MENTAL HEALTH CONTRACTED PROVIDER DOCUMENTATION MANUAL

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Quality Improvement - Outpatient

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Riverside University HEALTH SYSTEM Behavioral Health

INTRODUCTION

The 2023 Documentation Manual for Riverside University Health System - Behavioral Health (RUHS-BH) contracted providers has been revised to include changes in Medi-Cal documentation requirements due to the CalAIM initiative (California Advancing and Innovating Medi-Cal). This manual is intended for use by contracted mental health programs to provide guidance on Medi-Cal documentation standards.

Behavioral health documentation is a critical aspect of the provision of mental health services. Accurate, timely and complete documentation is essential to ensure that individuals receive appropriate and effective care, and it is also necessary for compliance with legal and regulatory requirements.

This manual is intended to serve as a teaching, training, and documentation resource for RUHS-BH contract provider mental health staff. Policies and procedures must also be followed, and in some instances a Riverside County or RUHS-BH department policy may be referenced within this manual to assist. Managers and supervisors are encouraged to use the documentation manual as a reference and resource to train staff. All staff providing clinical services should refer to the manual whenever they need an answer to a documentation question. In addition to referencing this manual, all contracted providers should complete trainings assigned for their staff role available on the RUHS-BH Provider Training Moodle website.

Inevitably, situations arise when staff will need clarification or further direction. In such cases, the program manager or supervisor should be consulted. Outpatient Quality Improvement staff will be available to address any further questions concerning documentation. If you have any questions regarding this manual, or need assistance with clinical documentation, please contact:

Outpatient Quality Improvement
951.955.7320 or email QITraining@ruhealth.org

RUHS-BH PMoodle Training:
http://pmoodle.rcmh.local/

ORGANIZATION AND SYMBOLS

This manual is organized into sections and clickable links to help with navigation. The following symbols and graphics are used to help highlight key information:

This symbol can be found throughout this document and provide answers to some frequently asked questions.

This symbol indicates that careful attention should be paid to the following information.

This symbol signifies a county or department policy. It is highly recommended to access and thoroughly read the complete policies.

ACCESSING RUHS-BH POLICIES AND PROCEDURES

To ensure a comprehensive understanding of the RUHS-BH policies referenced in this manual, it is recommended to access and read the complete policies. Copies of RUHS-BH policies can be obtained by contacting the program's contract liaison and/or QI. Providers are expected to follow Riverside County and RUHS-BH Department policies as well as adhere to their agency's policies. If an agency's policy is of higher standard than our department policy, RUHS-BH will hold the program to those standards. Contractor policies are reviewed during annual contract monitoring.

TERMINOLOGY

In this documentation manual, the terms "beneficiary", "member", "consumer", "client" and "patient" will be used interchangeably to represent an individual who is seeking or receiving mental health services. The terms "staff", "provider", and "practitioner" will be used interchangeably to represent and individual who is providing mental health services.

NAVIGATION

Each section of the **Table of Contents** contains navigation links that will link to the named section in the Documentation Manual. To navigate to a specific section page, click on the section name.

Table of Contents

SECTIONS OVERVIEW

This Documentation Manual is broken down into the following sections:

SECTION	TITLE	OVERVIEW
SECTION 1	**Access to Services**	Reviews No Wrong Door, access to specialty mental health services, pre-assessment services, Z codes and medical necessity.
SECTION 2	**Legal Forms & Other Required Forms**	Provides description of Informed Consent, Consent for Medication, Telehealth Consent, Authorization to Release, insurance verification, Informing Materials, NOABDs, and additional record keeping and communication considerations.
SECTION 3	**Scope of Practice**	Describes the difference between LPHA and Non-LPHA, scope of practice by profession and co-signature requirements.
SECTION 4	**Assessment & Diagnosis**	Discusses assessment, re-assessment and diagnosis.
SECTION 5	**Assessment & Treatment Tools**	Covers the Child Assessment Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35).
SECTION 6	**Problem List & Care Plans**	Provides information regarding the problem list and care plans.
SECTION 7	**Progress Notes**	Describes progress note requirements, note format, and documentation timelines.
SECTION 8	**Specialty Program Services & Populations**	Discusses full service partnerships, intensive care coordination, intensive home-based services, and Medicare consumers.

SECTION 9	**Direct vs. Indirect Services**	Provides definitions of direct and indirect services and documentation for each type of service.
SECTION 10	**Service Codes Definitions**	Provides service codes, definitions, and examples.
SECTION 11	**Transfers, Transitions & Discharges**	Describes transfers, integrated referrals, transition of care tool, and discharge summary.
SECTION 12	**Data & Outcome Measures**	Provides an overview of the importance of accurate documentation and the impact it has on consumer outcome data.
SECTION 13	**Specialized Contract Programs**	Provides information specific to TBS, STRTP, CSU/MHUC, CRT, ART, and MHRC contracts.
SECTION 14	**Appendices**	Provides additional resources and information.

SECTION 1: ACCESS TO SERVICES

No Wrong Door

Beneficiaries can initially access services through any entry point, without being turned away or referred to multiple agencies. Specifically, beneficiaries are able to contact either mental health delivery systems [i.e., the Mental Health Plan (MHP) or the Managed Care Plan (MCP)].

Mental Health Plans

MHPs are operated by county behavioral health departments. In Riverside County, the MHP is operated by RUHS-BH. Services are provided by county clinics and contract providers. MHPs manage what is referred to as Specialty Mental Health Services (SMHS). These are an array of services designed to meet the needs of individuals who have significant and/or complex care needs. The array includes highly intensive services and programs (such as Full Service Partnerships, Mobile Crisis Response Teams, etc.) and includes therapy, community-based services, wraparound, and intensive case management. MHPs serve vulnerable populations with moderate and severe impairments.

Managed Care Plans

MCPs provide physical healthcare services and behavioral health services. The MCPs are operated by either publicly-run or commercial entities such as Community Health Centers, IEHP or Molina. MCPs provide what are referred to as Non-Specialty Mental Health Services (NSMHS). These mental health services are for those with less significant or complex care needs, so they may require less frequent and less intense mental health services. Services may include individual and group therapy. NSMHS is a lower level of care than SMHS for those with mild or moderate impairments.

Once the beneficiary initiates services through either the MHP or the MCP, then the MHP/MCP must determine appropriate access to services for that beneficiary for their circumstances.

Access to Specialty Mental Health Services (SMHS)

Access to services refers to the delivery system best suited to serve a beneficiary, either the MCP or the MHP. MCPs and MHPs will utilize the Adult/Youth Screening Tools for beneficiaries not currently receiving mental health services to determine whether the beneficiary qualifies for SMHS through the MHP or non-SMHS through the MCP. Beneficiaries will not be re-screened after being referred to a different system.

Only RUHS-BH access points, such as CARES (Community Access, Referral, Evaluation, and Support) and outpatient clinics, are required to use the Screening Tools. Providers are not required to use the Screening Tools.

Access to Services Criteria

An included diagnosis is no longer required to determine access to SMHS. Youth (under the age of 21) and adults (over the age of 21) each have distinct criteria. Access criteria allow for those with a *suspected* diagnosis to begin services, and youth who are homeless, involved in child welfare, and/or the juvenile justice system automatically have access to SMHS.

OVERVIEW OF ACCESS CRITERIA FOR PERSONS	
AGE 21 YEARS & OLDER	**UNDER 21 YEARS OF AGE**
The person has significant impairment in social, occupational, or other important life activities *and/or* there is reasonable probability of significant deterioration in important area of life functioning.	The person is experiencing homelessness, significant trauma placing them at risk for a mental health condition, and/or is interacting with the child welfare or criminal justice system. **OR** The person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or need for SMHS even when there is no presence of impairment.
AND	
The significant impairments listed above are due to a mental health disorder from the most recent version of the Diagnostic Statistical Manual (DSM), either diagnosed or suspected but not yet diagnosed.	

Co-Occurring Treatment

Under CalAIM, the No Wrong Door policy aims to ensure that beneficiaries have access to the right care at the right time. Through No Wrong Door, clinically appropriate SMHS are covered and reimbursable even when the individual has a co-occurring substance use disorder. It's crucial to address the specific needs of individuals with co-occurring disorders, recognizing that treating one condition without addressing the other can result in incomplete recovery and an increased risk of relapse. Proper care coordination and referrals to specialized treatment are essential for providing comprehensive and effective care.

Timely Access to Services

Standards

The state requires timely access to services *from the date of the beneficiary's request for services*, not the date of the receipt of referral from RUHS-BH. These requirements aim to prioritize the prompt delivery of mental health services, enabling beneficiaries to access the care they need in a timely manner. To meet timely access standards for all providers in California, an appointment must be offered:

- **Within 10 business days** for initial non-urgent non-psychiatric SMHS.
- **Within 15 business days** for initial non-urgent psychiatric services.
- **Within 48 hours** without prior authorization or **96 hours** with prior authorization for urgent appointments. Urgent means a situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition.
- **Within 10 business days** of the prior appointment for follow-up non-psychiatric appointments (e.g., second appointment).

In addition, RUHS-BH also expects that following an inpatient hospital discharge, consumers be offered an appointment **within 7 calendar days.**

A Notice of Adverse Benefit Determination (NOABD) must be issued if unable to meet timely access requirements for initial appointments. More information on NOABDs is reviewed in Section 2 of this Documentation Manual.

For more information, refer to the following policy: RUHS - BH Policy #267 - Access to Services.

Data Collection

The CSI Assessment Contractor form has been used to collect timeliness data to assessment and treatment appointments and aligned with pre-CalAIM DHCS data reporting guidelines.

Pre-Assessment Services

If a beneficiary meets access criteria, staff can begin establishing rapport, identifying their needs and start providing clinically appropriate services prior to completing an

assessment. During the pre-assessment phase of a beneficiary's treatment, when a diagnosis has yet to be established, the use of Z codes is permissible to be used to claim for services.

Z Codes

Z codes are a set of codes used in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) to classify factors that impact health outcomes and are not due to a disease or injury. These codes are used to record a wide range of social determinants of health (SDOH), such as unemployment, homelessness, low income, lack of education, poverty, lack of housing, and food insecurity, to name a few. These SDOH are known as Z codes in the ICD-10-CM *(reference Appendix C: Z55-65 Social Determinants of Health Codes for the list)*.

Z codes in the range of Z55-65 are within scope for Licensed Practitioners of the Healing Arts (LPHAs) and Non-Licensed Practitioners of the Healing Arts (Non-LPHAs). Staff are required to identify and address SDOH in their service delivery. In cases where services are provided due to a suspected disorder that has not yet been diagnosed, LPHAs may use any clinically appropriate ICD-10 code, which may include Z codes. Z codes reflected on the problem list *(problem list will be reviewed in section 6)* help facilitate continuity of care by providing a comprehensive list of problems to quickly identify the consumer's care needs, including key health and

social issues.

Medical Necessity

Medical necessity ensures that all on-going Medi-Cal services provided are deemed necessary to treat a specific condition. This determination is typically based on medical evidence and standards of care and is important to ensure that beneficiaries receive appropriate care that is tailored to their individual needs. The definition for medical necessity differs for those aged 21 and older than for those under 21 years of age.

MEDICAL NECESSITY FOR SERVICES	
AGE 21 YEARS & OLDER	**UNDER 21 YEARS OF AGE**
Services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.	Services are necessary to correct or ameliorate a mental health illness or condition. These services need not be curative or restorative, and can be delivered to sustain, support, improve or make more tolerable a mental health condition.

SECTION 2: LEGAL FORMS AND OTHER REQUIRED FORMS

Informed Consent

To provide ethical and effective care, an informed consent must be obtained before beginning any treatment. Informed consent involves providing consumers with clear and concise information about the nature of the proposed treatment, its potential benefits and risks, and any available alternatives. The Consent to Treat form is a crucial component of informed consent and should be thoroughly reviewed with the consumer before they sign it. The Consent to Treat is valid for up to **three (3) years** from the date it was signed. A copy of the Consent to Treat should be offered to the consumer.

For more information, refer to the following policy: RUHS - BH Policy #239 - Confidentiality/Privacy Disclosure of Personal Information (PI), Personally Identifiable Information (PII) or Protected Health Information (PHI).

Consent to Treat for Minors

Consent to treat with minors happens in the following ways:

1. The Parent or Guardian signs the Consent to Treat.
2. A minute order authorizing mental health services is obtained if the minor is in placement with DPSS or Probation.
3. Assembly Bill 655 (enacted 10/7/23) allows minors, age 12 and older, to consent to receive mental health treatment or counseling on an outpatient basis or through residential shelter services. It is no longer necessary that the minor be mature enough to participate, be a danger to self or others, or to be the alleged victim of incest or child abuse.

4. A Caregiver Authorization Affidavit permitting a relative or other qualified individual to consent for treatment.

When a consumer turns 18 years of age during treatment, obtain an Authorization to Release Information form(s) for family members to remain involved in their treatment and a new Consent to Treat with the consumer's signature.

For more information, refer to the following policy: RUHS - BH Policy #294 Caregiver's Authorization to Consent for Minor's Medical Care.

Consent to Treat for Consumers Under Conservatorship

If a consumer is under conservatorship, the conservator must sign the Consent to Treat form including any other legal documents. Legal documents such as minute orders, guardianship, conservatorship, and other court documents should be obtained and maintained in the consumer's record.

Notice of Privacy Practices

The Notice of Privacy Practices (NPP) is a document that informs consumers about how their protected health information (PHI) will be used, disclosed, and protected by mental health professionals or facilities. This document is required by law under the Health Insurance Portability and Accountability Act (HIPAA) and outlines patients' rights regarding their PHI. Consumers are required to sign an acknowledgement that they have received the NPP before they can receive mental health services. Notice of Privacy Practices is valid for up to **three (3) years** from the date it was signed. A copy of the NPP should be offered to the consumer.

For more information, refer to the following policy: County of Riverside - California Board of Supervisors - Policy B-23 Health Information Privacy and Security.

Consent for Medication

Informed Medication Consent is to be completed for all prescribed psychotropic medications. Each consumer who will be receiving psychotropic medications for treatment of a mental disorder(s) must be given information about the medication by the prescriber. A medication consent can either be completed on a Medication Consent form or documented in a progress note. If the medication consent is documented in a progress note, it must indicate the consumer

received and understood the medication information provided and has given consent for the medication to be prescribed. Informed consents for psychotropic medications will be considered valid for up to **three (3) years** from the date signed.

For more information, refer to the following policy: RUHS - BH Policy #549 - Psychotropic Medication: Informed Consent for Psychotropic Medications.

Psychotropic Medication Consents for Dependents of the Juvenile Court System

State law requires that all psychiatric medication prescribed to Wards and Dependents of the Court who have been removed from the physical custody of their parents be first approved by Juvenile Court. Physicians must follow the legal procedures to be compliant with all mandates. As such an application must be completed and presented to the court, using the Application Regarding Psychotropic Medication (form JV220) and Prescribing Physician's Statement Attachment (form JV220 (A)). These forms must be completed in addition to the Consent for Medication because they do not include all the required elements of a medication consent, as prescribed by Title 9 CCR § 851.

For more information, refer to the following policy: RUHS - BH Policy #280 - Consent for Medication of Court Wards and Dependents Not Under Conservatorship.

