (Attachment J) is completed (legibly) and submitted to the Care Manager when requesting additional treatment for the Beneficiary for a second time within a year. Providers are encouraged to send the Outpatient Treatment Progress Report form prior to the end of the currently authorized group of sessions to avoid risk of non-authorization and non-payment of services. It is important to provide sufficient medical necessity criteria to be approved additional treatment. The standard time for processing this form is fourteen (14) calendar day after receipt, and the authorization is valid for up to one (1) year from the authorization start date.
Helpful Hint: Refer to VI. Authorization Criteria and Guidelines on page 7 for medical necessity criteria. Also, refer to Attachment E, which is an excellent example for how you would complete pages 2-3 of the Outpatient Treatment Progress Report.

Progress Notes
Progress Notes (Attachment K) are required for each contact with a client and should be retained in the Beneficiary’s chart. Only submit Progress Notes to the Care Manager when you are billing for Case Management Services. They all must be distinct, non-repetitive, and individualized to each session. Solano MHP has a standard Progress Note available or Providers may use their own form. Each note must be legible and include:

- Beneficiary’s (Client) Name
- Date, duration, and location of service
- An account of the Beneficiary’s culture and language in understanding the Beneficiary’s problems
- The client’s diagnosis and related presenting problems, impairments and symptoms, and treatment objectives. Be sure to document ongoing medical necessity in your reference to these factors
- Type of service provided
- Intervention(s) used for the service
- A distinct, non-repetitive, and individualized report of each session.
- Beneficiary’s response to the intervention described
- Beneficiary progress toward achieving their identified goal(s) and plans for future treatment
- Documentation that justifies the time billed
- Referrals to community resources, when appropriate. A list of community resources can be found in the Resource, Rights and Support Guide for Beneficiaries found on Solano County Mental Health web page at: https://admin.solanocounty.com:4433/civicax/filebank/blobdload.aspx?blobid=16876
- Provider’s printed or stamped name, signature and license type

Psychiatric Medication Evaluation/Progress Report
The Psychiatric Medication Evaluation/Progress Report (Attachment L) form is used by Psychiatrist Providers to request additional treatment for the Beneficiary.

VIII. Verifying Eligibility

Verifying Member Medi-Cal Eligibility
Membership Eligibility: Provider is responsible to verify eligibility of Beneficiary for the month of service. Verification is necessary every month for each recipient to assure accurate payments to Providers of mental health care services. This must be accomplished before services are provided.

The Automated Eligibility System can be accessed 24 hours a day – 7 days a week by calling (707) 863-4120, Option 3 or 800-863-4155, Option 3 or by visiting the Partnership HealthPlan of California (PHC) website at http://www.partnershiphp.org/. Please contact Solano County Managed Care Provider Relations at 800-547-0495, Option 5 to request a user name and password.
If Provider is unable to verify eligibility using the PHC website they may call the PHC Members Services Department (707) 863-4120 or (800) 863-4155.

Authorizations for services that cover more than one calendar month do not establish nor guarantee Beneficiary’s Medi-Cal eligibility; it is the Provider’s responsibility to assure that services are provided to eligible Beneficiaries.

Individual Medi-Cal eligibility is established monthly by the Department of Social Services. Individual members who are eligible are classified into different "Aid Codes" which represent different Medi-Cal eligibility programs. All Medi-Cal recipients with identification number beginning with County Code "48" (Solano County) who are eligible to receive medical benefits under Medi-Cal or as Medicare/Medi-Cal crossovers are served through the Partnership HealthPlan of California.

When a Beneficiary has Medicare and/or other insurance, the other insurance or Medicare must be pre-authorized and billed first. Medi-Cal will only reimburse what the Beneficiary’s other insurance does not cover, up to the allowed Medi-Cal reimbursement amount for the service rendered.

**Share of Cost (SOC)**

Depending upon a person’s monthly income, Medi-Cal may determine that they must meet a SOC before Medi-Cal will pay for medical expenses. Therefore, the person may not be eligible for Medi-Cal benefits until their Share of Cost is met.

**IX. Claims & Billing Instructions**

**Billing Procedures**

Claims must be submitted on the HCFA CMS-1500 Form (Attachment I). Please refer to direction below for each. These forms must be filled out completely and legibly to be processed for payment.

**HCFA CMS-1500 (Outpatient) Form:**

_The Provider must complete items 1 through 33 on the claim form._

- **Box 1-a** Beneficiary’s Social Security Number or CIN
- **Box 2** Beneficiary’s Last Name, First Name, Middle Initial (if any)
- **Box 3** Beneficiary’s Date of Birth and Sex
- **Box 11-c** “Solano County Medi-Cal”
- **Box 12** Either Obtain Signature OR Enter “Signature on File” as appropriate AND Enter Date
- **Box 17-b** Your NPI Number
- **Box 19** Enter Your Reporting Unit #, Enter a dash “-,” and Enter Your Provider #
- **Box 21** Minimum of one Covered ICD-9 (same as DSM-IV-TR) Code Enter Code to the greatest diagnostic specificity (include 4th or 5th digit)
- **Box 23** Enter authorization number from the Authorization for Services Letter
Box 24-A  Date of Service
Box 24-D  Procedure Code (CPT Code). Refer to the Service Authorization letter for “Services Authorized” and “Service Codes Allowable”. Refer to Attachment B for sample letter.
Box 24-E  If CPT Group Code 90853 is entered in Box 24-D, list number of members in group.
Box 24-F  Charges. Refer to Attachment M for the appropriate charges on the list of codes by licensure type.
Box 24-G  Units = Number of Minutes (include documentation time)
Box 25  Federal Tax I.D. Number
Box 28  Total Charges for All Services Listed
Box 31  Your Signature and the Date Signed. Signature of Provider must be original (no copies, stamps or “signature on file”).
Box 33  Your Address (where you want check sent) & Phone number

Where to Mail Claims

For Outpatient Claims:
    Solano County Mental Health Plan
    Managed Care Claims Division
    275 Beck Avenue MS 5-210
    Fairfield, CA 94533

Claims must be received in our Claim's Office within sixty (60) days following the month in which services were rendered. This requirement is referred to as the 60-day billing limit. Claims received after sixty (60) days may be denied.

Claims for family therapy must be billed under the name of the primary Beneficiary.

Payment Policies
You have agreed to the Solano County Mental Health Managed Care Medi-Cal fee schedule. Reimbursement levels are determined by the practitioner's licensure (not degree) and the type of service provided.

Medi-Cal guidelines do not allow payment of sessions for which a Beneficiary fails to show.

Medicare/Medi-Cal "Crossover" claims. Services for Solano County Medi-Cal Recipients with Medicare as the primary insurer do need pre-authorization from Solano MHP. Provider must bill Medicare prior to billing Medi-Cal. Ensure a copy of Medicare EOB is attached to claim. Claims must be received within sixty (60) days of EOB date at Solano MHP.

Claims are generally paid within thirty (30) days of submission.

Billing Tip:  Attach a dated copy of Medicare/HMO EOB for the date of service, to the claim. Payment
cannot be made without proof of payment/denial from HMO.

Explanation of Benefit (EOB) Claims Voucher Mailed to Providers Details:
- Providers name & address
- Members’ name
- Authorization numbers
- Date of service
- Amount you billed (your standard rate)
- Amount allowed (Medi-Cal Reimbursement Rate)
- Other insurance payment
- Co-payment
- Amount paid
- Explanation of Benefit (EOB) code which explains the action taken on the claim or reasons for denial of submitted charges.

Coordination of Benefits
Many Beneficiaries are covered under more than one insurance plan. When this is the case, the “other insurance” is considered to be the Primary Insurer. In order to control health care costs and to prevent overpayment of plan benefits, Solano MHP Medi-Cal Managed Care Program applies standard coordination of benefit rules where applicable.

When Medi-Cal is the secondary insurer, Solano MHP will only reimburse, as the secondary payer, the difference between the Medi-Cal rates for the services billed, minus the payment amount by the primary insurer. The total reimbursement will not exceed Solano MHP Managed Care rates.

Note: (M.D., Ph.D. and LCSW) - If you are not currently a Medicare Provider, you can download a Provider application at the Centers for Medicare and Medicaid Services website at www.cms.gov or call 855-609-9960 for assistance. If you are treating Medicare/Medi-Cal Beneficiaries, it will be necessary for you to be Medicare authorized so that you will be able to bill Medicare.

Medicare Part B (non-institutional)
Medical services for Medicare/Medi-Cal recipients will be reimbursed as explained above, with pre-authorization.

Claims missing the Medicare EOB will be denied.

Billing Inquiries
Billing inquiries may be made by calling 800-547-0495, Option 4.

An inquiry is used to reconcile claims that have over or underpayments or to request a tracer or status on a claim line that has not appeared on an EOB.