Telehealth Consents

Telehealth services are a two-way transfer of medical data and information between a consumer and practitioner provided through interactive video, audio, or data communication in real time. Phone calls, e-mails, and faxes are not considered to be telehealth. A practitioner providing services through telehealth must be enrolled as a Medi-Cal provider. The Telemedicine/Telehealth Informed Consent is required prior to providing telemedicine/telehealth services. The Telemedicine/Telehealth Informed Consent does **NOT** replace the Consent to Treat and other required informed consent forms. Telehealth Informed Consent is valid for **one (1) year** from the date it was signed.

For more information, refer to the following policy: RUHS - BH Policy #262-Telemedicine & Telehealth Use.

The use of Skype or FaceTime is not HIPAA compliant and is not an acceptable means of providing Telehealth services.

Authorization to Release Information

The Authorization to Release Information (a.k.a. Release of Information or ROI) documents the consumer's permission to release their protected health information (PHI) to an outside entity or individual. The individual must be clearly identified when referenced in a progress note.

ROIs must be filled out completely to be valid. ROIs expire **one (1) year** from the date of authorization, but the consumer has the right to revoke the authorization at any time. ROIs require the wet signature of the consumer or authorized legal representative after the ROI has been filled out.

Changes to an ROI after the consumer has signed will require a new ROI with the consumer's updated signature and date.

For more information, refer to the following policy: RUHS - BH Policy #299 Authorization to Use/Disclose Individually Identifiable Health Information. For additional guidance on when to release information, reference the HIPAA, Confidentiality, and Sensitive Information Manual.

Insurance Verification

For insurance verification, providers need to:

- ✓ Obtain the consumer's insurance information
- ✓ Obtain consent for their insurance to be billed
- ✓ Request identification to ensure the consumer is the insured person presenting

Medi-Cal eligibility should be verified prior to rendering services and must be verified each month thereafter as status can change. Programs can verify eligibility on the Medi-Cal website.

For more information, refer to the following policy: RUHS - BH Policy #413 Notice of Financial Responsibility.

Informing Materials

State regulations require that programs provide specific information at the beginning of services. This bundle of information is called Informing Materials and includes the following:

- ✓ Beneficiary Handbook (available on the county website)
- ✓ Grievance and Appeals Brochure (available in each program's lobby)
- ✓ List of Providers (available on the county website)
- ✓ Advance Directives Brochure (provided to adult consumers at first face-to-face contact). Staff must document if there is an advance directive in place.

For more information, refer to the following policies: RUHS – BH Policy #290 MH Consumer Brochures and Posters & RUHS – BH Policy #213-0 Advance Medical Directives.

Notice of Adverse Benefit Determination (NOABD)

The Notice of Adverse Benefit Determination (NOABD) is a Medi-Cal requirement that notifies the consumer in writing of a program's "determination" in response to a request from, or on behalf of, the consumer.

An NOABD is required for consumers who are enrolled in Medi-Cal and should be completed in the following situations:

1. If the consumer was denied or given limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner *(REMINDER: Appointments must be offered **within 10 business days** for non-urgent non-psychiatric requests for SMHS services and **within 15 business days** for non-urgent psychiatric services);*
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a consumer's request to dispute financial liability.

Consumers must receive a written NOABD when a program takes any of the actions described above. The program must give consumers timely and adequate notice of an adverse benefit determination in writing.

Programs must mail the notice to the consumer within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least **10 days before** the date of action.
2. For denial of payment, at the time of any action denying the provider's claim; or,
3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, **within two business days** of the decision.

It is a federal requirement to use standardized templates when sending a written NOABD to the consumer. Standardized templates and instructions are available by request from RUHS-BH QI Outpatient. Providers are to fax a copy of any NOABDs they issue to QI at 951-955-7203.

Do **NOT** complete an NOABD when:

- ✓ The consumer does not have Medi-Cal.
- ✓ The consumer has met their treatment goals and is moving to another level of care.
- ✓ The consumer has decided to discontinue services.

For any instance where services are being terminated, denied, or reduced, and the consumer expresses disagreement with these actions, it is important to complete an NOABD. This process ensures that consumers enrolled in Medi-Cal receive proper notification and information about changes to their benefits and services. By completing the NOABD, we adhere to regulatory requirements and provide transparency and clarity to the consumer regarding any modifications in their treatment.

Additional Record Keeping and Communication Considerations

Clinical Records

The clinical record serves as a vital communication tool within the interdisciplinary team, enhancing the quality of information shared for consumer treatment. All documents within a consumer's record must be accurate and completed in a timely manner. RUHS-BH utilizes an electronic health record (EHR) referred to as "ELMR" (**EL**ectronic **M**anagement of **R**ecords). RUHS-BH has designed provider forms and templates based off ELMR which are compliant with the state's documentation standards. Contract providers are not required to use RUHS-BH forms. Providers can develop their own forms and templates, ensuring they align with the necessary documentation standards.

Contracted providers utilize a variety of EHRs and some have traditional paper chart systems. Regardless of an electronic or paper system in use, each agency must have policies and procedures in place for clinical record keeping.

For more information, refer to the following policy: RUHS - BH Policy #245 -- Clinical Recordkeeping.

All written materials for consumers must be easily understood, in a font size no smaller than 12 point, be available in alternative formats, and through the provision of auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of potential beneficiaries or beneficiaries with disabilities or limited English proficiency.

Signatures

It is important for providers to obtain valid signatures on documents that live in the clinical record. There are two methods providers can obtain valid signatures:

1. A wet signature (preferably in black ink for legibility and clarity when documents are copied/scanned)
2. A secured electronic signature, as through an EHR (for staff signature) and signature pad (for consumer signature).

Documents requiring a consumer signature may:

- Be completed with staff and signed by the consumer while in person prior to future telehealth services.
- Be printed out and mailed/faxed/scanned to the consumer for their signature, then stored with the consumer's chart upon return.

Documents **cannot** be validly signed through programs such as Adobe or Microsoft Word where a typed "signature" cannot be verified. Software such as DocuSign requires a Business Associate Agreement (BAA).

E-mails

Communication with consumers or with others involved in their treatment may include e-mail, although this indirect activity is not billable. E-mail communication must adhere to HIPAA standards. Follow your agency policy on sending e-mails which contain PHI (private health information) securely.

When pertinent information is included, a copy of e-mails should be kept in the consumer's chart.

E-mailing with consumers and/or with other departments is NOT a Medi-Cal billable activity regardless of the intent/content.

For more information, refer to the following policy: RUHS - BH Policy #238-E-Mail Protocol.

SECTION 3: SCOPE OF PRACTICE

LPHA vs. Non-LPHA

A **Licensed Practitioner of the Healing Arts (LPHA)** is a professional who has obtained a license to provide mental health services. This includes individuals such as Psychiatrists, Psychologists, Clinical Social Workers, Professional Clinical Counselors, Marriage and Family Therapists, Professional Student Interns, Nurse Practitioners, Physician Assistants and Registered Nurses who have completed the required education and training and passed licensing exams to practice in their respective fields. Also included are license-eligible practitioners who are registered with the Board of Behavioral Sciences (BBS) and working under the supervision of licensed clinicians.

A **Non-LPHA** refers to an individual who does not hold a license to provide mental health services. This can include individuals who provide supportive services such as Mental Health Rehabilitation Specialists and Non-Certified and Certified Peer Support Specialists, including Parent Partners and TAY Peer Support Specialists. Non-LPHA may have limitations on their scope of practice based on their own education, training, and experience. In general, Non-LPHAs are not able to provide clinical or diagnostic mental health services, such as diagnosing mental health conditions, providing psychotherapy, or prescribing medication. Therefore, Non-LPHAs must always stay within their scope of practice to ensure safe and effective care for consumers.

In general, mental health professionals should always refer consumers to other qualified professionals if their needs fall outside of their scope of practice.

Scope of Practice by Profession

Psychiatrist, Physician's Assistant	✓ Assessment ✓ Care/Treatment Plan ✓ Crisis Intervention ✓ Medication Support ✓ Medication Prescribing or Furnishing ✓ Medication Administration ✓ Medication Dispensing ✓ Problem List ✓ Psychotherapy ✓ Targeted Case Management	**Licensed or Waivered Psychologist (post-doctorate)**	✓ Assessment ✓ Care/Treatment Plan ✓ Crisis Intervention ✓ Intensive Care Coordination (ICC) ✓ Intensive Home-Based Services (IHBS) ✓ Problem List ✓ Psychological Testing ✓ Psychotherapy ✓ Skill Building ✓ Targeted Case Management
Licensed, Registered or Waivered Clinician: ACSW/LCSW, AMFT/LMFT, APCC/LPCC (Post MA/MS)	✓ Assessment ✓ Care/Treatment Plan ✓ Crisis Intervention ✓ Intensive Care Coordination (ICC) ✓ Intensive Home-Based Services (IHBS) ✓ Problem List ✓ Psychotherapy ✓ Skill Building ✓ Targeted Case Management	**Professional Student Intern NOT registered with BBS (Post BA/BS degree. Enrolled in MA, MS, or doctorate program.)**	✓ Assessment* ✓ Care/Treatment Plan* ✓ Crisis Intervention*, ++ ✓ Intensive Care Coordination (ICC)* ✓ Intensive Home-Based Services (IHBS)* ✓ Problem List* ✓ Psychological Testing+++ ✓ Psychotherapy* ✓ Skill Building* ✓ Targeted Case Management*
RN with Master's degree in MH Nursing or related field	✓ Assessment ✓ Care/Treatment Plan ✓ Crisis Intervention ✓ Medication Support ✓ Medication Administration ✓ Medication Dispensing+ ✓ Problem List ✓ Psychotherapy ✓ Skill Building ✓ Targeted Case Management	**Psychiatric Nurse Practitioner**	✓ Assessment ✓ Care/Treatment Plan ✓ Crisis Intervention ✓ Medication Support ✓ Medication Prescribing or Furnishing ✓ Medication Administration ✓ Medication Dispensing ✓ Problem List ✓ Psychotherapy ✓ Targeted Case Management

* Under the direct supervision of an LPHA/LMHP and within scope of practice
+ Training and certification requirement may apply
++ May require close supervision if issues of danger to self or others are present
+++ Typically limited to post-master's doctorate students

Registered Nurse	✓ Care/Consumer/Treatment Plan ✓ Crisis Intervention++ ✓ Medication Support ✓ Medication Administration ✓ Medication Dispensing+ ✓ Problem List ✓ Skill Building ✓ Targeted Case Management	**Licensed Vocational Nurse or Licensed Psychiatric Technician**	✓ Care/Consumer/Treatment Plan* ✓ Crisis Intervention++ ✓ Medication Support ✓ Medication Administration ✓ Problem List* ✓ Skill Building* ✓ Targeted Case Management
Mental Health Rehabilitation Specialist	✓ Care/Consumer/Treatment Plan* ✓ Crisis Intervention++ ✓ Intensive Care Coordination (ICC)* ✓ Intensive Home-Based Services (IHBS)* ✓ Problem List* ✓ Skill Building ✓ Targeted Case Management	**Peer Support Specialist, Non-Certified or Certified**	✓ Care/Consumer/Treatment Plan* ✓ Intensive Care Coordination (ICC)* ✓ Intensive Home-Based Services (IHBS)* ✓ Problem List* ✓ Skill Building * ✓ Peer Services* ✓ Targeted Case Management* ✓ Certified Peer Services+

* Under the direct supervision of an LPHA/LMHP
+ Training and certification requirement may apply
++ May require close supervision if issues of danger to self or others are present
+++ Typically limited to post-master's doctorate students

Co-Signature Requirements

Co-signatures for clinical documentation can help ensure that certain quality standards are met. Co-signatures can be an important part of training and supervision. A supervisor can use clinical documentation to teach staff about different types of interventions, help them to identify areas for improvement, and ensure that they are providing high-quality care to consumers.

RUHS-BH currently requires co-signatures for the following circumstances:

- Care Plan Progress Notes created by Non-LPHAs.
- Transition of Care Tool completed by staff other than a clinician.
- All documentation completed by Professional Student Interns.

If a provider agency's policy on co-signatures is of a higher standard, RUHS-BH will monitor to the agency's policy.

SECTION 4: ASSESSMENT & DIAGNOSIS

Assessments

The assessment is a vital tool for healthcare providers to gain a comprehensive understanding of a consumer's mental health status, needs, and circumstances. This understanding enables healthcare providers to offer the best possible care to the consumer. The assessment should be completed by an LPHA but can include information obtained by other mental health staff.

Only one assessment is needed in the consumer's chart whether completed by a clinician or prescriber. The assessment should be completed as expeditiously as possible, in accordance with each consumer's clinical needs and generally accepted standards of practice. RUHS-BH recommends that an assessment be completed within **30 days** of the episode entry date. If the assessment cannot be completed in one session, there must be a progress note documenting which portions were completed with a plan for continued assessment. It is essential to complete all areas of the assessment. In cases where certain information is unknown or not applicable, it should be clearly indicated in the respective section.

It is permissible to review an assessment from an inpatient or other facility to provide case management or pre-assessment services for up to 30 days or clinically appropriate until a new assessment reflecting the consumer's current mental, emotional, or behavioral health status is completed.

There are specific requirements to the assessment process that are based on age and type of service being sought:

- ✓ All mental health assessments for consumers of all ages must address the seven (7) domains described below.
- ✓ In addition to the mental health assessment, youth consumers still also require the Children and Adolescent Needs and Strengths (CANS-50) for youth ages 0-20 and the Pediatric Symptom Checklist (PSC-35) for youth ages 3-17.
- ✓ All assessments for substance use disorders for consumers of all ages should use the American Society of Addiction Medicine (ASAM) criteria when determining level of care.

Upon completion of an assessment, PSIs must obtain Clinical Supervisor's approval and co-signature. When entering the diagnosis in the county's EHR, enter the PSI's name as the "Diagnosing Practitioner". Clinical Supervisors of PSIs will not claim time to Medi-Cal for the assessment.

Assessment Domains

The assessment contains standardized domains to help understand the consumer's care needs. The following provides an overview of domain categories and essential components in each domain. The RUHS-BH assessment forms are designed to address all the domains. When conducting an assessment, it is important to consider the individual's developmental stage and their social environment, including cultural practices and values.

Domain 1: Presenting Problem/Chief Complaint - Presenting Problem(s) (Current and History), Mental Status Exam, Impairment(s) in Functioning

Domain 2: Trauma - Trauma Exposures, Trauma Reactions, Systems Involvement

Domain 3: Behavioral Health History - Behavioral Health History, Substance Use/Abuse, Previous Treatment Services

Domain 4: Medical History and Medications - Medical History, Medications, Developmental History, Co-occurring Conditions (other than Substance Use)

Domain 5: Psychosocial Factors - Family History, Social and Life Circumstances, Cultural Considerations

Domain 6: Strengths, Risks, and Protective Factors - Strengths and Protective Factors, Risk Factors and Behaviors, Safety Planning

Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination - Clinical Impression, Diagnostic Impression, Treatment Recommendation, Medical Necessity Determination/Level of Care/Access Criteria

Re-Assessments

RUHS-BH is recommending a re-assessment be completed every **3 years** to ensure the consumer's progress, or lack thereof, is formally recorded. A clinician or a psychiatrist may complete the re-assessment; one re-assessment is sufficient. The diagnosis form

must be updated with the re-assessment date, even if the diagnosis remains the same.