Inquiry time lines: Providers have six (6) months to inquire about a claim from the original date of the denial on the Solano MHP EOB. Inquiries made after six months are subject to denial.
If the issue is not resolved, the Provider may submit an appeal within ninety (90) days inquiry. See Section XI: Problem Resolution and Appeals Process.

**Important Points Regarding Claims**
Treatment of any Medi-Cal Beneficiary must be performed by the practitioner to whom the referral was made. *You may not bill in your name for treatment provided by another practitioner or an assistant.*

You *may not in any case bill the Beneficiary for amounts above the Medi-Cal rate.*

Solano MHP will not reimburse for covered services that were improperly submitted to other insurance carriers.

**Claims Processing Overview**
All incoming paper claims and other documents are date stamped.

All claims are subject to a comprehensive series of edits and audits by Claim Representative.

Claims missing pertinent information e.g., Beneficiary name, procedure codes, diagnosis codes, or billing amount will be returned to Provider with a cover letter identifying missing information or other problems.

Claims that are denied are included on the Explanation of Benefits, (EOB) along with the reason why the claim was denied.

**Billing Tip:** Ensure each claim submitted is fully completed.

**X. Provider Responsibilities**

Medi-Cal Beneficiaries receiving or seeking mental health services shall be informed of how to access the Problem Resolution process. They shall be provided or have easy access to brochures for Beneficiary Rights, Appeal Form, Grievance Form, and Request to Change Provider Form. These forms are mailed to the Beneficiary upon first request for service. Beneficiaries shall be informed of their right to access advocate assistance if they wish to submit a grievance, appeal or expedited appeal at any time during the problem resolution process. Beneficiaries must also be informed of their option to request a State Fair Hearing.

At the request of the Provider, Solano MHP will assist in the education and/or training of Providers and their staff in Medi-Cal billing procedures.

Treatment shall be provided in a **culturally competent** manner by providing services in a language appropriate and culturally sensitive manner, in a setting accessible to diverse communities. Contact Solano MHP if you desire a copy of the Solano County Mental Health Services Cultural Competence Plan.

Notify Beneficiaries they are entitled to the following rights:
- Respectful treatment by all mental health staff
- Service provided in a safe environment
- Informed consent to treatment and informed consent to prescribed medications and options
available

- Protection of personal health information
- Participate in treatment planning
- Request a change in the level of care, change of therapist, and a second opinion
- Consideration of a problem or concern about services by the staff person or agency providing care
- File a Grievance regarding services
- File for a State Fair Hearing following an Action
- File an Appeal regarding an Action
- Delegate a person to act on their behalf during the Grievance, Appeal or State Fair Hearing process
- Culturally sensitive services
- Use of an interpreter at no cost
- Request and receive a copy of his/her medical records, and request they be amended or corrected
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- The right to an Advanced Health Directive

XI. Problem Resolution and Appeals Process

**Problem Resolution and Appeals Process**
These procedures are designed to enable Providers to resolve complaints or concerns about authorizations, claims, or other issues. Solano County Mental Health Plan will make every effort to utilize informal problem resolution whenever possible.

**Informal Problem Resolution**
A Provider can call the Access line at (800) 547-0495 to register a complaint or concern and discuss informal problem resolution. A Provider may also submit a complaint or concern in writing to:

Solano County Mental Health Plan
Managed Care Provider Relations Coordinator
275 Beck Ave., MS 5-235
Fairfield, CA 94533

Within five working days, the Provider will be contacted by either the Managed Care Provider Relations Coordinator or the Managed Care Clinical Supervisor to discuss actions, plans, etc. to resolve the problem.

**Grievance Process**
A Provider may register a grievance if the complaint or concern is not resolved informally to the Provider’s satisfaction. Grievances are to be filed in writing to:

Solano County Mental Health Plan
Managed Care Provider Relations Coordinator
275 Beck Ave., MS 5-235
Fairfield, CA 94533
There shall be a twenty-five (25) working day resolution period during which time Solano County Mental Health Plan staff shall prepare a resolution to the Provider in writing. If the proposed resolution is not satisfactory, the Provider may request a meeting of the Grievance Review Committee.

The Grievance Review Committee is composed of the Managed Care Program Manager or designee, Medical Director or medical staff designee, and two Mental Health Providers Members (licensure based on circumstance of complaint and/or licensure level of grievant). The committee will meet monthly based on need. A hearing will be scheduled to review the grievance at the earliest possible date. Decisions of the Grievance Review Committee are binding unless reversed through the appeal process.

**Appeals Process**

A Provider may file a written appeal when the complaint or concern involves (a) an authorization or (b) the processing or payment of a claim. The appeal must include all supporting documentation regarding the Provider’s complaint or concern. Providers have the right to access the appeals process--before, during, or after an informal or grievance process. The written appeal should be submitted to:

Solano County Mental Health Plan  
Provider Appeals Coordinator  
275 Beck Ave., MS 5-250  
Fairfield, CA 94533

The written appeal must reach Solano County Mental Health Plan within ninety (90) calendar days of the authorization decision or the dispute regarding the claim. Solano County Mental Health Plan will have sixty (60) calendar days from receipt of the appeal to inform the Provider in writing of the decision. This will include a statement of the reasons for the decision that addresses each issue raised by the Provider and any action required by the Provider to implement the decision. Solano County Mental Health Plan will also provide the name of a person who may be contacted regarding the status of the appeal.

Solano County Mental Health Plan will utilize personnel not involved in the initial decision to determine the appeal decision.

If the appeal is upheld, the Provider Appeals Coordinator will notify the Provider of the decision. The Provider shall submit a revised authorization request or claim to the Managed Care Unit within thirty (30) calendar days from receipt of the Provider Appeals Coordinator’s decision.

If the appeal is denied or not granted in full, the Provider will be notified of his/her further right (second level appeal) for review. If a second level appeal is requested, the Provider must submit the request within thirty (30) days of receipt of the appeal denial to the Solano County Behavioral Health Director. The Provider will be notified in writing within sixty (60) days of the Provider’s appeal to the Behavioral Health Director of his/her decision. The decision of the Behavioral Health Director shall be final.

If the Behavioral Health Director upholds the Provider’s appeal, Solano County Mental Health Plan will have fourteen (14) calendar days to take any other corrective action described within the decision. The Provider may be requested to submit a revised claim under the circumstances of specific decisions by the Behavioral Health Director.
Initial Authorization for Services

Solano County Health & Social Services Department
Solano Mental Health Managed Care Plan
275 Beck Avenue, MS 5-235
Fairfield, CA 94533-0677
Phone (800) 547-0495  Fax (707) 425-4320

Date: January 14, 2014

Client Name: TESTDATA,TEST
Address:
123 HAPPY TRAILS
Suite 200
City, State, Zip: FAIRFIELD, CA 94533

This letter is confirmation that the Solano County Mental Health Plan has recently authorized payment for the following services under your Managed Care Medi-Cal benefits as a Solano County recipient.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Outpatient Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days/Sessions Authorized</td>
<td>4</td>
</tr>
<tr>
<td>Authorization #</td>
<td>5982</td>
</tr>
<tr>
<td>Provider Name:</td>
<td>TEST</td>
</tr>
</tbody>
</table>
| Address: | 123 MANAGED CARE LANE
RIO VISTA, CA 94571 |
| Telephone: | 707-555-5555 |

Effective Date: January 07, 2014

All payment for services is contingent upon Medi-Cal eligibility at the time services are rendered. A letter has also been sent to your provider confirming authorization for the above services.

This authorization is valid for 30 days from the effective date listed above. You are responsible for contacting the provider named in this letter to access services within that time.

If you have any questions about this authorization information, or if you have a concern or complaint about the services you have been provided, please call (800) 547-0495.

For questions about your Medi-Cal eligibility or physical health care services, please call the Partnership HealthPlan of California at (707) 863-4120 or (800) 863-4155.

Solano County Mental Health Managed Care Plan will make arrangements for language interpretation to be available at no cost to you.

Attachment A - Sample Only
Initial Authorization for Services

Solano County Health & Social Services Department
Solano Mental Health Managed Care Plan
275 Beck Avenue, MS 5-235
Fairfield, CA 94533-0677
Phone (800) 547-0495 Fax (707) 425-4320

Please Note: Payment for the services described in this authorization is subject to the Medi-Cal beneficiary's eligibility at the time services are provided.

Provider Name: TEST
Address: 123 MANAGED CARE LANE
          RIO VISTA, CA 94571

Date: January 14, 2014

Consumer Name: TESTDATA, TEST
Address: 123 HAPPY TRAILS
          Suite 200
          FAIRFIELD, CA 94533

Consumer ID: 1
Medi-Cal CIN #: 99999999A
Date of Birth: 8/12/1980
Sex: Female

Telephone: 707-784-5621 707-784-5478

Care Manager: TEMPORARY SYSTEM ADMINISTRAT
Authorization #: 5982
Telephone: (800) 547-0495
Authorization Start: 1/7/2014
Authorization End: 1/7/2015

Services Authorized

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Service Codes Allowable</th>
<th>Days/ Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Diagnostic Assessment</td>
<td>90791</td>
<td>1</td>
</tr>
<tr>
<td>Outpatient Therapy CPT Codes</td>
<td>90832, 90834, 90837, 90846, 90847, 90853</td>
<td>3</td>
</tr>
</tbody>
</table>

ATTENTION: Appointment Information

Please record the appointment date and time offered to the client and fax to the Managed Care Unit at (707) 425-4320 within 72 hours of scheduling the appointment.