A re-assessment is **not necessary** when a consumer is reassigned from one staff to another, as the assessment belongs to the consumer, not the staff. Similarly, if a consumer transfers from one program to another within the MHP and the assessment remains valid, no re-assessment is required. Sharing assessments under the RUHS-BH umbrella for transfer or coordination of care does not require a Release of Information (ROI). This applies to various scenarios, such as sharing assessments between contracted providers, from County programs to contracted providers, and vice versa. If there are updates or additional information to be documented after the assessment was completed, this can be recorded in a progress note instead of conducting a new assessment.

Diagnosis

A diagnosis must be completed for any service to be claimed. If a service is provided prior to the assessment being completed, the first staff to see the consumer must enter a Z code. Non-LPHA staff can use Z codes Z55-65 during the first contact and when billable services are provided. LPHA staff may use any Z code when indicated or an ICD-10 code if able to determine a diagnosis prior to completion of the assessment.

Once the assessment is complete, the clinician or psychiatrist should enter the formal diagnosis that corresponds with the date when they **started** the assessment. This is necessary because if the dates don't match, ELMR will indicate "No Diagnosis," which could cause potential problems with reports and billing processing.

Due to the functionality of ELMR, the first Z code must be an admission diagnosis and match the date of the episode opening.

Following the initial assessment, the diagnosis may be updated at any time with the rationale included in the progress note dated the same date. Whenever a re-assessment is completed, the diagnosis must also be updated (or re-entered if remaining the same). If there is a difference of opinion regarding a diagnosis between a clinician and prescriber, both should consult and collaborate to determine the most accurate diagnosis.

The diagnosis must be updated every time a new assessment form is completed, even if the diagnosis remains the same. The date of the diagnosis must match the date of the assessment.

SECTION 5: ASSESSMENT & TREATMENT TOOLS

Child Assessment of Needs and Strengths (CANS) for Ages 0-20

The CANS is a tool mandated by the state for counties to assess for child and family actionable needs and useful strengths that can be used to develop treatment plans including level of care for services for all youth prior to their 21st birthday. Prior to completing the CANS, clinicians must be CANS-trained and certified. Certification is attained through an online training course provided by the Praed Foundation, the organization responsible for developing the tool.

The CANS must be completed within 30 days of admission, every 6 months, and at discharge. Time spent completing the CANS and entering the information into the software platform (Objective Arts) should be separated from the time spent completing the assessment. The CANS should still be completed even if medical necessity for services is not met. An administrative closure should then be made to close the consumer in Objective Arts.

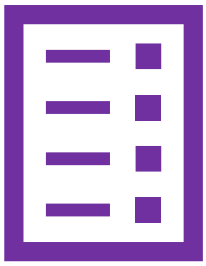
Pediatric Symptom Checklist (PSC-35) for Ages 3-17

The PSC-35, a tool also mandated by the state, assists counties in identifying cognitive, emotional, and behavioral issues. This early detection aids in the development of appropriate interventions, including the identification of the correct level of care for services. The PSC-35 must be completed within 30 days of admission, every 6 months, and at discharge. Time spent entering the information into Objective Arts should be separated from the time spent completing the assessment. The parent/caregiver completing the PSC-35 may be assisted by a Parent Partner, but the PSC-35 **MUST** be reviewed by the clinician.

SECTION 6: PROBLEM LIST & CARE PLANS

Problem List

With the implementation of CalAIM, client care plans have been replaced with a Problem List for most programs (see below for the list of programs still requiring a care plan). The Problem List is a comprehensive list of the consumer's symptoms, conditions, diagnoses, and/or risk factors created by staff involved in the consumer's care. It is intended to provide necessary information about the consumer's current challenges and tracks issues over time in services.

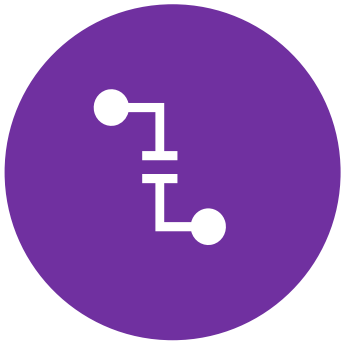


The Problem List should include the following:

- ✓ Problems and diagnoses identified by the provider. Diagnoses should include diagnosis-specific specifiers from the DSM and the ICD-10 codes.
- ✓ Problems identified by the consumer or other significant support person.
- ✓ The date the problem was identified, added or resolved and the name/title of the staff who identified, added or resolved the problem.

The Problem List does not need to be signed by the consumer. However, consumer involvement in identifying the issues they are seeking assistance with should be included in the progress note.

All treatment staff can create and edit the Problem List within their scope of practice. Staff are permitted to enter a medical problem along with the associated ICD-10 code, as the focus is not on the specific diagnosis code but rather on conveying the general nature of the consumer's medical condition. When adding a medical condition to the Problem List, indicate in a comments field the source of the information (e.g., reported by the consumer, family member, etc.)



It is important that the Problem List be updated regularly to reflect the consumer's current presentation. When not updated, continuity of care across providers may be poor, and the Problem List loses its intended purpose to be a quick reference document.

Types of problems that can be added to the Problem List include:

- ✓ Mental Health Diagnosis (ICD-10)
- ✓ Substance Abuse Diagnosis (ICD-10)
- ✓ Social Determinants of Health Needs (Z55-Z65), including DHCS Priority SDOH List

Care Plan/Treatment Plan

Due to regulations, a care plan is still required (in addition to the Problem List) for **TBS** (Therapeutic Behavioral Services) and in the settings of **STRTP** (Short-Term Residential Therapeutic Program), Social Rehabilitation Programs (**CRT, ART**), and **MHRC** (Mental Health Rehabilitation Centers).

More information on care plans for these specific contracted services can be found in Section 13.

Additionally, all **services** listed below must document care plans, which can be in the narrative of a progress note or elsewhere in the clinical record:

- **Case Management**
- **Peer Support Services**
- **Intensive Care Coordination (ICC)**

Although the care plan for these services is not required to be a standalone document, the provider must be able to produce the care plan during an audit.

Care plan progress notes can be completed with the service being provided (e.g., individual therapy, case management, etc.).

In RUHS-BH, care plans are referred to as Care Plan Progress Notes. It is recommended that Care Plan Progress Notes be clearly identified within the consumer record. RUHS-BH recommends the following suggested elements for Care Plan Progress Notes:

Identified need(s) and goal(s)

Activities to help meet need(s) and goal(s)

Person(s) who will assist

Quote from consumer what they will do to partner in meeting these needs (this will show consumer participation)

Care Plan Progress Notes created by a non-LPHA (e.g., MHRS, PSS, PP) will need a co-signature from an LPHA.

Consumer signatures are not required on Care Plan Progress Notes; however, consumer participation needs to be documented in the progress note. A quote from the consumer on their thoughts on how they can assist themselves in their recovery journey is highly recommended as a way of demonstrating their participation and agreement for the services being provided.

Care Plans no longer have annual due dates but should be reviewed regularly and updated as appropriate to convey the current service delivery plan. Reviews and updates should be documented in a progress note.

SECTION 7: PROGRESS NOTES

Progress Notes

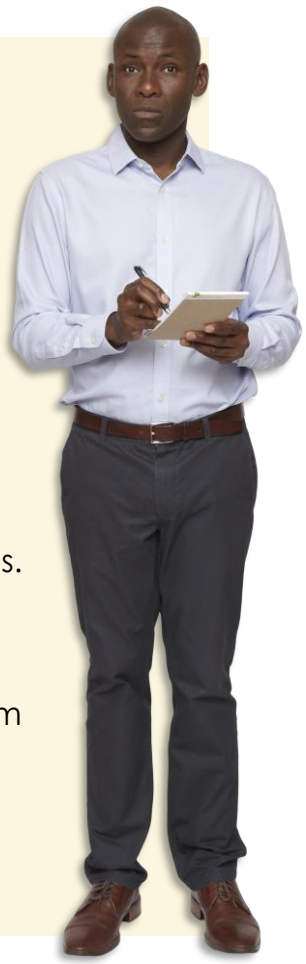
Progress notes serve multiple purposes. Progress notes are used to verify billed services for reimbursement from outside payers (such as Medi-Cal) and must contain basic information necessary to justify payment. In addition to facilitating reimbursement, progress notes serve as a valuable tool for monitoring clinical effectiveness and communicating the consumer's current condition, treatment, and response to care with other providers.

Documentation should be individualized, concise, and easily understandable by others, especially considering that consumers have a legal right to review their medical records. Staff should avoid using clinical or programmatic jargon and make sure that consumers can comprehend the treatment described in their medical record.

Progress Note Requirements

Progress notes MUST include the following:

- ✓ The date that the service was provided.
- ✓ The appropriate service code for the service provided.
- ✓ The duration of direct consumer care for the service.
- ✓ The location/place of service *(reference Appendix B for a list of location codes)*.
- ✓ A brief description of how the service addressed the consumer's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors) and the consumer's perception of their progress.
- ✓ A brief summary of next steps such as planned action steps by the provider or by the consumer, collaboration with the consumer, collaboration with other provider(s) and any update to the problem list as appropriate.
- ✓ A typed or legibly printed name and title, and signature of the service provider with date of signature.



Be clear that the service required a mental health professional. For example, clerical duties such as leaving messages or making photocopies do not require a mental health professional, so these activities are not billable.

When the service is provided by two or more staff, each staff's involvement must clearly document their intervention/connection to the mental health needs of the consumer.

Progress Note Format

The RUHS-BH recommended progress note format is **ACT**:

A	**Activity/Action:** interventions addressing the consumer's needs, symptom, condition, diagnosis and/or risk factors.
C	**Consumer Progress/Perspective:** progress toward resolving the consumer's needs.
T	**The Next Steps:** planned action steps by the provider and/or consumer.

Group Progress Notes

The same requirements for progress notes apply to group progress notes. However, it is important to consider to not template notes from week to week, but to individualize them by giving examples of the topic discussed and what different interventions and plans were, specific to each group session. The consumer's response to the group service must be captured in their progress note. A list of group participants must be documented by the provider.

If the group is facilitated by two facilitators using the same code, only one group note needs to be completed. This is true for two Certified Peers as the code each will use for the group service is the same. However, if one of the group facilitators is a Certified Peer, each staff will write

their own group note, use their appropriate service code, and include the name of the co-practitioner in the body of their note.

When two notes are required for a co-facilitated group session, it not necessary to document in the group note the co-practitioner's interventions. At minimum, each staff must record their unique contribution in the service provided on their own note.

Documentation Timelines

All progress notes should be completed by the staff who provided the service on the same day. If not on the same day, they should be completed no later than **3 business days** after providing the service. The date of the service is counted as day zero. Notes for crisis services, however, must be completed **within 24 hours**.

For example, if the service date was Tuesday 8/1/23 at 1pm, the progress note must be completed no later than Friday 8/4/23 *(within 3 business days)*. If the service was a crisis service, then the progress note must be completed no later than Wednesday 8/2/23 at 1pm *(within 24 hours)*.

Co-signatures should occur within 10 business days from the date the service was rendered per RUHS-BH standard.

Travel and Documentation Time

CalAIM Payment Reform, effective July 1, 2023, included changes to payment policies related to travel and documentation time for services provided to consumers. Under the new payment policies, the cost for travel and documentation are embedded into the new reimbursement rates. This means travel and documentation time will not be added to the total duration claimed for direct services. RUHS-BH strongly recommends both continue to be captured on the progress note as this will help providers collect data to use for future rate-setting consideration.

Documentation of No Shows/Cancellations

Documenting a missed appointment is essential for tracking a consumer's treatment progress. Consumer no shows, consumer cancellations, and staff cancellations should also be documented in the record.

SECTION 8: SPECIALTY PROGRAM SERVICES & POPULATIONS

Intensive Care Coordination (ICC)

Children and youth, ages 0 up to 21, who have intensive needs, are involved in multiple child-serving systems, or who may require cross-agency collaboration are eligible for Intensive Care Coordination (ICC). ICC is an intensive form of targeted case management, where an Intensive Care Coordinator is designated, and a Child and Family Team (CFT) is created. The CFT consists of the youth, family members, professionals, natural community supports, and other individuals identified by the youth and family who are invested in the youth and family's success.

Child and Family Team Meetings (CFTMs) are held to ensure the plans from all involved are integrated to comprehensively address the identified goals and objectives, and that the activities of all parties involved are coordinated. A CFTM should be held within 30 days of ICC determination by a mental health program. The CFTM schedule and location is guided by the family's needs and preferences; however, a CFTM must occur every **90 days.** When a consumer is involved with DPSS or Probation, the placing agency is the lead for convening the CFTM. When a youth is not involved with either the child welfare or probation systems, the contracted provider is responsible for convening the BH-driven CFTM.

A CFTM service plan is reviewed at the meeting and documents what is discussed for the entire team. This document is to be signed by participants and placed into the consumer's chart.

An Authorization to Release of Information must be signed for all parties participating in the CFTM. For dependents, the Social Service Practitioner should initiate the completion of the Children's Services Division CFTM Authorization for Use of Protected Health and Private Information (CSD 4130). Providers should request a copy and place within the consumer's chart.

Upon ICC determination by the mental health program, ICC codes may be used—even prior to a CFTM—to ensure appropriate services are being provided; however, a CFTM must follow within 30 days.

Intensive Home-Based Services (IHBS)

Youth who are receiving ICC may also receive Intensive Home-Based Services (IHBS). IHBS are individualized, strength-based interventions designed to improve mental health conditions that interfere with a youth's functioning. **The IHBS Authorization Process must be followed *prior* to the provision of IHBS**. The ICC Coordinator is responsible for completing the IHBS Authorization and obtaining the supervisor's signature. After completing IHBS Authorization, the form is placed in consumer's chart.

Full Service Partnerships

Full Service Partnership (FSP) programs offer comprehensive wellness and recovery-based support to consumers who have been previously unserved or underserved. These consumers have severe mental health conditions and often face homelessness or are at risk of becoming homeless. They may also have frequent hospitalizations or incarcerations related to their mental health disorder, or be at risk for hospitalization or becoming criminally justice-involved. RUHS-BH provides specialized FSP programs for children, Transition Age Youth (TAY) aged 16-25, adults aged 26-59, and older adults aged 60 and older, as well as Forensic FSPs. To help connect or transfer consumers to FSP services, contact your Contract Liaison. If the consumer is a dependent, email both your Contract Liaison and ACT.

Medicare Consumers

There are important restrictions for Medicare consumers:

- ✓ For services to be billable, the service must be a **face-to-face** service, and provided in a **Medicare certified facility**.
- ✓ Services are billable only when provided by a Psychiatrist, PA, NP, RN, Licensed Psychologist, or LCSW. LMFTs will not be able to bill for Medicare consumers until January 2024. All LMFTs will need to be enrolled in the Provider, Enrollment, Chain, and Ownership System (PECOS) in order to claim to Medicare.

SECTION 9: DIRECT VS. INDIRECT SERVICES

What Are Direct Services?