Appointment Date: __________________________ Appointment Time: __________________________

Comments: __________________________

Procedures:

1. If enclosed, the Behavioral Health/Primary Physician Care Communication Form must be completed and faxed to the Primary Care Physician as well as to Solano County Managed Care Program at fax (707) 425-4320.
2. Please be sure to fax or mail the Biopsychosocial Assessment form ASAP, but no later than four weeks from the date of this authorization.
3. To request additional treatment, please fax or mail an Outpatient Treatment Progress Report two weeks prior to the last authorized visit.
4. Upon the conclusion of treatment, please fax or mail a Closing Summary Report no later than one week after treatment is concluded.
5. If an emergent issue arises with any referral, please call the Solano County Crisis Services at (707) 428-1131.
6. For any other non-emergent issue, such as a referral to another provider or level of care, please call (800) 547-0495.
7. The client must call the provider within 30 days from the authorization start date or this authorization will no longer be valid.
8. To receive payment, claims must be received within 60 days of the date of service being claimed.

Attachment B - Sample Only
Acknowledgement of Receipt

I have received the following items at the start of service with this Provider. In addition, I understand that I may receive any of the following information upon request. I have also been informed that alternative formats are available and have been given information on how to access these formats:

<table>
<thead>
<tr>
<th>Initial all that apply</th>
<th>Document Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Service Provider Notice of Privacy Practices</strong></td>
<td>The Notice of Privacy Practices tells you how your Mental Health Service Provider may use or disclose information about you. Not all situations will be described. As your Mental Health Service Provider, we are required to give you a notice of our privacy practices for the information we collect and keep about you.</td>
</tr>
<tr>
<td><strong>Solano County MHP “Guide to Medi-Cal Mental Health Services”</strong></td>
<td>The MHP “Guide to Medi-Cal Mental Health Services” contains information on how a member is eligible for mental health services, how to access mental health services, who our service providers are, what services are available, what your rights are, our Grievance and State Fair Hearing process and includes important phone numbers regarding our Mental Health Plan.</td>
</tr>
<tr>
<td><strong>Advance Directive Fact Sheet</strong></td>
<td>The Advance Directive Fact Sheet explains your rights to make decisions about your medical treatment. It includes how to appoint a health care agent who can make decisions on your behalf and how to change your directives at anytime.</td>
</tr>
<tr>
<td>Do you have an Advance Directive?</td>
<td>Please circle one:</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, can you provide a copy of your Medical Records?</td>
<td>Please circle one:</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Solano County MHP Provider List</strong></td>
<td>The MHP Provider List is a list of MHP Providers in our community. You may contact the MHP Access Unit at 1-800-547-0495 for further information regarding this list of Providers.</td>
</tr>
</tbody>
</table>

I, ________________________________, (Print Client Name) have been given a copy of the above-initialed documents and have had a chance to ask questions regarding these documents.

<table>
<thead>
<tr>
<th>Client Signature:</th>
<th>Client Number:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Legal Representative of Client (If applicable):</th>
<th>Relationship to Client:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised February 2012

Attachment C - Sample Only – For actual form click [here](#).
DEPARTAMENTO DE SERVICIOS SOCIALES Y DE SALUD DEL
CONDADO DE SOLANO DIVISIÓN DE SALUD MENTAL

Acuse de recibo

Cuando este proveedor comenzó a prestar sus servicios, recibí los siguientes artículos. Además, entiendo que puedo recibir cualquier información de la siguiente si así lo deseo. Yo también he sido informado que formatos alternativos están disponibles y han sido dado información en cómo conseguir acceso a estos formatos:

<table>
<thead>
<tr>
<th>Firme con sus iniciales todo lo que corresponda</th>
<th>Documento entregado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Notificación de Prácticas de Privacidad del Proveedor de Salud Mental</strong></td>
</tr>
<tr>
<td></td>
<td>La Notificación de Prácticas de Privacidad le informa de qué manera el Proveedor de Salud Mental puede usar o divulgar información acerca de usted. No se describirán todas las situaciones. Proveedor de Salud Mental debe brindarle una notificación de nuestras prácticas de privacidad para la información que reunimos y guardamos sobre usted.</td>
</tr>
<tr>
<td></td>
<td><strong>“Guía para los servicios de salud mental de Medi-Cal” del Plan de Salud Mental (Mental Health Plan, MHP) del Condado de Solano</strong></td>
</tr>
<tr>
<td></td>
<td>La “Guía para los servicios de salud mental de Medi-Cal” del MHP contiene información sobre cómo un miembro es elegible para los servicios de salud mental, cómo acceder a los servicios de salud mental, quiénes son nuestros proveedores de servicios, qué servicios están disponibles, cuáles son sus derechos, nuestro proceso de Quejas y Audiencia Estatal Imparcial, e incluye números de teléfono importantes relacionados con nuestro Plan de Salud Mental</td>
</tr>
<tr>
<td></td>
<td><strong>Hoja informativa sobre las directivas anticipadas</strong></td>
</tr>
<tr>
<td></td>
<td>La hoja informativa sobre las directivas anticipadas le explica sus derechos para tomar decisiones sobre su tratamiento médico. Incluye información sobre cómo nombrar un agente para el cuidado de la salud que pueda tomar decisiones en su nombre y cómo cambiar las directivas en cualquier momento.</td>
</tr>
<tr>
<td></td>
<td>¿Tiene una directiva anticipada? Encierre con un círculo una Si No N/A</td>
</tr>
<tr>
<td></td>
<td>Si la respuesta es Sí, ¿puede brindarnos una copia para nuestros expedientes médicos? Encierre con un círculo una Si No N/A</td>
</tr>
<tr>
<td></td>
<td><strong>Lista de proveedores del MHP del Condado de Solano</strong></td>
</tr>
<tr>
<td></td>
<td>La lista de proveedores del MHP es una lista de los proveedores del MHP en nuestra comunidad. Puede comunicarse con la Unidad de Acceso del MHP al 1-800-547-0495 para obtener más información acerca de esta lista de proveedores.</td>
</tr>
</tbody>
</table>

Yo, ____________________________, (nombre del cliente en letra de imprenta) he recibido una copia de los documentos que firmé con mis iniciales anteriormente y he tenido la oportunidad de hacer preguntas relacionadas con dichos documentos.

<table>
<thead>
<tr>
<th>Firma del cliente:</th>
<th>Número de cliente:</th>
<th>Fecha:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firma del representante legal del cliente (si corresponde):</td>
<td>Relación con el cliente:</td>
<td>Fecha:</td>
</tr>
</tbody>
</table>

Attachment C - Sample Only – For actual form click [here](#).
Attachment D - Sample Only – For actual form click here.
### Client's Risk Assessment

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Ideation</th>
<th>Plan</th>
<th>Intent w/o means</th>
<th>Intent with means</th>
<th>Homicidality</th>
<th>None</th>
<th>Ideation</th>
<th>Plan</th>
<th>Intent w/o means</th>
<th>Intent with means</th>
<th>Impulse Control</th>
<th>Sufficient</th>
<th>Moderate</th>
<th>Minimal</th>
<th>Inconsistent</th>
<th>Explosive</th>
<th>Substance Abuse:</th>
<th>None</th>
<th>Abuse</th>
<th>Dependence</th>
<th>Unstable Remission</th>
<th>Medical Risks:</th>
<th>No</th>
<th>Yes</th>
<th>if yes, explain:</th>
</tr>
</thead>
</table>

[Continued on Addendum Page]

### Assault/Legal History


[Continued on Addendum Page]

### Medical Information

- Current Primary Medical Provider: 
- Phone: 
- Address: 
- Date of last exam: 
- Allergies: Yes | No 
- Physical disabilities that require accommodations: Yes | No 
- If yes, specify: 

#### Current Prescribed Medications and Over-the-Counter Medications

(include psycho-tropics, herbal remedies, nutritional supplements, etc.):

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Date Started</th>
<th>Last Dose</th>
<th>Results/Reactions (per client report)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

[Continued on Addendum Page]

#### Past Prescribed, Over-the-Counter Medications

(include psycho-tropics, herbal remedies, nutritional supplements, etc.):

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Date Started</th>
<th>Last Dose</th>
<th>Results/Reactions (per client report)</th>
</tr>
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<tbody>
<tr>
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</table>

[Continued on Addendum Page]

#### Mental Health Treatment History

(include outpatient and inpatient/hospitalization treatment):

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Location</th>
<th>Type of Treatment</th>
<th>Provider</th>
<th>Client's Impression of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

[Continued on Addendum Page]

Client Name: 
Date of Birth: 

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Attachment D - Sample Only – For actual form click [here](#).
## Mental Status Exam

Note: consider factors for cultural and age influences.