Direct services are **mental health services** that directly assist consumers with their mental health challenges. Mental health services are defined by mental health interventions that are intended to reduce a consumer's mental health impairment and improve or maintain the consumer's present level of functioning.

There are two types of direct services:

1. **Mental Health Services**: Are comprised of variety of treatment services provided to individuals, groups, and/or families that are intended to reduce a consumer's mental health impairment and improve or maintain the consumer's present level of functioning.
2. **Case Management Services**: Assist the consumer with access to services needed to reduce mental health impairments. This is done through coordination, referral, monitoring the consumer's progress, and monitoring the consumer's continued access to services. The consumer's need for assistance must be due to their mental health impairment, with specific issues documented in the consumer's Problem List.

Lockouts

Direct services are non-billable during specific lockout situations where Medi-Cal regulations **do not** permit reimbursement.

Examples:

- ✓ **Juvenile Hall -** For consumers in juvenile hall, services can only be billed after a placement order has been made by the court. A copy of the placement order must be in the chart. Without a placement order, services provided cannot be billed.
- ✓ **Adult Detention -** Services are not reimbursable while a consumer is residing in an institutional setting.
- ✓ **Institution for Mental Disease (IMD) –** Includes the following settings: psychiatric hospitals, psychiatric health facilities (PHF), skilled nursing facilities with special treatment programs (SNF-STP), mental health rehabilitation centers (MHRC), or state hospitals.

For these settings only, case management services are reimbursable on the day of admission PRIOR to admission into the IMD facility and for up to 30 days prior to the day of discharge to coordinate placement when a consumer will be transferred to an alternate placement outside the home.

Direct Services Documentation

Direct mental health services, whether billable or non-billable, are documented in progress notes. Select the service code that best meets the definition for the service provided. More information on service codes will be reviewed in Section 10 of this manual.

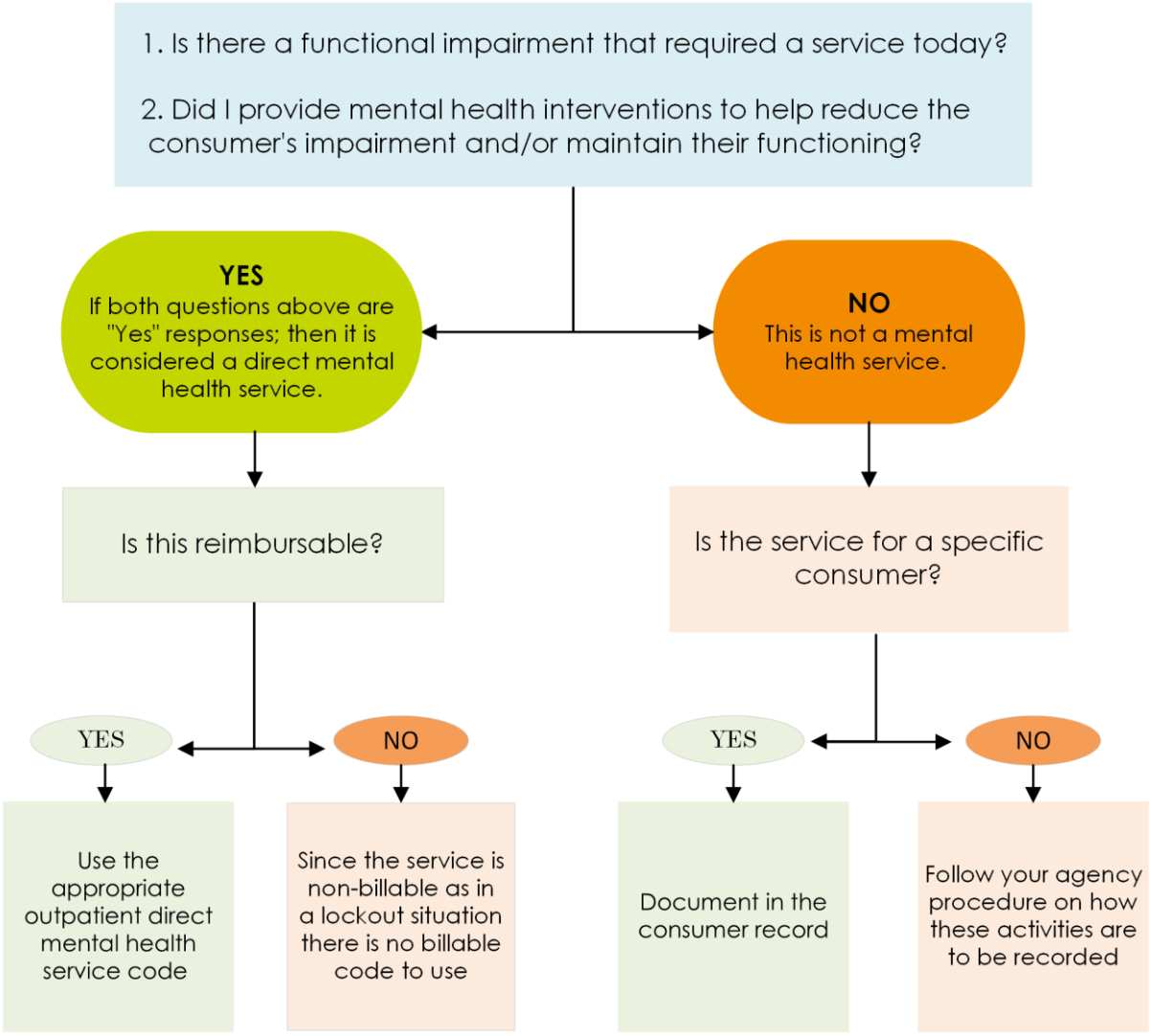
What are Indirect Services?

Indirect services are non-billable activities that benefit the consumer's overall wellbeing, and may **indirectly** assist with the consumer's mental health challenges, but the activities are not a Medi-Cal reimbursable service for one or more of the following reasons:

1. The service provided is a non-reimbursable service and was solely for one of the following:
    a. Academic educational service
    b. Vocational service that has work or work training as its actual purpose.
    c. Recreation
    d. Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.
    e. Transportation
    f. Clerical
    g. Payee-related
2. Could be provided by anyone in the community (does not require 'mental health expertise).
3. Are provided more for the benefit of others in the consumer's life.
4. The activity is provided for the benefit of multiple consumers, not for the individual.
5. Are more of a physical health service than a mental health service.
6. Consumer is capable, but service is done *for* the consumer, not *with* the consumer.
7. Benefit the staff's learning/awareness, not the consumer's.
8. Are more of an administrative or clerical type of activity.

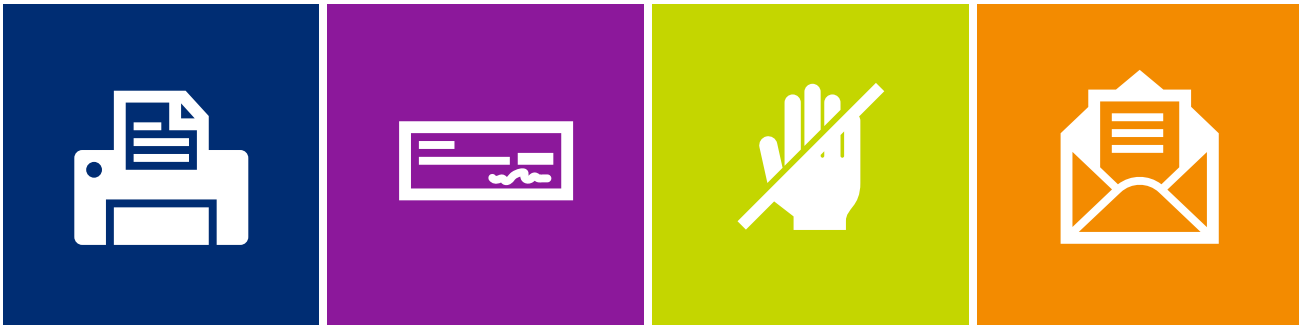
Mental Health Services Decision Tree

To determine whether a service is considered a direct mental health service or an indirect non-billable service, first ask these two questions:



Time spent only transporting a consumer from one place to another is not billable. However, if the time spent transporting a consumer includes interventions that meet the definition for another billable service, then the time can be billed. In general, for the service to be billable, the service must directly benefit the consumer's mental health needs.

Indirect Service Documentation



Indirect service activities do not have service codes and will not be billable. Indirect services can be recorded in the consumer chart when necessary to communicate with other treatment providers, for record keeping or for data collection.

Documentation Format for Indirect Services

Indirect service documentation should be brief and does not need to follow the ACT format used for direct services. Examples Include:

- Attempted to call consumer on 7/5/23, 7/6/23, and 7/7/23. No answer. Clinician left message requesting call back.
- Sent 10-day notice letter to consumer.
- Sent NOABD letter to consumer.
- Faxed housing application to Housing Authority for consumer.
- Provided consumer with personal needs check.

SECTION 10: SERVICE CODES DEFINITIONS

This section will provide descriptions of RUHS-BH mental health services codes, scope of practice for each service code, and specific examples on when to use the service code described in outpatient mental health settings.

Specialized contracted programs such as Therapeutic Behavioral Services (TBS), Crisis Stabilization Unit (CSU), Mental Health Urgent Care (MHUC), Crisis Residential Treatment (CRT), and Adult Residential Treatment (ART) have distinct service codes to be utilized. Please reference in Section 13: Specialized Contract Programs for more information.

To promote compliance with Medi-Cal requirements and RUHS-BH billing procedures, it is important to follow the guidance below. This will ensure that claims get processed correctly and the quality of care delivered is accurately documented.

- Ensure there is no fraud, waste, or abuse by documenting accurately and in a timely manner.
- Select the service code that best meets the definition for the service provided.
- Refrain from documenting more than one service type within a single progress note, which can only have one service code. When a note combines various services, it becomes challenging to determine the accuracy of the associated service code, which could potentially result in a recoupment for incorrect code. If, however, the staff briefly provides a different type of service, such as providing resources or a quick follow-up about a previously given resource, this practice is considered acceptable. For instance, if a clinician conducts a therapy session and reserves a small timeframe to address the status of prior resources, it is acceptable to write this in one progress note coded for individual therapy.
- Whenever a duration is specified for a service code, adhere to the minimum/maximum duration listed for the code.
    - Service codes with specified durations do not include travel and documentation time.
    - Use the G2212 add-on code only when exceeding maximum durations for service codes that require the add-on code: 90791CA, 90791KTACA, 90837CA, 90847CA, 99205CA, 99215CA.
    - If under the minimum duration, consider if the service meets the definition for the code or if another service code can be used (e.g., 360, 520). If no other

code can be used, it is acceptable to use the code when the duration is less than the minimum duration specified.

- Whenever possible, use one progress note to document the same type of services provided on the same day, for the same consumer, with the same service code, by the same staff, in order to avoid duplicate claim errors.
- Review current/revised PMoodle trainings/resources, FAQs, and department updates. Consult with your supervisor and/or QI when unsure of which service codes to use.

10.1 ASSESSMENT SERVICES

Assessment

Description

SERVICE CODE
90791CA* (15 minutes)
***Note:** For 90791CA over 15 minutes, staff will use 'add-on' code G2212 for the additional time.*

A service activity designed to evaluate the current status of a consumer's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the consumer's past and present condition, medical and psychiatric treatment history; analysis of relevant cultural issues, psychosocial history leading to a diagnosis; and may involve utilizing various testing methods.

SCOPE OF PRACTICE: LPHA

Additional Information:

- ✓ An assessment may take more than one session to complete. If this occurs, there must be a separate progress note for each additional contact with the consumer to complete the information. In the note, indicate that the service is for the purpose of continuing and/or completing the assessment.
- ✓ The assessment should document the consumer's strengths, psychosocial history, and cultural factors that can be utilized to help understand the consumer's life experiences and what can be built upon to assist in successful outcomes.

There is no need to include in the assessment progress note that forms such as consents and ROIs were completed since that is evident by viewing the consumer's chart.

Examples:

- Reviewing information as part of the assessment that day.

- A second assessment on a Katie A consumer after the 90791KTACA (or as it was previously known, 90791MHST) code has already been used by the same or a different clinician.
- Clinical re-assessments on all consumers.

10.2 PSYCHOLOGICAL TESTING SERVICES

SERVICE CODES	
PSYCHOLOGICAL TESTING	**TEST ADMINISTRATION AND SCORING**
96130* (1-60 minutes) Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the consumer, family member(s) or caregiver(s).	**96136* (1-30 minutes)** Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method.
***Note: Over 60 minutes ELMR will generate the 'add-on' code 96131 for additional time.**	***Note: Over 30 minutes ELMR will generate the 'add-on' code 96137 for additional time.**

SCOPE OF PRACTICE: Psychiatrist, Psychologist/Licensed/Waivered/Registered Psychologist

10.3 THERAPY SERVICES

Individual Therapy

Description

A service activity that serves as a therapeutic intervention aimed at symptom reduction as a means to reduce functional impairments of the consumer. This is achieved through assisting the consumer in gaining insight into their condition, moods, feelings, thoughts and behaviors during the therapy sessions.

SERVICE CODES
90832CA (16-37 minutes)
90834CA (38-52 minutes)
90837CA* (53-60 minutes)
***Note:** Over 60 minutes staff will use 'add-on' code G2212 for the additional time.*

SCOPE OF PRACTICE: LPHA

Additional Information:

If additional staff are involved in providing an individual service, the additional staff must write their own progress note following the documentation requirements for billing a service (including that staff's specific actions during the session and justification for having additional staff participate in the session).

Client and Family Therapy

Description

SERVICE CODE
90847CA* (26-50 minutes)
***Note:** Over 50 minutes staff will use 'add-on' code G2212 for the additional time.*

Contact with one or more family members (with the consumer present) providing consultation and training to assist in service planning and delivery, promoting better utilization of services, assisting members with understanding the consumer's mental illness, and helping the family member(s) understand the services being provided.

SCOPE OF PRACTICE: LPHA

Additional Information:

If providing family therapy with two open consumers (e.g., siblings), split the total time of the service between the two consumers and enter a progress note in each consumer's chart.

10.4 GROUP SERVICES

Group Mental Health Services

Description

SERVICE CODE
363

Group services refer to counseling sessions that are provided to a group of individuals at the same time, who are experiencing similar mental health issues or concerns. These group sessions involve activities such as discussion, education, skills building, and support. Group services can take a variety of forms, including support groups, psychoeducational groups, and therapy groups.

SCOPE OF PRACTICE: All Staff except Certified Peer Support Specialists

Additional Information:

- ✓ Groups should be limited to 12 or fewer members in order to maintain the integrity of the service being provided. Groups larger than 12 should be

discussed with the program supervisor to separate the service into smaller groups that are more individualized for the needs of the consumer.

- ✓ Groups with consistently two to three members in attendance should be re-evaluated to determine if it is viable to continue.
- ✓ Separate documentation must exist for each consumer participating in the group service.
- ✓ No more than two staff can bill for any group session.
- ✓ Group should support the number of facilitators. (A group with two consumers may not justify having two facilitators.)
- ✓ If only one note is written for each consumer, EACH staff's interventions during the group MUST be clearly documented.
- ✓ If only one co-staff is a Certified Peer, each staff must write their own progress note with the appropriate service code that includes the actions taken by that staff in the group.
- ✓ Group services may include development of consumer's individually designed Wellness and Recovery Action Plans. Group services may be provided to a biological parent, step-parent, foster parent, or potential adoptive parent in a consumer's life with the intent of improving or maintaining the mental health status of the consumer.