### Appearance
- [ ] Appropriate grooming/
dress for age/culture
- [ ] Younger than stated age
- [ ] Older than stated age
- [ ] Unique features
- [ ] Eccentric
- [ ] Seductive
- [ ] Poor hygiene
- [ ] Unusual Physical
Characteristics

### Eye Contact
- [ ] Normal for culture
- [ ] Little
- [ ] Avoids
- [ ] Erratic

### Speech
- [ ] Normal for age/situation
- [ ] Brief responses
- [ ] Rambling
- [ ] Stammer/stutter
- [ ] Loud
- [ ] Non-verbal
- [ ] Monotone
- [ ] Vocal tic
- [ ] Soft
- [ ] Rapid
- [ ] Excessive profanity
- [ ] Other speech difficulty
- [ ] Overly talkative
- [ ] Pressured
- [ ] Starred

### Attitude
- [ ] Responsive
- [ ] Superficial
- [ ] Angry/hostile
- [ ] Apathetic
- [ ] Engaging
- [ ] Guarded/distant
- [ ] Shy/shy
- [ ] Isolated
- [ ] Cooperative
- [ ] Provocative/limit testing
- [ ] Dramatic
- [ ] Withdrawn
- [ ] Uncooperative
- [ ] Manipulative/deceitful
- [ ] Demanding/insistent
- [ ] Dependent

### Behavior/ Motor Activity
- [ ] Normal for age/situation
- [ ] E.P.S.
- [ ] Unusual mannerism
- [ ] Motor tic
- [ ] Slowed
- [ ] Impulsive
- [ ] Akathisia
- [ ] Other involuntary movement
- [ ] Overactive/restless
- [ ] Agitated
- [ ] Tremor
- [ ] Other

### Mood
- [ ] Within normal limits
- [ ] Happy
- [ ] Unhappy or angry
- [ ] Fearful
- [ ] Irritable or angry
- [ ] Sad
- [ ] Anxious
- [ ] Bored
- [ ] Other
- [ ] Tearful
- [ ] Irritable
- [ ] Fearful
- [ ] Incongruent with topic or thoughts
- [ ] Tearful
- [ ] Irritable
- [ ] Fearful
- [ ] Congruent with mood
- [ ] Overly Happy
- [ ] Silly
- [ ] Labile (rapidly shifting)
- [ ] Flat, blunted, constricted

### Perceptual Disturbance
- [ ] None apparent
- [ ] Hallucinations:
- [ ] Visual
- [ ] Auditory
- [ ] Command
- [ ] Other
- [ ] Delusions
- [ ] Persecutory
- [ ] Somatic
- [ ] Other
- [ ] Ideation
- [ ] Bizarre
- [ ] Religious
- [ ] Religious
- [ ] Paranoid
- [ ] Religious
- [ ] Phobic
- [ ] Suspicious
- [ ] Obsessive
- [ ] Blames others
- [ ] Paraphasic
- [ ] Magical thinking
- [ ] Irrational/Excessive Worry
- [ ] Sexual Preoccupation
- [ ] Excessive/Inappropriate Guilt
- [ ] Excessive/Inappropriate Religiosity

### Thought Process Disturbance
- [ ] None apparent
- [ ] Concentration
- [ ] Intact
- [ ] Brief
- [ ] Impaired by:
- [ ] Ruminating
- [ ] Thought Blocking
- [ ] Clouding of Consciousness
- [ ] Fragmented
- [ ] Abstractions
- [ ] Concrete
- [ ] Overly Abstract
- [ ] Circumstantial
- [ ] Confabulation
- [ ] Flight of Ideas
- [ ] Word Salad
- [ ] Associations
- [ ] Unimpaired
- [ ] Loose
- [ ] Tangential
- [ ] Incongruities
- [ ] Circumstantial
- [ ] Confabulation
- [ ] Flight of Ideas
- [ ] Word Salad

### Thoughts of Harmful Self or Others
- [ ] None
- [ ] Suicidal Ideation
- [ ] Suicidal plan
- [ ] Thoughts or plan of non-lethal self-injury
- [ ] Thoughts or plan of harming another person

### Sensorium
- [ ] Oriented to:
- [ ] Person
- [ ] Place
- [ ] Time
- [ ] Situation
- [ ] Intellectual functioning:
- [ ] Average or higher
- [ ] Below average
- [ ] Borderline or below
- [ ] Alertness
- [ ] Clouded/Confused
- [ ] Other
- [ ] Memory intact for:
- [ ] Immediate
- [ ] Recent
- [ ] Remote
- [ ] Attention:
- [ ] Immediate
- [ ] Recent
- [ ] Remote
- [ ] Poor

### Comments

[ ] Continued on Addendum Page

---

Client Name: ____________________________  Date of Birth: ____________________________

Page 3 of 6

Attachment D - Sample Only – For actual form click [here](#).
Medical Necessity Criteria and Justification

Diagnostic Criteria (List included Title 9 diagnosis):

Impairment Criteria (must have ONE of the following impairments as a result of the included Title 9 diagnosis):

1. A significant impairment in an important area of life functioning, OR
   □ Yes □ No
2. A probability of significant deterioration in an important area of life functioning, OR
   □ Yes □ No
3. A probability that the child/youth will not progress developmentally as individually appropriate, OR
   □ Yes □ No
4. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.
   □ Yes □ No

Intervention Criteria (must meet 5,6, & 7 OR 7 & 8):

5. The focus of treatment is to address the condition identified in the Impairment Criteria.
   □ Yes □ No
6. It is expected the client will benefit from treatment by diminishing the impairment or preventing significant deterioration in an important area of life functioning.
   □ Yes □ No
7. The condition would not be responsive solely to physical health care based treatment.
   □ Yes □ No
8. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.
   □ Yes □ No

Provide brief description of impairments/presenting problems in activities of daily living, social, occupational/academic or other important area(s) of life functioning:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Symptoms to Support Diagnosis (include DSM diagnostic criteria and functional impairment):

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Current Diagnosis (check only one Primary Diagnosis)

Axis I □ Pri □ Sec DSM Code: ___________ Name:

Axis II □ Pri □ Sec DSM Code: ___________ Name:

Axis III General Medical Condition ICD Code: ___________ Name:

Axis IV Psychosocial and Environmental Problems  Check all that apply:

□ A. primary support group □ B. social environment □ C. education □ D. occupational

□ E. housing □ F. economics □ G. access to health care □ H. interaction with legal system

Axis V Current GAF: ___________ Highest GAF (in past 12 months): ___________

Client Name: __________________________ Date of Birth: __________________________

Attachment D - Sample Only – For actual form click here.
Proposed Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. "as evidenced by..."

Goal #1:

Proposed Method for Achieving Goal/Interventions:

Proposed Duration:

Goal #2:

Proposed Method for Achieving Goal/Interventions:

Proposed Duration:

Proposed Treatment Level

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Frequency</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>Monthly, Every other week, Weekly</td>
<td>Total Sessions Requested</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>Monthly, Every other week, Weekly</td>
<td>Total Sessions Requested</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Monthly, Every other week, Weekly</td>
<td>Total Sessions Requested</td>
</tr>
</tbody>
</table>

Signatures

The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan.

Check one:  ☐ Client accepted a copy of this plan  ☐ Client declined a copy of this plan

Client Signature  Date  Provider Signature (must include Licensure/Degree)  Date

Parent/Caregiver/Guardian  Date  Print Provider Name and Licensure/Degree

If no client signature, document why and describe how the client/caregiver was involved in the development of this plan and how they have indicated agreement with the plan:

Client Name:  Date of Birth:

Attachment D - Sample Only – For actual form click here.
Medical Necessity Criteria and Justification

Diagnostic Criteria (List included Title 9 diagnosis): Major Depressive DO, Recurrent, Severe without Psychotic Features

Impairment Criteria (must have ONE of the following impairments as a result of the included Title 9 diagnosis):
1. A significant impairment in an important area of life functioning, OR □ Yes □ No
2. A probability of significant deterioration in an important area of life functioning, OR □ Yes □ No
3. A probability that the child/youth will not progress developmentally as individually appropriate, OR □ Yes □ No
4. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate. □ Yes □ No

Intervention Criteria (must meet 5, 6, & 7 OR 7 & 8):
5. The focus of treatment is to address the condition identified in the impairment Criteria. □ Yes □ No
6. It is expected the client will benefit from treatment by diminishing the impairment or preventing significant deterioration in an important area of life functioning. □ Yes □ No
7. The condition would not be responsive solely to physical health care based treatment. □ Yes □ No
8. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate. □ Yes □ No

Provide brief description of impairments/presenting problems in activities of daily living, social, occupational/academic or other important areas(s) of life functioning:

Daily Living: CT stays in bed most of the day, everyday; rarely showers; rarely brushes teeth; does not eat regularly.