Examples:

- Topics may focus on assistance in restoring or maintaining consumer's functioning skills, daily living skills, social skills, grooming and personal hygiene skills, meal preparation skills, medication compliance, and support resources.
- Positive parenting skills to help build relationships so that conflicts can be addressed and proper interventions can be provided.
- Helping to promote children's development or help manage consumer's behaviors.
- Increasing knowledge of proper self-care for parents to help better support the child(ren)'s needs.

If there are multiple parents or support persons in a group, the number of consumers claimed for the service may not match the number of attendees. Parent group services should be claimed based on registered consumers who benefit, not the number of people present.

10.5 CRISIS INTERVENTION SERVICES

Crisis Intervention

Description

SERVICE CODE
90839CA (minimum 15 minutes)

Crisis intervention is a quick emergency response service enabling an individual to cope with a mental health crisis, while maintaining his/her status as a functioning community member to the greatest extent possible. A crisis is an unplanned event that results in the individual's need for immediate service intervention. A crisis service lasts less than 24 hours and requires more timely response than a scheduled visit. Service activities may include but are not limited to assessment, care coordination, consultation and therapy.

SCOPE OF PRACTICE: All Staff within Scope except Certified and Non-Certified Peer Support Specialists

Additional Information:

- ✓ When intervening with consumers experiencing distress due to significant factors occurring in their lives (e.g., unable to pay rent, death of a loved one), consider if the intervention is truly a mental health crisis where intervention is necessary to divert imminent hospitalization. If the consumer is just "highly upset," consider using alternative service codes.
- ✓ Crisis that lasts less than 15 minutes is unlikely a true mental health crisis. Consider using another code that may better fit the service provided such as 360, 520 or an individual therapy code.
- ✓ Can be used by LPHA who provide crisis interventions for consumers at risk of harm, regardless of if it results in a 5150 hold.
- ✓ Staff should be 5150-certified to complete the placement application.

10.6 MENTAL HEALTH SERVICES

Mental Health Services

Description

SERVICE CODE
360

This category is for all mental health services that do not fall into any of the other categories defined above. They involve support in restoring or maintaining skills such as functioning, daily living, social interactions, grooming,

personal hygiene, meal preparation, and medication adherence. Services may include counseling for the individual or their family, training in leisure activities to enhance their goals, and creating plans or monitoring progress for individuals in care.

SCOPE OF PRACTICE: All Staff except Certified Peer Support Specialists

Additional Information:

- ✓ It must be clear that the service required a staff member with mental health expertise and/or experience.
- ✓ The documentation should make it clear that the service was intended to assist the consumer with addressing their mental health needs.

Examples:

- Reviewing anger management techniques.
- Practicing relaxation techniques.
- Coaching.
- Educating the consumer, family, or significant persons on consumer's mental health symptoms.
- Providing parenting skills such as limit setting that are intended to manage consumer's behaviors (which is part of the focus of treatment).
- Increasing knowledge of proper self-care for parents to help better support the child(ren)'s needs.
- Increasing the consumer's knowledge of the cycle of domestic violence.
- Collaborating with the consumer to develop a Care Plan Progress Note.

10.7 CASE MANAGEMENT SERVICES

Case Management

Description

SERVICE CODE
520

Services that assist a consumer to access needed mental, medical, educational, social, vocational, rehabilitative, or other community resources. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure the consumer has access to service and the service delivery system; and monitoring of the consumer's progress. Providing such service is appropriate, if the consumer's mental health symptoms make it difficult

for the consumer to access resources on their own and staff assisting the consumer gain access to a resource that would help address their mental health needs.

SCOPE OF PRACTICE: All Staff except Certified Peer Support Specialists

Additional Information:

- ✓ Linkage can be to an entity outside or inside of Behavioral Health (e.g., DPSS, Social Security Administration, HHOPE Housing, a Benefit Specialist, program closer to their home).
- ✓ The linkage should be for the purpose of assisting the consumer with their mental health needs.
- ✓ Monitoring how a consumer is doing is part of case management but should involve more than just a 'check-in'.
- ✓ When reviewing cases during treatment team meetings, only staff that contributed may claim for their time. Each staff should write their own progress note and document what they contributed that benefits the consumer and the time spent providing that contribution.
- ✓ Clinical Consultation: Time spent formally or informally consulting with other staff can be billed to Medi-Cal when the activity directly benefits the consumer (not the staff). The progress note should document the outcome of the consultation. Consultation cannot be billed if only used for updating other staff.
- ✓ Clinical supervision can only be billed to Medi-Cal when the activity directly benefits the consumer and not used solely for staff training/knowledge. Medi-Cal billing should be limited to the portion of the meeting that directly relates to the consumer (not the entire supervision time). The progress note should document the time involved for the mental health service and what the staff actually did (e.g., consulting and monitoring a consumer's progress, developed new plan, etc.).

Examples:

- Exchange of information with entities outside of the agency (e.g., county programs and other service providers) in support of consumer's mental health needs.
- Making a referral to additional community services that are necessary due to the consumer's mental health impairment(s) and following up.
- If the consumer's mental health symptoms make it difficult for them to fill out forms independently and completing those forms would help them gain access to a resource that would help address their mental health needs then this would be appropriate.

- When done as part of "arranging placement" (e.g., telephoning group homes, board and care facilities). *Note: The consumer does not need to be present.*
- When a consumer is in an inpatient hospital, inpatient psychiatric health facility, or psychiatric nursing facility and the service is provided to coordinate alternate placement, outside of home, upon discharge during the last 30 days. ***Note: "Placement" is not returning the consumer to their home.***
- Completing housing forms that require a clinical assessment of the current appropriateness for the program.
- Communication with a teacher to receive an update of the consumer's level of functioning in school.
- Providing community resources including shelter placement, emergency food, and temporary restraining orders.

Family Case Management

Description

The same definition as above but includes contact with a family member.

SCOPE OF PRACTICE: All Staff except Certified Peer Support Specialists

SERVICE CODE
590

Additional Information:

- ✓ Family Case Management is only billable when the service has a direct benefit to the consumer. For example, if working with a parent, it needs to be clear how that benefits the consumer (the child's) treatment needs.
- ✓ If providing services with two open consumers (e.g., siblings), split the total time of the service between the two consumers and enter a progress note in each consumer's chart.

Examples:

- When involving a family member in linking the consumer with services.
- Coordinating with the parent to connect the consumer with TBS services.
- Case management with the consumer's family while the consumer is in a Crisis Stabilization Unit (CSU).

10.8 CERTIFIED PEER SERVICES

Therapeutic Activity

Description

SERVICE CODE
621

These services are structured non-clinical activities provided by a Certified Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values. These services also include assisting a consumer with the maintenance of community living skills to support the consumer's treatment to attain and maintain recovery within their community.

SCOPE OF PRACTICE: Certified Peer Support Specialists

Examples:

- Supporting a family member of a consumer to talk about how the consumer is doing, providing resources.
- Providing reflective listening one-on-one, discussing family relationships, practicing conversation skills, building upon wellness tools, assisting a family member to understand consumer's challenges.
- Providing support with linkage to other services.
- Resource navigation and collaboration with the consumer and others providing care or support to the consumer, family members, or significant support persons.

Engagement

Description

SERVICE CODE
622

Engagement services are Certified Peer Support Specialist-led activities and coaching to encourage and support consumers to participate in behavioral health treatment.

SCOPE OF PRACTICE: Certified Peer Support Specialists

Examples:

- Engagement may include supporting consumers in their transitions between levels of care/programs and supporting consumers in developing their own recovery goals and processes.

- Encouraging the individual and/or their family member to participate in behavioral health services.

Educational Group

Description

SERVICE CODES
623/623C*
***Note:** When the co-staff is any other staff other than a Certified Peer.*

Educational groups provide a supportive environment in which consumers and their families learn coping mechanisms and problem-solving skills to help the consumer achieve desired outcomes. These groups should promote skill building for the consumer in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

SCOPE OF PRACTICE: Certified Peer Support Specialists

Additional Information:

When co-leading a group with a Non-Certified Peer or other staff classification, separate progress notes and service codes are required by both staff.

10.9 PATHWAYS TO WELLNESS (KATIE A)

Assessment

SERVICE CODES	
OPTION 1	**OPTION 2**
90791KTACA* (can only be used once) ▶ Assessments completed by ACT ▶ Assessments completed by programs on Pathways to Wellness referrals by ACT following the CSD 4010 (previously the MHST), when ACT has determined they qualify for system of care ▶ Assessments completed by programs on Pathways to Wellness referrals by ACT following the CSD 4010, without ACT having made a determination on qualification for system of care	**90791CA*** Any subsequent assessment session(s) or assessments completed with a dependent **<u>after the KTACA assessment code has been used</u>**
***Note:** For assessments over 15 minutes, staff will use 'add-on' code G2212 for the additional time.*	***Note:** For assessments over 15 minutes, staff will use 'add-on' code G2212 for the additional time.*

SCOPE OF PRACTICE: LPHA (except PSI)

Intensive Care Coordination (ICC)

Description

Targeted Case Management with others on the CFT involving coordinating or planning for a CFTM, evaluating needs and strengths, reviewing information provided by family/other sources, evaluating effectiveness of interventions, coordinating services and resources, ensuring services equip the parent/caregiver to meet the child's needs, ensuring mental health services are in alignment with the service plan, and developing a transition plan including community resources/supports.

SCOPE OF PRACTICE: All Staff

SERVICE CODES			
ALL STAFF EXCEPT CERTIFIED PEERS		**CERTIFIED PEER SPECIALISTS ONLY**	
OPTION 1	**OPTION 2**	**OPTION 1**	**OPTION 2**
520ICC Does not include active participation from the family*.	**590ICC** Must include the family*.	**621ICC** Can include care coordination activities with or without family*.	**622ICC** Engagement activities with or without family*.
***NOTE:** Family can include resource parent(s)*			

Additional Information:

Must include what service is being evaluated/monitored/coordinated and how it relates to the CFTM service plan.

Examples:

- Coordinating services with the family (590ICC) or without the family (520ICC).
- Developing/planning goals, interventions, and strategies with members of the CFT.
- Attending a meeting of the CFT without the child present.
- Attending a meeting of the CFT for a probation-involved youth without the Probation Officer present.
- Attending a meeting of the CFT for a dependent without the Social Services Practitioner present.
- Attending an IEP for a consumer and their family is present, and consumer's behavior addressed in the IEP addresses a goal on consumer's CFT plan.

- Treatment team meetings for youth that are determined eligible for ICC.
- Evaluating, monitoring or coordinating services with others on consumer's treatment team, such as other mental health program staff working with consumer (provided it is not an internal agency check-in) but rather includes movement consumer's CFT plan.
- Coaching and support to engage a consumer who is child/youth receiving Intensive Care Coordination into services (622ICC).
- Advocacy/resources to child/youth receiving Intensive Care Coordination (621ICC).
- Providing resources for family of child/youth receiving Intensive Care Coordination; attendance at CFTMs (621ICC).

Intensive Home-Based Services (IHBS)

Description

Services provided are individualized and focused on utilizing the strengths of the consumer to address behaviors or symptoms that hinder a youth's functioning. The interventions aim to assist the youth in developing skills essential for successful functioning in the home and within the community, while also enhancing the family's capacity to support the youth.

SERVICE CODES
360IHBS
621IHBS*
***NOTE:** Certified Peer Specialists only.*

SCOPE OF PRACTICE: All Staff, typically MHRS and Peer Staff

Additional Information:

- ✓ The determination of the necessity of IHBS is made by the CFT and documented in the CFTM service plan.
- ✓ Must be provided in any setting the child is naturally located (i.e., home, school, day care center, community setting).

IHBS cannot be provided in a hospital, day rehab/day treatment, or office setting.

Examples:

- Skill building with the consumer to increase functioning in the home and community, or with the family to support the consumer's functioning
- Skill building with the consumer to improve self-care/self-regulation in the field.

- Skill building with the parent to improve parental behavior(s) with the consumer (which will in turn reduce consumer's behaviors) in the home.
- Developing replacement behaviors with the consumer at school.
- Modeling and reinforcing behaviors in the community.
- Coaching the consumer in the field.
- Improvement of self-management including self-administration of prescribed medication in the home.
- Certified PP providing Intensive Home-Based Service skill-building with parent to set limits with child receiving services (621IHBS).
- Certified PSS documenting advocacy, resources, skill building and CTFM participation (621IHBS).

Intensive Care Coordination Review (ICCR)

Description

Activities of attending a Child and Family Team Meeting (CFTM) for a youth receiving ICC.

SCOPE OF PRACTICE: All Staff except Certified Peer Support Specialists

SERVICE CODE
530ICCR

Additional Information:

- ✓ Must include documentation of changes made to the service plan.
- ✓ Can occur frequently, but must occur a minimum of every 90 days.
- ✓ Child must be present.
- ✓ Should always include family involvement. Must document if the family was not involved and why.
- ✓ For probation youth, the Probation Officer must be present.
- ✓ For dependent youth, the Social Service Practitioner must be present.

Without the child (or Probation Officer and/or Social Service Practitioner when applicable) present, it can be Intensive Care Coordination, but it is not technically a CFTM.

10.10 PSYCHIATRIC SERVICES

General Information:

Physician/other qualified health care professional time claimed includes the following activities, when performed:

- ✓ Preparing to see the consumer (e.g., review lab results, medical records)
- ✓ Obtaining and/or reviewing separately obtained history
- ✓ Performing a medically appropriate examination and/or evaluation
- ✓ Counseling and educating the consumer/family/caregiver
- ✓ Prescribing medications, ordering lab tests or diagnostic procedures
- ✓ Referring and communicating with other health care professionals
- ✓ Documenting clinical information in the electronic or other health record
- ✓ Independently interpreting results and communicating results to the consumer/family/caregiver
- ✓ Care coordination

Billing for chart review is permissible, but it is crucial to note that a service must be provided to the consumer for it to be billable. If the consumer does not attend the scheduled appointment, then chart review cannot be claimed for billing purposes.

A consumer cannot be billed more than a maximum of 240 minutes (4 hours) per day of medication services by all providers.

Psychiatric Assessment with E&M

Description

The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the consumer. Face-to-face services provided by a person licensed to prescribe, dispense, or administer medication(s) necessary to maintain individual psychiatric stability in the treatment process.