Social: CT is isolating from friends and family members; rarely leaves house except for occasional grocery shopping.

Health: CT complains of back and joint pain and has not seen a physician regarding these issues.

Living Arrangement: CT is feeling unsafe in her neighborhood.

Symptoms to Support Diagnosis (include DSM diagnostic criteria and functional impairment):

Major Depressive Disorder: Client has daily suicidal thoughts; is crying every day, lacks motivation to do anything, doesn’t enjoy her hobbies anymore, lacks energy (currently 2, 10=good energy), can’t sleep at night (sleeps 3-4 hrs/nt).

Current Diagnosis (check only one Primary Diagnosis)

Axis I □ Pri □ Sec DSM Code: 296.33 Name: Major Depressive DO, Recurrent, Severe (cont’d) without Psychotic Features

Axis II □ Pri □ Sec DSM Code: 

Axis III General Medical Condition □ Sec Code: 

Axis IV Psychosocial and Environmental Problems □ E. housing □ I. other psychosocial/environmental

Check all that apply:
A. primary support group
B. social environment
C. education
D. occupational

Axis V Current GAF: 45 Highest GAF (In past 12 months): 45

Client Name: Date of Birth:

Attachment E - Sample Only
Proposed Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. “as evidenced by…”

Goal #1: Decrease suicidal thoughts from daily to < 2x/wk. Reduce depressive Sx by 3 mos AEB reduction of crying episodes from daily to <3x/wk, involvement in 1+ enjoyable activity, improve sleep (5-7 hrs/nt), better energy (from 2 to 5)

Proposed Method for Achieving Goal/Interventions: Do risk assessment & create safety plan as needed. Encourage & check-in w/CT re: meds compliance & attendance at psychiatric appointments. CBT to challenge & reframe

Proposed Duration: (cont’d) negative thoughts that exacerbate depressive Sx. Encourage awareness & expression of feelings. Explore activities and physical exercise that would be pleasurable for client. Introduce sleep hygiene.

Goal #2: (Daily Living) By 3 months, CT’s self-care regimen will have improved AEB her maintaining regular sleep pattern, showering at least 1-2x weekly, brushing her teeth at least 1x daily, and eating at least 2-3 meals daily.

Proposed Method for Achieving Goal/Interventions: Use CBT to challenge & reframe negative thoughts that are keeping CT in depressed & unmotivated state. Assist CT in setting goals around self-care & creating an action plan

Proposed Duration: (cont’d) for weekly self-care using a chart to track her daily self-care activities.

Proposed Treatment Level

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Frequency</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>□ Monthly</td>
<td>□ Every other week</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>□ Monthly</td>
<td>□ Every other week</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>□ Monthly</td>
<td>□ Every other week</td>
</tr>
</tbody>
</table>

Signatures

The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan.

Check one: □ Client accepted a copy of this plan □ Client declined a copy of this plan

Client Signature Date Provider Signature (must Include Licensure/Degree) Date

Parent/Caregiver/Guardian Date Print Provider Name and Licensure/Degree

If no client signature, document why and describe how the client/caregiver was involved in the development of this plan and how they have indicated agreement with the plan:


Client Name: ___________________________ Date of Birth: ___________________________

Attachment E - Sample Only
(Future goals may look like these once suicidal ideation and symptoms of depression and impairment in daily living have improved).

Goal #3 (Social): By 3 months, CT is connecting with either a friend or family member at least 1x/week in face-to-face manner away from her home. Method to achieve goal: Use CBT to challenge & reframe CT’s negative thoughts that are keeping her in a depressed and isolated state. Engage client in discussion of people she might enjoy connecting with and assist her in creating an action plan for getting out of the house and meeting a friend or family member.

Goal #4 (Health): Client will have a medical exam with her physician to check on physical issues within next 3 months. Method to achieve goal: Explore CT’s concerns regarding her physical health & what barriers are present preventing her from seeing her physician. Empower & motivate client in creating an action plan.

Goal #5 (Living Arrangement): By 3 months, CT will have decided whether or not to pursue other housing options. Method to achieve goal: Facilitate discussion about concerns client has about her housing situation and explore what choices she has regarding the situation.

__________________________  ____________________________  ____________________________
Signature & License          Print Name                      Date

Client Name: ____________________________________  Date of Birth: ____________________________

Attachment E - Sample Only
**Solano County Mental Health Plan – Managed Care Network Provider**

**Client Biopsychosocial Assessment Update**

Name of Assessor: __________________________ Date of this Assessment Update: ____________

**SECTION I: Relevant Client Updates**

Please describe any changes to the following areas since the most recent
Client Assessment dated: _______________ (required)

Type of Assessment Update (must check one): ☐ Annual ☐ Periodic

<table>
<thead>
<tr>
<th>Resources (interests, family, community, school and peers, etc.):</th>
<th>☐ Continued on Addendum Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Status Exam:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
<tr>
<td>Significant Events:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
<tr>
<td>Substance Use:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
<tr>
<td>Relevant Physical Health Conditions:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
<tr>
<td>Cultural Factors:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
<tr>
<td>Social Factors:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
<tr>
<td>Developmental Status:</td>
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</tr>
<tr>
<td>Medications:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
<tr>
<td>Coordinated Services/Agencies:</td>
<td>☐ Continued on Addendum Page</td>
</tr>
</tbody>
</table>

Client Name: __________________________ Date of Birth: ____________

Page 1 of 4

**Attachment F - Sample Only – For actual form click** [here](#).
Section II: Medical Necessity Criteria and Justification

Diagnostic Criteria (List included Title 9 diagnosis):

Impairment Criteria (must have ONE of the following impairments as a result of the included Title 9 diagnosis):

1. A significant impairment in an important area of life functioning, OR
   □ Yes □ No

2. A probability of significant deterioration in an important area of life functioning, OR
   □ Yes □ No

3. A probability that the child/youth will not progress developmentally as individually appropriate, OR
   □ Yes □ No

4. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental
disorder that specialty mental health services can correct or ameliorate.
   □ Yes □ No

Intervention Criteria (must meet 5,6, & 7 OR 7 & 8):

5. The focus of treatment is to address the condition identified in the Impairment Criteria.
   □ Yes □ No

6. It is expected the client will benefit from treatment by diminishing the Impairment or preventing
   significant deterioration in an important area of life functioning.
   □ Yes □ No

7. The condition would not be responsive solely to physical health care based treatment.
   □ Yes □ No

8. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental
   disorder that specialty mental health services can correct or ameliorate.
   □ Yes □ No

Provide brief description of impairments/presenting problems in activities of daily living, social, occupational/academic or other important area(s) of life functioning:

Section III: Symptoms to Support Diagnosis (Include DSM diagnostic criteria and functional impairment):

Section IV: Current Diagnosis (check only one: Primary Diagnosis)

Axis I  □ PrI  □ Sec  DSM Code:  __________________ Name: __________________

Axis II □ PrI  □ Sec  DSM Code:  __________________ Name: __________________

Axis III General Medical Condition  ICD Code:  __________________ Name: __________________

Axis IV Psychosocial and Environmental Problems  Check all that apply:

☐ A. primary support group  ☐ E. housing  ☐ I. other psychosocial/environmental

☐ B. social environment  ☐ F. economics  ☐ J. inadequate information

☐ C. education  ☐ G. access to health care

☐ D. occupational  ☐ H. interaction with legal system

Axis V Current GAF:  __________________ Highest GAF (in past 12 months):  __________________

Section V: Individual &/or Family Strengths Relevant to Achieving Treatment Goals

Client Name: __________________ Date of Birth: __________________

Attachment F - Sample Only – For actual form click here.
**Section VI: Treatment Plan**

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. “as evidenced by...”

Goal #1:

---

Proposed Method for Achieving Goal/Interventions:

---

Proposed Duration:

---

Progress Since Last Report:

- [ ] New Goal
- [ ] Much Worse
- [ ] Slight Improvement
- [ ] Somewhat Worse
- [ ] Significant Improvement
- [ ] No Change
- [ ] Resolved

Goal #2:

---

Proposed Method for Achieving Goal/Interventions:

---

Proposed Duration:

---

Progress Since Last Report:

- [ ] New Goal
- [ ] Much Worse
- [ ] Slight Improvement
- [ ] Somewhat Worse
- [ ] Significant Improvement
- [ ] No Change
- [ ] Resolved

**Section VII: Re-Authorization of Services Request**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Frequency</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Every other week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>Total Sessions Requested</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Every other week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>Total Sessions Requested</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Every other week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>Total Sessions Requested</td>
</tr>
</tbody>
</table>

**Section VIII: Signatures**

The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan. 

Check one:  [ ] Client accepted a copy of this plan  [ ] Client declined a copy of this plan

---

Client Signature Date Provider Signature and Licensure/Degree Date

Parent/Caregiver/Guardian Date Print Provider Name and Licensure/Degree

If no client signature, document why and describe how the client/caregiver was involved in the development of this plan and how they have indicated agreement with the plan:

---

Client Name: ___________________________ Date of Birth: ___________________________

Attachment F - Sample Only – For actual form click [here](#).
Attachment F - Sample Only – For actual form click [here].
Client Services Information Sheet (CSI)
Solano County Managed Care Program
275 Beck Ave. MS 5-235
Fairfield, CA 94533-0677
Phone: (800) 547-0495 FAX: (707) 425-4320

Check One: ☐ New Admission ☐ Update of Information

Instructions: May be completed by client, client's representative, clerical support, or practitioner/provider. "Client" is the individual receiving services.

1. Your (Client) Legal Name: (Last) ______________ (First) ______________ (Middle) ______________
2. (Client) Birth Name: (Last) ______________ (First) ______________ (Middle) ______________
3. AKA (other names used): (Last) ______________ (First) ______________ (Middle) ______________
4. Social Security #: ___________________________ Date of Birth: ___ / ___ / ___ Age: ___ Mother's First Name: ___________________________
5. Place of Birth: (City) ______________________ (County) ____________________ (State) ____________ (Country) ____________________
6. Sex: ☐ Male ☐ Female ☐ Other Identification: ☐ Valid Driver's License ☐ I.D. State ______ Number ______
7. Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Coupled ☐ Separated ☐ Unknown
8. Address: (Mailing Address) ______________________ (City) ______________ (Zip) ______________
9. Address: (Physical Address) ______________________ (City) ______________ (Zip) ______________
10. Phone 1: ___________________________ Phone 2: ___________________________ Email: ___________________________
11. Client is of Hispanic or Latino Origin? ☐ Yes ☐ No
12. Race: Please check or list the race(s) that best describe your identity. (You can check or list up to 5)
   ☐ A- White or Caucasian ☐ G- Chinese ☐ M- Other Asian ☐ S- Asian Indian
   ☐ B- Black or African American ☐ H- Viatnamese ☐ N- Other Non White ☐ T- Native Hawaiian
   ☐ C- American Indian or Alaska Native ☐ I- Laotian ☐ O- Unknown ☐ U- Guamanian
   ☐ D- Mexican American/Chicano ☐ J- Cambodian ☐ P- Other Southeast Asian ☐ V- Amerasian
   ☐ E- Latin American ☐ K- Japanese ☐ Q- Korean ☐ X- Multiple
   ☐ F- Other Spanish ☐ L- Filipino ☐ R- Samoan
13. Primary Language: Please check or list one. ☐ English ☐ Spanish ☐ Tagalog ☐ Other ___________________________
14. Preferred Language: I prefer to receive services in the following language:
   ☐ English ☐ Spanish ☐ Tagalog ☐ Other ___________________________
15. Please list your next of kin and other members of your family/household:
<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Client</th>
<th>Date of Birth</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

16. Insurance Coverage: Do you have any of the following insurance plans or benefits? Check all that apply.
   ☐ Medi-Cal ☐ Medicare - Part A ☐ Healthy Families: ___________________________ (Plan)
   ☐ VA Benefits ☐ Part B ☐ Other Health Insurance: ___________________________ (Plan)
   ☐ No Health Insurance ☐ Part D
17. Source of Income: ☐ 0- Not Collected ☐ 2- Earned Through Employment ☐ 4- Retirement ☐ 6- Other
   ☐ 1- None ☐ 3- Disability ☐ 5- General/Public Assistance

OVER

Attachment G - Sample Only – For actual form click here.
18. Living Situation: (* asterisks apply to adults only)
- 06- Single Room (e.g., hotel)
- 07- Group quarters (e.g., migrant camp)
- 08- Group Home
- 09- Crisis Residential
- 10- Satellite Housing
- 11- House or apartment
- 14- House or apartment, w/support*
- 15- House or apartment, w/ supervision*
- 16- Supported housing*
- 20- Small board & care home (6 beds or less)
- 21- Large board & care home (7 + beds)
- 22- Residential treatment center
- 23- Community treatment center
- 24- Adult residential/social rehab
- 31- State hospital
- 32- VA hospital
- 33- SNF/ICF/IMD, for psychiatric reasons
- 34- SNF/ICF/Nursing Home, for physical
- 35- General hospital
- PHF/inpatient psych hospital
- Drug abuse facility
- Alcohol Abuse facility
- Justice related
- Temporary arrangement
- Homeless, no identifiable res.
- Homeless, in transit
- Other
- Unknown

19. Education
- 00- None, Kindergarten
- 01-9 Grade level (code 12 for GED): _____
- 98- Vocational education & training
- 99- Unknown

20. Employment Status:
- 01- Competitive job market, 35+ hrs/wk
- 02- Competitive job market, 1-19 hrs/wk
- 03- Competitive job market, 20-35 hrs/wk
- 04- Full time homemaking responsibility
- 05- Rehabilitative work, 35+ hrs/wk
- 06- Rehabilitative work, 1-19 hrs/wk
- 07- Rehabilitative work, 20-35 hrs/wk
- 08- School, full-time
- 09- Job training, full-time
- 10- Part-time school/job training
- 11- Volunteer work
- 12- Unemployed, seeking work
- 13- Unemployed, not seeking work
- 14- Retired
- 15- Not in the labor force
- 16- Unknown
- 17- Residential/inmate

21. Number of Children the client cares for or is responsible for at least 50% of the time: ______

22. Number of Dependent Adults the client cares for or is responsible for at least 50% of the time: ______

23. Conservatorship/Court Status:
- A- Temporary Conservatorship (W&I Code, Sec. 5353)
- B- Lanterman-Petris-Short (W&I Code, Sec. 5358)
- C- Murphy (W&I Code, Sec. 5008)
- D- Probate (Probate Code, Division 4, Sec. 1400)
- E- PC 2974 (Penal Code, Sec.2974)
- F- Representative Payee w/o Conservatorship (W&I Code, Sec. 5686)

24. Trauma - Has the client experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having been a victim of physical, emotional, or sexual abuse, having lived through a natural disaster, having been a combatant or civilian in a war zone, or having witnessed or having been a victim of a severe accident?  Yes  No

25. Referred from:
- 01- Self
- 02- Family
- 03- Friends
- 04- Employer
- 05- Other
- 10- State Hospital (MH)
- 12- Other Psychiatric Hospital
- 13- Psychiatric SNF
- 17- Jail
- 30- Emergency Psychiatric
- 31- Suicide & Crisis
- 32- Outpatient Clinic
- 33- Private MH Practice
- 37- Case Management
- 38- Homeless Program
- 47- School/College
- 48- Vocational Rehab Program
- 49- Veterans Administration
- 50- Clergy/Religious
- 51- Other Human Service

Printed Name of Person Completing Form  Signature of Person Completing Form  Date

Attachment G - Sample Only – For actual form click here.
## Client Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>Client Name* (First &amp; Last)</td>
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</tr>
<tr>
<td>Guardian/Parent Name</td>
<td></td>
</tr>
<tr>
<td>Client’s Home Phone</td>
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<tr>
<td>Work Phone</td>
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</tr>
<tr>
<td>Medi-Cal Number</td>
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</tr>
<tr>
<td>Initial Telephone Contact Date</td>
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</tr>
<tr>
<td>Provider Name</td>
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<tr>
<td>Provider Phone</td>
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<td>Provider Fax</td>
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<tr>
<td>Provider Email Address</td>
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## Symptoms & Problems

<table>
<thead>
<tr>
<th>Severity Rating</th>
<th>Severity</th>
<th>Description</th>
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<tbody>
<tr>
<td>1 = Mild</td>
<td>Anxiety</td>
<td>Poor Interpersonal Skills</td>
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<tr>
<td></td>
<td>Appetite Disturbance</td>
<td>Poor Judgment</td>
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<td></td>
<td>Bizarre Behavior</td>
<td>Impaired Memory</td>
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<td>Conduct Problems</td>
<td>Obsessive-Compulsive</td>
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<td>Depression</td>
<td>Panic Attacks</td>
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<td>Gender Issues</td>
<td>Paranoid Ideation</td>
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<td>Somatization</td>
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<td>Independ. Living Problems</td>
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<td></td>
<td>Poor Self-Care Skills</td>
</tr>
</tbody>
</table>

## Current Medication

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Name</td>
<td></td>
</tr>
<tr>
<td>Dosage</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td></td>
</tr>
<tr>
<td>Prescribing Physician</td>
<td></td>
</tr>
</tbody>
</table>

## Current Diagnosis

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM Code:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>General Medical Condition</td>
<td></td>
</tr>
<tr>
<td>ICD Code:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
</tbody>
</table>