SCOPE OF PRACTICE: Psychiatrist, Physician Assistant, Nurse Practitioner

NEW CONSUMER	SERVICE CODES
This service is billable by any MHP prescriber. Office or other outpatient visit for the evaluation and management of a new consumer which requires **three** key components: 1. A problem focused history 2. A problem focused examination 3. Medical decision making **-AND-** Consumer has **not** received any professional services from the physician or another physician of the same specialty who belongs to the same practice.	**99202CA (15-29 Minutes)** **99203CA (30-44 Minutes)** **99204CA (45-59 Minutes)** **99205CA* (60-74 Minutes)** ***Note:** Over 74 minutes staff will use 'add on' code G2212 for additional time.*

ESTABLISHED CONSUMER	SERVICE CODES
Office or other outpatient visit for the evaluation and management of an established consumer that requires at least **two of three** key components: 1. A problem focused history 2. A problem focused examination 3. Medical decision making **-AND-** Consumer has received professional services from **any** MHP prescriber.	**99212CA (10-19 Minutes)** **99213CA (20-29 Minutes)** **99214CA (30-39 Minutes)** **99215CA* (40-54 Minutes)** ***Note:** Over 54 minutes staff will use 'add on' code G2212 for additional time.*

10.11 MEDICATION SERVICES (PRESCRIBERS)

Medication Services

Description

Pharmacologic management, including prescription use, and review of medication with no more than minimal psychotherapy. Evaluation of the need for medication prescribing, the clinical effectiveness and side effects, obtaining informed consent, medication education (including discussing risks, benefits, and alternatives, collateral involvement), treatment planning.

SERVICE CODES
99212MD (10-19 Minutes)
99213MD (20-29 Minutes)
99214MD (30-39 Minutes)
99215MD* (40 and above)
***Note:** No add on code needed.*

SCOPE OF PRACTICE: Psychiatrist, Physician Assistant, Nurse Practitioner

Additional Information:

These services shall include documentation of the clinical justification for use of the medication(s) and evaluation of side effects and/or results of medication(s).

Medication Services Non-Face-to-Face

Description

SERVICE CODE
99215NF (All durations)

Services which are not face-to-face with the consumer including evaluations of clinical effectiveness and side effects, medications, education, and treatment planning related to the delivery of the service and/or assessment of the consumer. Also includes services provided by phone.

SCOPE OF PRACTICE: Psychiatrist, Physician Assistant, Nurse Practitioner

10.12 MEDICATION THERAPY (NURSES)

Medication Therapy

Description

Pharmacologic management, including prescription use and review of medication.

SERVICE CODES
99215MT (All durations)
99214IJ (All injections, dosages, and durations)

SCOPE OF PRACTICE: Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician

Examples:

99215MT

- Staff time providing medication therapeutic services, chart review, proper syringe disposal, and provision of relevant medical education.
- Obtaining vital signs such as blood pressure, respirations, temperature, and heart rate.
- Reviewing labs with a consumer receiving psychotropic medications.
- Providing a consumer with education on the potential benefits and side effects of medication(s) prescribed.

Billing for chart review is permissible, but it is crucial to note that a service must be provided to the consumer for it to be billable. If the consumer does not attend the scheduled appointment, then chart review cannot be claimed for billing purposes.

99214IJ

- Medication Injection – documentation of the preparation and administration, observation of individual post-injection, and proper syringe disposal.
- Also includes the 99215MT medication therapeutic services described above.

Medication Services Non-Face-to-Face

Description

Medication support services provided without the consumer being physically present.

SERVICE CODE
99215NF (All durations)

SCOPE OF PRACTICE: Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician

Examples:

99215NF

- Assisting a consumer to obtain medication by completing an authorization request for a prescription as it relates to the provision of medication support services.

Missed Medication Visits

Documenting a missed appointment is essential for tracking a consumer's treatment progress. Consumer no shows, cancellations, and staff cancellations should also be documented in the record.

SECTION 11: TRANSFERS, TRANSITIONS & DISCHARGES

Transfers

Transfers occur when consumers transition from one outpatient mental health program to another (e.g., from a county clinic to a contracted provider, from a contracted provider to a county program, or between contracted providers). It is crucial for the current program to continue providing services until the consumer is seamlessly connected to their new program. Implementing a warm handoff approach ensures a smooth transfer process while minimizing disruptions in the consumer's care.

Transfers may also take place when a consumer requires the addition of ongoing services, such as medication support, from one outpatient program while receiving other services like therapy, groups, and case management at a different outpatient program.

During the transfer process between two programs with different Reporting Units (RUs) within the same provider agency, it is not necessary to repeat the assessment and intake paperwork, including Consents, Notice of Privacy Practices (NPP), and Release of Information (ROI). The new program should review the existing assessment with the consumer and document any updated information in a progress note.

Integrated Referral

The Integrated Referral form is a communication and tracking tool used by RUHS-BH to refer a consumer to a specific program within the MHP. The information provided on this form allows programs to begin the process of connecting consumers to services in a timely manner. An Integrated Referral is sent to providers by RUHS-BH units such as CARES, ACT, and county clinics to initiate services for a new consumer or to transfer a consumer from a county program to a contracted provider.

When receiving an Integrated Referral:

1. Review the information on the referral.
2. Take actions to address the referral (e.g., schedule an appointment with the consumer). Efforts made to contact the consumer should be documented. Providers must make a minimum of **3 attempts** to contact the consumer within **10 business days** from the date of the request for services.
3. Complete the disposition field at the bottom of the Integrated Referral form and return it to the RUHS-BH unit that initiated the Integrated Referral within **10 business days** to "close the loop".

Closing the loop ensures the consumer's referral has been reviewed, addressed, and an outcome has been documented. Closing the loop for referrals improves consumer safety and satisfaction, as well as clinical care coordination.

Transition of Care Tool

The Department of Health Care Services (DHCS) developed a standardized Transition of Care Tool to ensure that consumers with Medi-Cal receive timely and coordinated care when transferring of services between Managed Care Plans (MCP) and Mental Health Plans (MHP), or when adding a service from the other delivery system.

The decision to transition is one that can only be made by a clinician in a consumer-centered decision process. Once a determination has been made by the clinician with the team, any direct service staff involved in the consumer's treatment can complete the Transition of Care Tool. If a staff other than an LPHA completes the form, it must be cosigned by an LPHA or supervisor.

If a consumer steps down from an MHP program to a MCP provider, a Transition of Care Tool must be completed. The referring MHP provider will complete the Transition of Care Tool. The referring MHP provider will fax the completed Transition of Care Tool to CARES and continue to serve the consumer until they are transitioned to the MCP. CARES will fax a Provider Referral Form with a disposition to the MHP provider to close the loop.

When the MCP requests a consumer be transitioned to the MHP, the referring MCP provider will complete the Transition of Care Tool. CARES will provide the Transition of Care Tool and an authorization letter to the MHP provider to which the consumer is being referred.

The Transition of Care Tool is not used for internal referral between county clinics and/or contracted providers, as they are all part of the MHP.

Discharge Summary

Upon the completion of services, it is essential to complete a comprehensive discharge summary. This summary serves as a record of the services rendered, the consumer's progress, prescribed medications, identified risk factors, and recommendations for aftercare. The discharge summary plays a critical role as a point of reference in case of future requests for the consumer's records or if the consumer seeks care at a later time when the original staff members involved may no longer be with the program. Discharge summaries should be completed within 30 days from the final service provided. If there have been missed services and a lack of response from a consumer, staff should make at least three outreach attempts before discharging within the 60 days of the last documented attempt to re-establish contact.

In instances when a consumer is stepped down to receiving medication services only, a discharge summary should be completed once all services including medication services have ended.

Completing thorough discharge summaries will facilitate continuity of care, enhance information sharing, and establish a valuable resource for future reference. This enables seamless transitions in the consumer's care, even when changes in staff or programs occur.

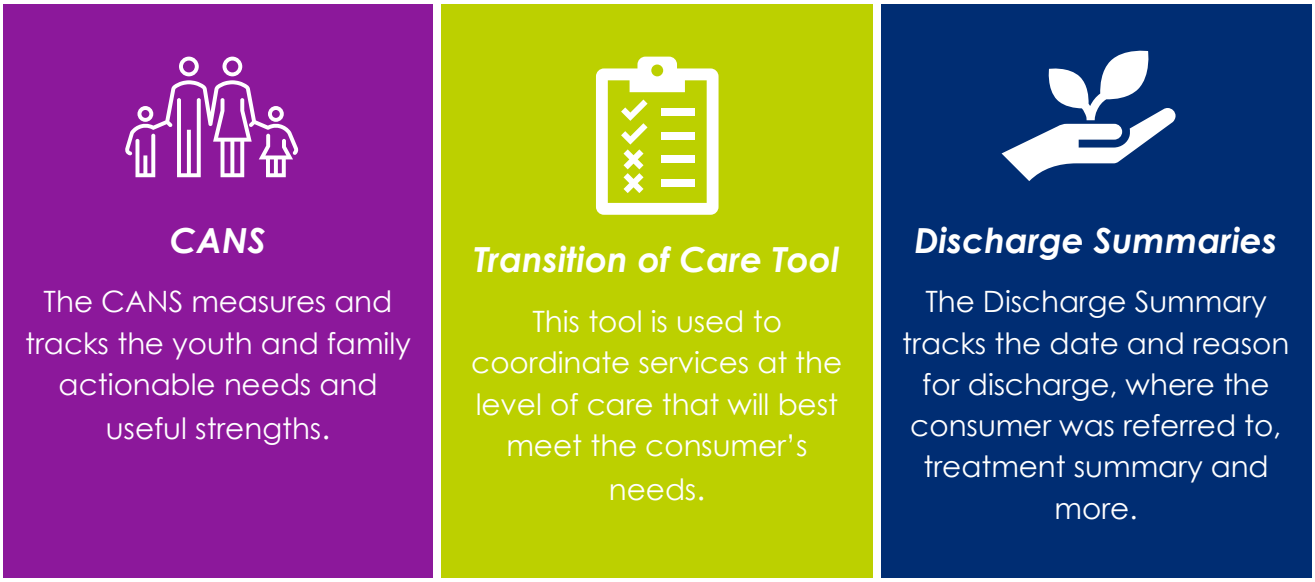
If staff met with the consumer and discussed the discharge, then staff would complete a progress note using the code of the service provided (e.g., individual therapy, family therapy). If not done with the consumer, completing the discharge summary is not a billable service.

SECTION 12: DATA & OUTCOME MEASURES

Data, or information gathered during services, is helpful to understand what is and isn't working when the information is accurate. Tracking this information enables:

- Better decision making
- Decreases risks
- Provides consistent results
- Reflects our true efforts

Outcomes are measured through a number of different reports that are created from the information submitted in a range of forms in our system. The following are a few examples of how this information is recorded.



Quality Consumer-Centered Care

When we rush to complete paperwork or do not carefully consider responses entered into data-collecting forms, such as the CSI Assessment Contractor (Timely Access) or Discharge Summary forms, inaccurate information may be captured and a whole different story may emerge about the consumer and the services they received. For example, a consumer met her goals right at the same time she was moving out of state. If we record "moved out of service area" versus "goals met" as the reason for discharge, we under-represent her progress and the positive outcome that occurred. Accurately representing the primary reason for discharge is important for many reasons.

Consumer-centered care, with a focus on outcomes, is key to the transformation of the CalAIM initiative. Outcome reporting is a quantifiable way to reflect the quality consumer-centered care that staff are providing.

SECTION 13: SPECIALIZED CONTRACT PROGRAMS

RUHS-BH contracts with specialty programs that provide higher level of care for consumers in crisis or who benefit from short term adjunctive, intensive, and/or residential services.

These programs provide a variety of services including therapy, case management, medication evaluations, care coordination, etc. Each program has a different anticipated or maximum length of stay with the goal of supporting consumers to stabilize and return to a lower level of care.

13.1 THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Services (TBS) is a one-to-one behavioral mental health intervention that provides help to children, youth, parents, caregivers, resource parents, and STRTP staff to learn new ways of reducing and managing challenging behaviors that put youth's placement at risk. TBS is an adjunctive service to the primary mental health service. For a youth to qualify for TBS, the service must be medically necessary, youth must be full-scope Medi-Cal and under the age of 21, have a need for specialty mental health services, and display specific behaviors that are jeopardizing their placement or putting them at risk for hospitalization.

TBS Assessment

Per Exhibit A of the TBS Contract, the contractor ***has two business days to schedule a date for the TBS assessment***. The TBS assessment must be completed by a licensed

clinician and includes meeting with the youth and caregiver to complete a Functional Analysis of Behavior. The assessment must identify:

- ✓ There is a need for specialty mental health services
- ✓ Identification of specific behaviors that require TBS

Identification of behaviors and individualized interventions in the assessment process are key to developing an effective TBS treatment plan.

TBS assessments must:

- ✓ Identify the youth's challenging behaviors that jeopardize continuation of the current residential placement or expected to interfere with transitioning to a lower level of residential placement or place consumer at risk for hospitalization
- ✓ Describe the severity of the youth's behaviors
- ✓ Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement or to successfully transition youth to lower level of residential placement or to reduce number of/risk of hospitalization
- ✓ Identify what changes in behavior TBS is expected to achieve and how the treatment team will know when services have been successful and can be reduced/terminated
- ✓ Identify skills and adaptive behaviors that youth will utilize to replace specified problem behaviors
- ✓ Identify consumer's strengths and interests

TBS Treatment Plan

Once the TBS Assessment / Functional Analysis of Behavior is complete, the TBS treatment plan will be written based on information gathered during the assessment. The TBS treatment plan is intended to provide clinical direction of interventions used to address specified challenging behaviors.

The TBS treatment plan must include:

- ✓ Specific challenging behaviors (also known as Target Behaviors) that are defined and include the baseline for frequency, duration, and intensity
- ✓ A specific individualized plan of interventions based on consumer's strengths/interests for *each* target behavior

- ✓ A specific time frame for when the interventions will produce change
- ✓ A transition plan that describes in measurable terms when youth has met their identified benchmarks that indicates how TBS will be decreased and ultimately discontinued
- ✓ Assisting caregivers with skills/strategies to provide continuity of care when TBS is discontinued, also known as Transfer of Training

Examples of Target Behaviors:

Physical Aggression, as defined as but not limited to, hitting, kicking, punching, biting, shoving, tripping others, and spitting.

- Frequency: 2x/day = 14x/week
- Duration: 20 minutes
- Intensity: High

Self-Harm Behaviors, as defined as but not limited to, cutting self, pulling hair out, making statements of wanting to die, jumping off the roof, and biting self until bleeding.

- Frequency: 4x/month
- Duration: 10 minutes
- Intensity: High

Example of Titration Schedule/Plan (based on example of target behaviors above):

Target Behavior	Frequency	Duration	Intensity	Benchmark
Physical Aggression	12x/week	15 minutes	High	1st Benchmark
	9x/week	10 minutes	Mid	2nd Benchmark
	5x/week	5 minutes	Mid	3rd benchmark
	2x/week	2 minutes	Low	Final Benchmark
Self-Harm Behaviors	3x/month	8 minutes	High	1st Benchmark
	2x/month	5 minutes	Mid	2nd Benchmark
	1x/month	2 minutes	Low	3rd Benchmark
	0x	N/A	N/A	Final Benchmark

Recommendations:

- Baseline measurement needs to match the titration schedule (by day, week, or month)
- Have 4 benchmarks total (1st, 2nd, 3rd, and Final) to allow for measurable progress to be made

- Make sure benchmarks are reasonable and attainable for youth (not all behaviors will be eliminated as it may not be age-appropriate)

Treatment Plan Addendums/Extensions

Treatment Plan Addendums are required when there have been significant changes in the youth's environment (for example, a change in placement). An addendum is also needed when TBS has not been effective, or youth's progress is slower than anticipated. There must be documented evidence in the chart indicating that alternatives have been considered and the request for additional days of service for TBS indicates that based on identified alternatives, the additional time will be effective. If a TBS treatment plan expires, an extension should be written to explain the extension (for example, consumer needs an additional 4 weeks of service to titrate out the service appropriately).

Behavioral Assessment Form (BAF)

The Behavioral Assessment Form (BAF) is a list of skills that are rated on a scale of 0-3

0	1	2	3
Youth unable to do	Youth able to do with a lot of help/prompting	Youth able to do with some help/prompting	Youth able to do independently

The BAF is:

- ✓ Scored with the caregiver at time of Assessment to obtain the baseline score
- ✓ Scored each month prior the monthly TBS treatment team meetings to track progress in each skill set
- ✓ Goal of the BAF is to identify skill sets that TBS coach can work with consumer to increase scores from 0/1 to 2/3.

Behavior Monitoring Tool (BMT)

The Behavior Monitoring Tool (BMT) is documentation of the youth's monthly progress that is reviewed during the monthly TBS treatment team meetings.

The BMT includes:

- ✓ List of the target behaviors with their definitions
- ✓ A table that shows the average frequency/duration/intensity and the benchmarks that were met for each target behavior
- ✓ A summary of the individualized interventions/skills that the coach taught the youth and the youth's response

- ✓ A summary of the transfer of training completed with the caregiver
- ✓ Any environmental factors that may be impacting the progress/ effectiveness of TBS

Progress Notes

TBS progress notes are required for each day service is provided.

Progress notes must:

- ✓ Clearly and specifically document the occurrence of target behaviors
- ✓ Significant, individualized interventions used during the service to help youth meet their benchmarks and decrease target behaviors
- ✓ A comprehensive summary covering the time that services were provided
- ✓ Indicate the next planned TBS coaching service date and time
- ✓ Be co-signed by a TBS Supervisor within 14 days of the date of service

Recommendations:

- Include non-billable notes to show communication, cancellations (reasons why and if make-up sessions were offered/accepted/declined)
- Each service type needs its own progress note (395-Assessment, 394-Coaching; 396-Collaterals)

Authorizations (Treatment Authorization Requests)

The initial Authorization is provided by the TBS Liaison and is good for 30 days. Within the first 30 days, the TBS provider needs to complete the Assessment, FAB, Treatment Plan, and Initial BAF and schedule the initial TBS treatment team meeting. Coaching may also start within the first 30 days upon completion of the assessment/treatment plan.

The TBS provider will submit reauthorizations for the duration of the service to the TBS Liaison assigned to the youth. The first reauthorization (also known as TAR #2) must be sent in with the FAB, TBS treatment plan, and initial BAF, as the TBS Liaison cannot sign it without the initial assessment documentation. For authorizations 3+, the TBS provider would send them into the TBS Liaison prior to the previous authorization expiration date. All reauthorizations are for 60 days.

Special Incident Reports (SIRs)

All special incidents shall be recorded in the form of a Special Incident Report (SIR) and sent to the TBS Liaison within 24 hours of the incident. SIRs are required for incidents that occur during the delivery of TBS. SIRs need to be included in the youth's chart. Examples of events that would require a serious incident report include AWOL, physical violence, suicide-related incident (attempt/ideation), hospitalization, police involvement, property damage/theft, substance abuse, sexually related incident, and child abuse report.

Discharge Documentation

Discharge documentation includes the Discharge Summary Form, the Termination Behavioral Assessment Form, and a final TBS chart note. The final TBS chart note should document that the youth/caregiver were given the youth/caregiver Satisfaction Surveys.

Timelines for Documentation

FORM/ACTIVITY	DUE DATE
• Assessment Functional Analysis of Behavior (FAB) • TBS treatment plan • Behavior Assessment Form (BAF)	Within 7 business days from date of assessment
• Signed TBS treatment plan (which must be signed by the youth, caregiver, Specialty Mental Health Provider (SMHP), TBS Supervisor, and TBS Coach)	Within 7 business days from the initial treatment team meeting
• Monthly BAFs/BMTs	24-48 hours in advance of the monthly TBS treatment team meeting
• If documents need corrections/revisions	Within 2 business days from date of consult
• Progress notes must be signed by coach and co-signed by licensed clinician	Within 14 days from date of service
• Authorizations	14 days prior to the expiration of the current authorization period

• SIRs	Within 24 hours of incident
• Discharge documentation	Within 7 business days from last billed service to youth (last coaching session)

TBS Service Codes

TBS Coaching

Description

SERVICE CODE
394

Service code covers the face-to-face (1:1) therapeutic contact between the TBS coach and the consumer.

SCOPE OF PRACTICE: Non-LPHA

TBS Assessment

Description

SERVICE CODE
395

Service code covers the TBS Supervisor who conducts the TBS assessment, including the compilation of the Functional Analysis of Behavior (FAB), treatment plan, and initial Behavioral Assessment Form (BAF) based on information gained through consultation with the SMHP, consumer, and caregiver.

SCOPE OF PRACTICE: LPHA

TBS Collateral

Description

SERVICE CODE
396

Service code covers a service activity to a significant support person in the consumer's life with the intent of improving or maintaining the mental health status of the consumer directly connected to the identified target behaviors that are jeopardizing placement and the TBS treatment plan.

SCOPE OF PRACTICE: LPHA and Non-LPHA

13.2 SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM (STRTP)

STRTP is a short-term residential therapeutic program for children, youth, and non-minor dependents under the age of 21. The goal of STRTPs is to provide structured therapeutic interventions and support to help youth address and manage their specific issues and to facilitate their transition to more stable living situations, such as returning home or to another lower level of care such as a resource family home. STRTP typically offers a range of services, including counseling, education, medical care, and other forms of support to address the unique needs of the youth in their care. STRTPs require a comprehensive team approach, stressing the importance of involving the child, parent, conservator, mental health professionals, and/or the individual identified by the court to collectively make decisions regarding the child, treatment and/ transition plan.

STRTPs must ensure that each child residing in the STRTP has an accurate and complete consumer record. In this sub-section, the unique documentation requirements for STRTPs will be reviewed, in accordance with the Interim STRTP Regulations Version II, beyond the consumer chart basics already covered in the proceeding portions of this Documentation Manual. Adherence to STRTP regulations play an important role in ensuring the well-being and effective treatment of youth in STRTP care.

Clinical Assessment

STRTP regulations require the assessment be completed within **5 calendar days** of a youth's arrival at the STRTP. An existing mental health assessment performed within a 60-day period preceding the date of the youth's arrival at the STRTP can be used with an addendum completed to document the acceptance of the existing assessment and adding any missing or updated information.

The Qualified Individual assessment is an independent evaluation to determine the appropriate level of care for the youth. This is separate from the biopsychosocial clinical assessment completed by the STRTP clinician. Please make sure to respond PROMPTLY as the Qualified Individual is on a strict deadline with the juvenile court to meet this legal mandate.

For additional information on assessments, see Section 4: Assessment and Diagnosis.

Emergency Placement

For emergency placements, a written determination is required within **72 hours** of the youth's arrival at the STRTP. The written determination does not take the place of the required mental health assessment; however, the assessment can be used in place of this written determination if it is completed within 72 hours of the youth's arrival.

The written determination must include the following information:

- Youth's presenting problem
- Confirmation that the STRTP meets the therapeutic needs of the youth
- Prior diagnosis if any
- Current prescription and non-prescription medications
- Current medical conditions, including prescribed treatment and medications
- Risk assessment
- Commonality of need with the other STRTP youth

Admission Statement

All STRTP placements require an Admission Statement be completed within **5 calendar days** of arrival. It affirms the Head of Service (HOS) completed the following:

- ✓ Read the youth's referral documentation and any previous mental health assessment, if applicable.
- ✓ Considered the needs and safety of the youth.
- ✓ Considered the needs and safety of the consumers already admitted to the STRTP.
- ✓ Concluded that admitting the consumer is appropriate.

Care Plan

The care plan is an agreement between the youth and the treatment team setting the expectation for treatment. STRTP youth must have a care plan created within **10 calendar days** of their arrival to the STRTP.

Guided by a trauma-informed perspective, the care plan must include the following:

- Anticipated length of stay
- Specific treatment goals, including a transition goal to support the rapid and successful transition of the youth back to community based mental health care
- Provider interventions/specific treatment services
- Participation from the consumer and family or support people on their CFTM

As of January 1, 2024 (BH-IN 23-068), a separate Care Plan Progress Note is no longer required when providing the following interventions, provided they are included in the standalone care plan:

- **Case Management**
- **Peer Support Services**
- **Intensive Care Coordination (ICC)**

For more information about care plans, see Section 6: Problem List and Care Plan.

Progress Notes

There are three types of STRTP progress notes: Specialty Mental Health Services (SMHS), Significant Change/Event, and Daily Mental Health Progress Notes.

Specialty Mental Health Services (SMHS) Progress Notes

Specialty Mental Health Services (SMHS) progress notes are notes that mental health staff write after providing a billable service to a Medi-Cal consumer. It is possible to have multiple SMHS progress notes in one day as multiple services may be provided to the youth in a day at the STRTP based off the youth's needs.

The purpose of SMHS progress notes includes the following:

- ✓ Documents how mental health interventions support the achievements of the youth's care plan goals.
- ✓ Monitors and evaluates the consumer's responses and progress to treatment.
- ✓ Provides information for continuity of care and communication between providers.

For more information about SMHS progress notes, see Section 7: Progress Notes.

Significant Change/Event Progress Notes

A Significant Change/Event is when an event or change is unintended or unexpected, which could or did lead to physical or emotional harm, or did not cause harm but could have, or the event should have been prevented. A progress note must be completed by Mental Health Program Staff when there is a significant change in the youth's condition or behavior, or a significant event involving the youth. It is important to clearly identify the progress notes as a Significant Change/Event note when documenting the event.

The following elements should be included:

- ✓ Date and time of the significant event.
- ✓ STRTP's response to the event.
- ✓ Determine whether the history of trauma precipitated the significant event.
- ✓ Determine if the significant event could be used to promote healing and growth from the youth's history of trauma.
- ✓ Determine whether the event has created a need for change to the care plan.

Following a Significant Change/Event, update the youth's care plan with any additional service needed or other changes, if applicable.

Daily Mental Health Progress Notes

The STRTP needs to ensure that there is a minimum of one written daily mental health progress note for every day a youth is present at the STRTP.

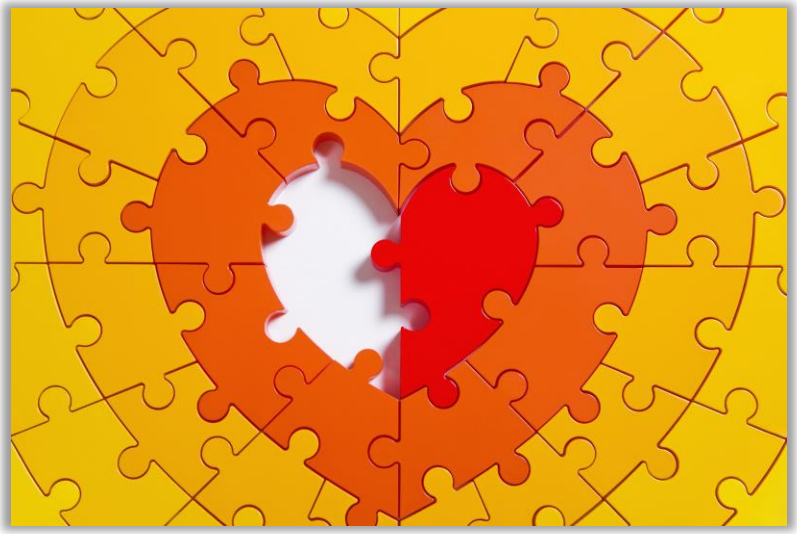
The following elements should be included as applicable:

- ✓ Youth's contact with family, friends, natural supports, CFT members, existing mental health team, authorized legal representative and public entities, when it occurs
- ✓ Description of youth's progress toward goals identified in care plan
- ✓ Specific services provided to the consumer

- ✓ Youth's participation and response to mental health treatment
- ✓ Observations of consumer's behavior and possible side effects of medication, if applicable

A SMHS progress note can replace a Daily Mental Health Progress Note. The Daily Mental Health Progress Note may be completed by any mental health or direct care staff. A Daily Mental Health Progress Note is not required if the youth is not physically present at the STRTP (e.g., on an extended home visit). Completing a Daily Mental Health Progress Note is a non-billable service.

Collaboration and Care Coordination



At the STRTP level of care, collaboration and care coordination are crucial, from the time of arrival until the completion of aftercare. Therefore, it is important to obtain the appropriate releases of information for all involved parties as well document any collateral contribution to a youth's treatment. At the STRTP level of care, Intensive Care Coordination (ICC) services often occur weekly, and youth are eligible for Intensive Home-Based Services (IHBS). These services should be documented and support a coordinated effort in between Child and Family Team Meetings (CFTMs). CFTMs for youth at an STRTP often occur every 30 or 60 days. They must occur as frequently as is needed but no less than every 90 days.

For more information on ICC, IHBS, and CFTMs, see Section 8: Specialty Programs.

30-Day Care Plan Reviews

After the care plan is developed with and agreed to by the consumer, it must be reviewed at a minimum of **every 30 days** by the STRTP mental health staff and documented in the youth's chart. Any changes to the care plan would need to have updated youth's agreement and clinician's signature.

Medication Reviews

Medication reviews should include:

- ✓ Any side effects observed or reported.
- ✓ Youth's response to each prescribed psychotropic medication.
- ✓ Youth's level of compliance with the medication plan.
- ✓ Justification for continued medication or warranted changes.
- ✓ A statement that the medical professional considered the youth's treatment goals and medication is being prescribed in support of the youth's care plan.

Medication reviews must be completed at least **every 45 days** for all STRTP youth who are prescribed psychotropic medication. A psychiatrist shall review the course of treatment for those who are not on psychotropic medications at least **every 90 days**.

90-Day Clinical Reviews/Meetings

90-Day Clinical Reviews/Meetings need to be completed at least **every 90 days**. This review should include youth's current mental health status and progress to determine if the youth should be transitioned to a different level of care.

The documented review should include the following:

- ✓ The types and frequency of services provided.
- ✓ Progress on the youth's achievement of care plan goals.
- ✓ Explanation that STRTP continues to meet the specific therapeutic needs of the consumer.
- ✓ Justification for continued STRTP stay or transition of consumer.
- ✓ Discussion of the youth's diagnosis and mental health progress
- ✓ Treatment planning and transition planning.

Transition Determination Plan and Aftercare Plan

A Transition Determination Plan (TDP) is a road map to help guide a youth's plan for transitioning from the STRTP to a lower level of care. The TDP can be started at the time of the youth's arrival at the STRTP and updated regularly but must be completed

and signed by a Mental Health Program Staff member prior to the date of the youth's transition from the STRTP.

Collateral participation can be included to support the youth in this transition and might be part of the creation of this document. A copy should be provided to the parent or legal guardian prior to or at the time of the youth's transition.