## Psychosocial and Environmental Problems

- A. primary support group
- B. social environment
- C. education
- D. occupational
- E. housing
- F. economics
- G. access to health care
- H. Interaction with legal system

## Axis V

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current GAF</td>
<td></td>
</tr>
<tr>
<td>Highest GAF (In past 12 months):</td>
<td></td>
</tr>
</tbody>
</table>

---

Attachment H - Sample Only – For actual form click [here](#).
Transition/Termination Plan

Referrals & Recommendations (Check all that apply):

☐ Individual Therapy  ☐ Structured Treatment Program  ☐ No continuing care recommended
☐ Community/Self-Help Support  ☐ Family/Couple Therapy  ☐ Medication Management
☐ Residential Treatment  ☐ Other (Specify): ____________________________  ☐ Other (Specify): ____________________________

Please list community resources that have been discussed with client as well as those resources the client has connected with that will aid them following termination from your services: ____________________________

-------------------------------------------

Reason for Submitting Closing Summary Report

☐ Treatment goals met  ☐ Provider discontinued treatment  ☐ Member discontinued treatment
☐ Annual benefit maximum reached  ☐ Lack of ongoing medical necessity  ☐ Client death
☐ Other (Specify): ____________________________

Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g., “as evidenced by…”

Goal #1: ____________________________

Method for Achieving Goal/Interventions: ____________________________

Progress Since Last Report: ☐ Much Worse  ☐ Slight Improvement
☐ Somewhat Worse  ☐ Significant Improvement
☐ No Change  ☐ Resolved

Goal #2: ____________________________

Method for Achieving Goal/Interventions: ____________________________

Progress Since Last Report: ☐ Much Worse  ☐ Slight Improvement
☐ Somewhat Worse  ☐ Significant Improvement
☐ No Change  ☐ Resolved

Additional Comments: ____________________________

Provider Signature and Licensure/Degree ____________________________
Date ____________________________  Print Provider Name and Licensure/Degree ____________________________

Attachment H - Sample Only – For actual form click here.
Outpatient Treatment Progress Report

To request further authorizations, please fax or mail to:
Solano County Managed Care Program
275 Beck Ave. MS 5-235
Fairfield, CA 94533-0677
Phone: (800) 547-0495 FAX: (707) 425-4320

Please type or print clearly and complete this form in its entirety. For entries marked with an asterisk (*), use the Authorization for Service letter you received to obtain the necessary information.

Indicate if this is an emergency: □ Yes □ No If yes, call 1-800-547-0495. If no, please fax form to 1-707-425-4320

**Client Information**

<table>
<thead>
<tr>
<th>Client Name* (First &amp; Last)</th>
<th>Authorization Number*</th>
<th>Date Last Seen</th>
<th>Client's Date of Birth*</th>
<th>Total # of Sessions You Have Client Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardiant/Parent Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client's Home Phone</td>
<td>Work Phone</td>
<td></td>
<td>Medi-Cal Number</td>
<td>Other Insurance (e.g., Medicare, HMO)</td>
</tr>
<tr>
<td>Client's Primary Care Physician</td>
<td></td>
<td></td>
<td>Initial Telephone Contact Date</td>
<td>Evaluation Date</td>
</tr>
</tbody>
</table>

**Provider Information**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Phone</th>
<th>Provider Fax</th>
<th>Provider Email Address</th>
</tr>
</thead>
</table>

**Current Risk Factors**

- Suicidality: □ None □ Ideation □ Plan □ Intent w/o means □ Intent with means
- Homicidality: □ None □ Ideation □ Plan □ Intent w/o means □ Intent with means
- *If risk exists, client is able to contract not to harm:*

  - Impulse Control: □ Sufficient □ Moderate □ Minimal □ Inconsistent □ Explosive
  - Medical Risks: □ Yes □ No □ Self □ Others
  - Substance Abuse: □ None □ Abuse □ Dependence □ Unstable remission
  - Specifics: □ Yes □ No

**Current Medication**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Physical Compliance</th>
<th>No Information</th>
<th>Prescribing Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

□ Allergies If yes, specify:

**Efforts of Coordination of Care with Primary Care Physician (PCP)**

Please list efforts to contact PCP and information shared. Communication between the Behavioral Health Provider and the PCP should include, at a minimum, diagnosis, expected duration of treatment and any psychological/pharmacologic treatment recommendations.

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Page 1 of 3

Revised 8-11

Attachment J - Sample Only – For actual form click [here](#).
## Symptoms & Problems

<table>
<thead>
<tr>
<th>Severity Rating</th>
<th>Duration Rating</th>
<th>Severity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Mild</td>
<td>1 = Less than 1 month</td>
<td>Poor Interpersonal Skills</td>
<td></td>
</tr>
<tr>
<td>2 = Moderate</td>
<td>2 = 1 to 6 months</td>
<td>Poor Judgment</td>
<td></td>
</tr>
<tr>
<td>3 = Severe</td>
<td>3 = 7 to 11 months</td>
<td>Impaired Memory</td>
<td>Sexual Dysfunction</td>
</tr>
<tr>
<td></td>
<td>4 = 1 year or longer</td>
<td>Obsessive-Compulsive</td>
<td>Sleep Disturbance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Panic Attacks</td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paranoid Ideation</td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phobia</td>
<td></td>
</tr>
<tr>
<td>Indep. Living Problems</td>
<td>Poor Self-Care Skills</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provide brief description of impairments/presenting problems in activities of daily living, social, occupational/academic or other important area(s) of life functioning:

---

### Current Diagnosis

**Check only one Primary Diagnosis**

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Prf</th>
<th>Sec</th>
<th>DSM Code</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II</td>
<td>Prf</td>
<td>Sec</td>
<td>DSM Code</td>
<td>Name:</td>
</tr>
<tr>
<td>Axis III</td>
<td>General Medical Condition</td>
<td>ICD Code</td>
<td>Name:</td>
<td></td>
</tr>
</tbody>
</table>

**Axis IV**

Psychosocial and Environmental Problems

- [ ] A. primary support group
- [ ] B. social environment
- [ ] C. education
- [ ] D. occupational

**Check all that apply:**

- [ ] E. housing
- [ ] F. economics
- [ ] G. access to health care
- [ ] H. Interaction with legal system
- [ ] I. other psychosocial/environmental
- [ ] J. inadequate information

**Axis V**

Current GAF: ________ Highest GAF (in past 12 months): ________

### Individual &/or Family Strengths Relevant to Achieving Treatment Goals

---

### Transition/Termination Plan

Please document progress client has made toward achieving treatment goals relevant to successful termination. Document community resources that have been discussed with the client, and which community resources the client has connected with that will aid them, following successful termination of services.

---

Attachment J - Sample Only – For actual form click [here](http://example.com).

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Page 2 of 3

Revised 8-11
Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. “as evidenced by...”

Goal #1:

Proposed Method for Achieving Goal/Interventions:

Proposed Duration:

Progress Since Last Report: □ New Goal □ Much Worse □ Slight Improvement
□ Somewhat Worse □ Significant Improvement
□ No Change □ Resolved

Treatment Plan - Continued

Goal #2:

Proposed Method for Achieving Goal/Interventions:

Proposed Duration:

Progress Since Last Report: □ New Goal □ Much Worse □ Slight Improvement
□ Somewhat Worse □ Significant Improvement
□ No Change □ Resolved

Re-Authorization of Services Request

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Frequency</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>□ Monthly</td>
<td>□ Every other week</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>□ Monthly</td>
<td>□ Every other week</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>□ Monthly</td>
<td>□ Every other week</td>
</tr>
</tbody>
</table>

Signatures

The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan.

Check one: □ Client accepted a copy of this plan □ Client declined a copy of this plan

Client Signature Date

Provider Signature and Licensure/Degree Date

Parent/Caregiver/Guardian Date

Print Provider Name and Licensure/Degree

If no client signature, document why and describe how the client/caregiver was involved in the development of this plan and how they have indicated agreement with the plan:

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Page 3 of 3 Revised 8-11

Attachment J - Sample Only – For actual form click here.
Begin typing your progress note here. You must include your clinical interventions, the client's response to those interventions, and follow-up plan for client's future treatment.
## Client Information

- **Client Name* (First & Last)**
- **Authorization Number***
- **Date Last Seen**
- **Client’s Primary Care Physician**
- **Guardian/Parent Name**
- **Client’s Date of Birth**
- **Total # of Sessions You Have Client Seen**
- **Initial Telephone Contact Date**
- **Evaluation Date**
- **+Provider Phone**
- **+Provider Fax**
- **+Provider Email Address**

## Current Risk Factors

- **Suicidality:**
  - [ ] None
  - [ ] Ideation
  - [ ] Plan
  - [ ] Intent w/o means
  - [ ] Intent with means
- **Homicidality:**
  - [ ] None
  - [ ] Ideation
  - [ ] Plan
  - [ ] Intent w/o means
  - [ ] Intent with means
- **If risk exists, client is able to contract not to harm:**
  - [ ] Sufficient
  - [ ] Moderate
  - [ ] Minimal
  - [ ] Self
  - [ ] Others
  - [ ] Inconsistent
  - [ ] Explosive
- **Impulse Control:**
  - [ ] Sufficient
  - [ ] Moderate
  - [ ] Minimal
  - [ ] Normal
  - [ ] Self
  - [ ] Others
  - [ ] Inconsistent
  - [ ] Explosive
- **Medical Risks:**
  - [ ] Yes
  - [ ] No
  - [ ] If “Yes,” explain:
    - [ ] dependence
    - [ ] plan
    - [ ] intent w/o means
    - [ ] intent w/o means
- **Substance Abuse:**
  - [ ] None
  - [ ] Abuse
  - [ ] Dependence
  - [ ] Unstable remission
- **Specifics:**
  - [ ] Physical or sexual abuse, or child/elder neglect:
    - [ ] Yes
    - [ ] No
    - [ ] Neither, but abuse exists in family
    - [ ] Legally reported:
      - [ ] Yes
      - [ ] No

## Risk History

Explain any significant history of suicidal, homicidal, impulse control, medical or substance abuse behavior.

## Symptoms & Problems

<table>
<thead>
<tr>
<th>Severity Rating</th>
<th>Duration Rating</th>
<th>Severity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Mild</td>
<td>4 = 1 year or longer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 = Moderate</td>
<td>3 = 7 to 11 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 = Severe</td>
<td>2 = 1 to 6 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Severity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Poor Interpersonal Skills</td>
<td>Sexual Dysfunction</td>
</tr>
<tr>
<td>Appetite Disturbance</td>
<td>Poor Judgment</td>
<td>Sleep Disturbance</td>
</tr>
<tr>
<td>Bizarre Behavior</td>
<td>Impaired Memory</td>
<td>Somatization</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>Obsessive-Compulsive</td>
<td>Other:</td>
</tr>
<tr>
<td>Depression</td>
<td>Panic Attacks</td>
<td>Other:</td>
</tr>
<tr>
<td>Gender Issues</td>
<td>Paranoid Ideation</td>
<td></td>
</tr>
<tr>
<td>Bizarre Ideation</td>
<td>Phobia</td>
<td></td>
</tr>
<tr>
<td>Indep. Living Problems</td>
<td>Poor Self-Care Skills</td>
<td></td>
</tr>
</tbody>
</table>

Confidential W&I Code 5328

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Revised 9-12

Attachment L - Sample Only – For actual form click [here](#).
Medical History
For Initial Evaluation, list significant past and present medical conditions. For Progress Report, list changes in medical condition since last update.

Medication History
For Initial Evaluation, list significant past and present medications not prescribed by yourself. For Progress Report, list discontinued trials since last report.

Current Medication
☐ None (if none, explain in plan) ☐ Psychiatric ☐ Physical ☐ No Information
Medication Name  Dosage  Frequency  Target Dose  Compliance  Prescribing Physician

☐ Allergies  If yes, specify:

Current Diagnosis (check only one Primary Diagnosis)
Axis I  ☐ Pri  ☐ Sec  DSM Code:  Name:
Axis II ☐ Pri  ☐ Sec  DSM Code:  Name:
Axis III  General Medical Condition  ICD Code:  Name:

Axis IV  Psychosocial and Environmental Problems  Check all that apply:
☐ A. primary support group  ☐ E. housing  ☐ I. other psychosocial/environmental
☐ B. social environment  ☐ F. economics  ☐ J. inadequate information
☐ C. education  ☐ G. access to health care
☐ D. occupational  ☐ H. Interaction with legal system

Axis V  Current GAF:  Highest GAF (in past 12 months):

Plan & Recommendations
Describe specific monitoring parameters to be followed, anticipated schedule of drug increase or decrease, change or discontinuation.

Medication Monitoring Request:  ☐ Monthly  ☐ Every other week  ☐ Weekly  Total Sessions Requested

Signatures
The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan.
Check one:  ☐ Client accepted a copy of this plan  ☐ Client declined a copy of this plan

Client Signature  Date  Provider Signature and Licensure/Degree  Date

Confidential W&I Code 5328  Page 2 of 2  Revised 9-12

Attachment L - Sample Only – For actual form click here.
### 2013 CPT Codes, Rates, and Service Descriptions

**Psychiatrist Services**
(Outpatient, MHRC, SNF with MH Special Treatment Program)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Rate</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90792</td>
<td>$150.00</td>
<td>Initial or Updated Medication Evaluation</td>
</tr>
<tr>
<td>99213</td>
<td>$62.00</td>
<td>Medication Management, Established Patient, Typically 15 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$15.00</td>
<td>Case Management Service, 15-29 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$30.00</td>
<td>Case Management Service, 30-44 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$45.00</td>
<td>Case Management Service, 45-59 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$60.00</td>
<td>Case Management Service, 60+ minutes</td>
</tr>
</tbody>
</table>

* Only one Conference/Coordination of Care per month per client is allowed.

Attachment M
### 2013 CPT Codes, Rates, and Service Descriptions

#### Psychologist Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Rate</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>$83.00</td>
<td>Initial or Updated Diagnostic Assessment</td>
</tr>
<tr>
<td>90832</td>
<td>$38.00</td>
<td>Psychotherapy, 20-37 minutes, with Client and/or Family Member</td>
</tr>
<tr>
<td>90834</td>
<td>$55.00</td>
<td>Psychotherapy, 38-52 minutes, with Client and/or Family Member</td>
</tr>
<tr>
<td>90837</td>
<td>$72.00</td>
<td>Psychotherapy, 53+ minutes, with Client and/or Family Member</td>
</tr>
<tr>
<td>90837</td>
<td>$72.00</td>
<td>Psychotherapy, with Client and/or Family Member</td>
</tr>
<tr>
<td>with</td>
<td></td>
<td>Interactive Complexity Add-On Code (Language Interpreter)</td>
</tr>
<tr>
<td>90785</td>
<td>$15.00</td>
<td>Interactive Complexity Add-On Code (Language Interpreter)</td>
</tr>
<tr>
<td>90846</td>
<td>$85.00</td>
<td>Family Psychotherapy, without Client Present</td>
</tr>
<tr>
<td>90847</td>
<td>$85.00</td>
<td>Family Psychotherapy, Conjoint with Client Present</td>
</tr>
<tr>
<td>90853</td>
<td>$36.00</td>
<td>Group Psychotherapy (maximum 8 persons)</td>
</tr>
<tr>
<td>96101</td>
<td>$50.00</td>
<td>Test administration, includes scoring, interpretation, and report preparation, per 60 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$15.00</td>
<td>Case Management Service, 15-29 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$30.00</td>
<td>Case Management Service, 30-44 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$45.00</td>
<td>Case Management Service, 45-59 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$60.00</td>
<td>Case Management Service, 60+ minutes</td>
</tr>
</tbody>
</table>

* Only one Conference/Coordination of Care per month per client is allowed.*

**Attachment M**
# 2013 CPT Codes, Rates, and Service Descriptions

## Licensed Clinical Social Worker Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Rate</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>$79.00</td>
<td>Initial or Updated Diagnostic Assessment</td>
</tr>
<tr>
<td>90832</td>
<td>$35.00</td>
<td>Psychotherapy, 20-37 minutes, with Client and/or Family Member</td>
</tr>
<tr>
<td>90834</td>
<td>$50.00</td>
<td>Psychotherapy, 38-52 minutes, with Client and/or Family Member</td>
</tr>
<tr>
<td>90837</td>
<td>$65.00</td>
<td>Psychotherapy, 53+ minutes, with Client and/or Family Member</td>
</tr>
<tr>
<td>90837</td>
<td>$65.00</td>
<td>Psychotherapy, with Client and/or Family Member</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with Interactive Complexity Add-On Code (Language Interpreter)</td>
</tr>
<tr>
<td>90785</td>
<td>$15.00</td>
<td>Interactive Complexity Add-On Code (Language Interpreter)</td>
</tr>
<tr>
<td>90846</td>
<td>$77.00</td>
<td>Family Psychotherapy, without Client Present</td>
</tr>
<tr>
<td>90847</td>
<td>$77.00</td>
<td>Family Psychotherapy, Conjoint with Client Present</td>
</tr>
<tr>
<td>90853</td>
<td>$36.00</td>
<td>Group Psychotherapy (maximum 8 persons)</td>
</tr>
<tr>
<td>99499</td>
<td>$15.00</td>
<td>Case Management Service, 15-29 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$30.00</td>
<td>Case Management Service, 30-44 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$45.00</td>
<td>Case Management Service, 45-59 minutes</td>
</tr>
<tr>
<td>99499</td>
<td>$60.00</td>
<td>Case Management Service, 60+ minutes</td>
</tr>
</tbody>
</table>

* Only one Conference/Coordination of Care per month per client is allowed

---

**Attachment M**