The Transition Determination Plan should include:

- ✓ Reason for Admission
- ✓ Reason for transition, referencing transition goals when possible
- ✓ Course of treatment, including mental health treatment services, and youth's response to treatment
- ✓ Diagnosis at the time of transition
- ✓ The youth's **After Care Plan**, which must include:
  - Youth's diagnosis and required follow-up
  - Medication including side effects and dosage schedules
  - Goals and expected outcomes
  - Treatment recommendations
  - Educational information
  - Referrals to medical and mental health providers

13.3 CRISIS STABILIZATION SERVICES (CSU/MHUC)

The programs described below reflect RUHS-BH's continual efforts to improve the continuum of care for those experiencing an acute mental health episode which requires short-term, intensive interventions. The **Crisis Stabilization Unit (CSU) and Mental Health Urgent Care (MHUC)** are available 24 hours a day, 7 days a week and are intended to stabilize consumers at risk of hospitalization in the least restrictive, trauma-informed setting, while avoiding costly emergency department visits.

Crisis Stabilization is defined as a service lasting less than 24 hours for a condition that requires a timelier response than a regularly scheduled visit. Service activities include but are not limited to assessment, medication support, and linkage.

The CSU is 5150-designated for involuntary mental health care and is designed to provide immediate crisis stabilization for those needing a high level of supervision in a supportive, locked milieu. Staff are trained to safely and legally contain consumers who may lack the capacity for informed consent or decision making.

The MHUC provides services in a welcoming, therapeutic environment with enriched peer-to-peer support. Interventions focus on consumer empowerment, symptom reduction, reduction of barriers to self-sufficiency in the community, and maximization of each consumer's engagement in their recovery.

Documentation of Crisis Stabilization Services

In the CRT and MHUC, each consumer record should have, at a minimum, diagnostic procedures, evaluation studies, problems to be addressed, medications provided, transition/aftercare plans, and records of all services provided by the various personnel.

As services are billed under a single billing as opposed to under individual staff, the names and titles of those completing entries should be readily identified in the documentation.

All documentation should be completed within 24 hours.

General provisions related to record keeping and communications still apply for CRT/MHUC programs. For more information, see Additional Record Keeping and Communication Considerations in Section 2.

Legal Forms

Upon admission, staff are to advise all consumers of their rights, complete the admission process, document all pertinent information, and obtain the consumer's signature on all forms.

The consumer's record should contain required legal documents described in Section 2, as well as:

- ✓ Patients Rights Advisement
- ✓ Admission Agreement
- ✓ Personal property inventory
- ✓ Copy of 5150 paperwork (if applicable)
- ✓ Insurance/financial data as required for billing for services

Please refer to Section 2: Legal Forms and Other Required Forms for more information on Informed Consent, Notice of Privacy Practices, Telehealth Consents, Authorization to Release Information, and Informing Materials.

In addition to documentation that Informing Materials have been made available to each consumer, the record should reflect that the following occurred:

- ✓ Orientation to rules and regulations, staff, and environment
- ✓ Notification of guardian/conservator (if applicable)

Assessment and Evaluation

All **assessments** shall be completed and present in the chart. They must include at a minimum:

- ✓ Presenting problem
- ✓ Mental Status Exam (MSE)

- ✓ Evaluation of imminent risk (danger to self, danger to others, and/or grave disability)
- ✓ Psychiatric history
- ✓ Basic medical clearance

Additionally, consumers must be assessed for issues resulting in frequent admission, and documentation should support that these issues were addressed.

RUHS-BH highly encourages using a standard domain-based format for assessments. See Section 4 Assessment and Diagnosis for more information on Assessment Domains.

A basic **nursing medical evaluation** is to be conducted at the time of initial assessment, including a brief medical history and vitals. An additional **medical evaluation** can be performed as needed by the treating psychiatric prescriber or by the facility's on-call internist. The psychiatric prescriber is to complete their assessment in a timely manner to ensure that the consumer can be discharged to the community or admitted to an inpatient facility, within 24 hours of being admitted.

The requirement and guidelines related to maintaining Problem Lists also applies to CSU and MHUC programs. Please refer to Section 6 for more information.

Medication

Medication in the CSU and MHUC should be prescribed in accordance with RUHS-BH policies.

The consumer's record should include:

- ✓ Vitals and weights
- ✓ Physical health assessment
- ✓ Copies of drug screens
- ✓ Complete medication consent for each prescribed medication
- ✓ Justification for medications and dosages
- ✓ Consumer received medication education
- ✓ Prescription provided upon discharge

For more information, refer to the following policies: RUHS-BH Policy #547 Ordering, Receiving, Storing, Providing, Disposing, Administering, and Paying for Medications, #548 Psychotropic Medication: Prescribing and Monitoring, #549 Psychotropic Medication: Informed Consent for Psychotropic Medication.

Discharge

Comprehensive discharge planning should be evident in the consumer's record and should include psychiatric and medication treatment received, family involvement, referrals/linkages provided (with program names/contact information), and any additional aftercare recommendations.

All consumers are to have **an appointment for outpatient services upon discharge.**

Written aftercare plans must include:

- Consumer's name
- Medications (including quantity provided and explanation of dosage)
- Expected course of recovery
- Follow up appointments and referral
- Admission date
- Diagnosis, including substance abuse disorders that are evident
- Discharge date and time
- Nurse/MD/Prescriber signature

Upon review of the consumer's chart, documents should support that the following occurred:

- ✓ Consumer's presentation/disposition at time of discharge.
- ✓ Assertive efforts were made to link the consumer back to their family, friends, other care providers, and outpatient treatment resources.
- ✓ Documentation of any medications provided with clear instructions of medication regimen.
- ✓ Three days of medication was provided if referred to a social rehabilitation program (CRT, ART).
- ✓ If the consumer did not receive medication services or have the evaluation completed, staff documented the reason why services were not provided (e.g., consumer declined, discharged prior to evaluation, etc.).
- ✓ Drug screen results were provided to either the appropriate inpatient or outpatient treatment provider.
- ✓ If discharge was unplanned or occurred against medical advice that circumstances are clearly documented.

If a consumer's stay will exceed 23 hours and 59 minutes, it must be adequately documented.

Crisis Stabilization Service Codes

Crisis Stabilization is reimbursed based on hours of time. Partial blocks of time shall be rounded up or down to the nearest one-hour increment, except for services provided during the first hour which are always rounded up.

Description

Crisis Stabilization means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy.

SERVICE CODES
BILLABLE:
208
NON-BILLABLE:
209NB*
***Note:** Use if consumer's stay exceeds 24 hours.*

13.4 SOCIAL REHABILITATION PROGRAMS (CRT, ART)

Crisis Residential Treatment (CRT) and Adult Residential Treatment (ART) programs provide a community-based treatment option in home-like settings that help reduce emergency department visits and divert hospitalization and/or incarcerations. The programs are available 24 hours a day, seven days a week.

Services are provided to adult residents of Riverside County (ages 18 – 59) in a non-institutional residential setting which provides a structured program for consumers experiencing an acute psychiatric episode or crisis and do not have medical complications requiring nursing care. Participation is voluntary or authorized by a conservator. The programs do not serve those who meet 5150 criteria and need to be involuntarily detained or those in crisis solely due to a substance use disorder.

Crisis Residential Treatment (CRT)

The Crisis Residential Treatment (CRT) program serves those with severe and persistent and/or short-term mental disorders who are in crisis and at risk of psychiatric hospitalization or need continual supervision due to a mental disorder. The goal of services is to minimize the risk of hospitalization or return to routine crisis-based care. A consumer's stay is typically 14 days or up to 30 days.

Stays exceeding 2 weeks must be adequately documented and justified. If a consumer's stay will exceed 2 weeks, it is necessary to obtain written authorization from the crisis program administrator.

Adult Residential Treatment (ART)

The Adult Residential Treatment (ART) program serves consumers who meet the following criteria: have a severe and persistent mental illness, are on an LPS Conservatorship, are currently residing in a locked treatment setting or preventing placement in a locked setting and have been recommended for a lower level of care but are not ready for independent living or placement in a licensed adult residential facility (i.e. board and care). The primary goal of the ART program is to act as a transitional placement to eliminate or shorten the need for treatment in an inpatient hospital or long-term locked facility. Length of stay is estimated to be about 90 days, but not to exceed 365 days.

Stays exceeding 90 days must be adequately documented and justified. Maximum stay is 1 year. If a consumer's stay will exceed 90 days, it is necessary to obtain written authorization from the crisis program administrator.

Program

Based on the Recovery Model of care, both CRT and ART programs include a range of activities and services that support consumers in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. Activities may include but are not limited to assessment, plan development, therapy, rehabilitation, groups, collateral, and crisis intervention. Socialization and interpersonal skills are encouraged within the program and general community.

Social Rehabilitation Programs (CRT, ART) Documentation

Documentation of services provided in CRT and ART programs should clearly reflect a consumer's course of treatment, effectively communicate relevant information such as the conditions of admission, the array of individualized interventions provided, the

consumer's response to treatment, as well as preparation for and justification for discharge.

In addition to documenting per community standards of mental health care, records created by CRT and ART programs must adequately provide evidence that certain mandated services were offered and/or provided per the needs identified in the assessment and the consumer's treatment/rehabilitation plan.

The consumer's chart should reflect a "wrap around" philosophy and commitment to the Recovery Model, and document services such as:

- ✓ Assistance with activities of daily living (ADLs) such as grooming, hygiene, care of personal belongings, laundry, and keeping clean their personal and community rooms.
- ✓ Budgeting assistance.
- ✓ Drug and alcohol recovery services, when appropriate, and linkage and transportation to programs, either on-site or in the community.
- ✓ Socialization skill building through group interventions.
- ✓ Direct linkage to vocational rehabilitation programs or volunteer opportunities when established as an identified goal prior to discharge in order to maximize successful follow-up community connection and support.
- ✓ Transportation for appointment and community service linkages and needs identified in the treatment/rehabilitation plan that cannot be met by the facility.
- ✓ Transportation for medical, dental, and other basic care.
- ✓ Linkage and coordination with Public Guardian and inpatient treatment facilities that may have initiated an application.
- ✓ Coordination for SSI/SSDI applications.
- ✓ Appropriate placement/housing arrangements.

The consumer's chart should also contain a record of contact with family and support persons with an emphasis on their participation and support of the consumers' treatment. If such contact is not possible or advisable, this should be documented.

General provisions related to record keeping and communications still apply for CRT and ART programs. For more information, see Additional Record Keeping and Communication Considerations in Section 2.

The following sections will describe the additional documentation necessary to meet regulatory and RUHS-BH guidelines.

Admission Agreement

In addition to required forms and disclosures provided upon admission to a mental health program (see Legal Forms and Other Required Forms in Section 2), an **admission agreement** is required.

Admission Agreements must:

- ✓ Be signed on entry by the consumer or an authorized representative and staff.
- ✓ Describe the services to be provided.
- ✓ Outline expectations and consumer rights regarding house rules, consumer involvement in the program, and fees.

The consumer shall receive a copy of the signed admission agreement.

Assessments and Evaluations

A written **Community Functioning Evaluation** of community living needs should be conducted within 24 hours of admission normally, and in no case more than 72 hours after admission.

The Assessment/Community Functioning Evaluation should include at a minimum:

- ✓ Health and psychiatric histories
- ✓ Psychosocial skills
- ✓ Social support skills
- ✓ Current psychological, educational, vocational and other functional limitations
- ✓ Medical needs, as reported; and,
- ✓ Meal planning, shopping, and budgeting skills
- ✓ Barriers to discharge to the community

RUHS-BH highly encourages using a standard domain-based format for assessments. See Section 4 Assessment and Diagnosis for more information on Assessment Domains.

A **screening for medical complications** which may contribute to the consumer's disability is to be conducted by a physician, nurse practitioner, or physician's assistant.

The medical screening must:

- ✓ Occur within 30 calendar days prior to, or after admission.
- ✓ Include a plan for follow-up.
- ✓ Documentation if a consumer refuses a screening for medical complications.

The consumer's record should also include alcohol and drug testing upon admission (or test results obtained within 24 hours of admission by other health care providers).

The requirement and guidelines related to maintaining Problem Lists also applies to CRT and ART programs. Please refer to Section 6 for more information.

Treatment/Rehabilitation Plan

Within 24 to 72 hours of admission, staff and consumer shall together develop a written treatment/rehabilitation plan establishing goals to be accomplished.

The Treatment/Rehabilitation Plan should contain:

- ✓ Statement of specific treatment needs and goals.
- ✓ Description of specific services to address identified treatment needs.
- ✓ Anticipated length of stay needed to accomplish identified goals.
- ✓ Methods to evaluate the achievement of goals.
- ✓ Identify consumer's strengths.
- ✓ Articulate consumer responsibilities and family/support persons' responsibilities.
- ✓ A plan for discharge, developed in collaboration with consumer, staff, and family/conservator.

Within 24 to 72 hours of admission, and with consumer consent, CRT and ART staff should contact and involve the consumer's family and support persons. The treatment/rehabilitation plan will clearly identify family and support persons' involvement in care whenever possible. If the consumer refuses, **document efforts to obtain consent until consent is obtained or consumer is discharged.**

The plan should include participation by **peer staff**, including a peer family advocate, whenever family or significant other engagement, support and participation are identified as a need.

Consumers are to be involved in an **on-going review of progress** towards reaching established goals and be involved in the planning and evaluation of their treatment goals. The plan should be updated as needed in accordance with sound clinical practice.

Documentation of reviews by staff and consumer of the treatment/rehabilitation plan are to be completed:

CRT	ART
At least weekly	At least once every 30 days

The plan must be signed by the consumer indicating agreement with the plan, an LPHA and support persons (when applicable).

Progress Note Requirements

Progress notes should clearly provide information regarding the consumer's level of involvement in treatment activities and progress towards goals.

At least one progress note for services is required per day. The progress note must support the services rendered. Weekly or periodic progress notes cannot be used in lieu of individual progress notes.

A separate or distinct progress note for all service types is not required. However, the note should accurately summarize all the services or activities delivered. If the consumer participated in one or more group services, the consumer's response to each group service should also be documented in the note.

In cases when a service is not included in a program's bundled rate, there must also be a progress note to support the second, unbundled service. For example, Medi-Cal medication evaluation services are claimed on the same day as, and separately from, residential services. In this scenario, one progress note is required for the bundled residential service, and a separate progress note to support the additional, unbundled claim for medication services. These requirements apply regardless of whether the bundled and unbundled services are delivered by the same provider or by different providers.

For services documented and billed separately, progress notes must meet the requirements outlined in Section 7: Progress Notes.

Medication

The medication section of the chart should include:

- Vitals and weights
- Progress notes for unbundled services
- Justification for medications and dosages
- Consumer education, provided by program staff or consultants, about the role of medications
- Assessment of physical health
- Complete medication consent for each medication prescribed
- Prescription within RUHS-BH guidelines
- Prescription provided upon discharge

Medication orders received over the phone shall be accurately and clearly written in the chart and signed by the licensed nursing personnel receiving the orders. All phone orders shall be countersigned by the licensed prescribing practitioner within seven days from the time the orders are issued.

Medication follow up by the prescribing provider must occur:

CRT	ART
As needed, but no less than once every seven days	As needed

Dispensing Medications

Staff qualified and authorized to dispense medication shall document the consumer's response to medication and any reported, observed or suspected side effects. The prescribing practitioner shall be notified immediately if any side effects occurred in response to medication, and the response/notification documented in the consumer's chart.

Relapse Prevention and Safety Plans

Relapse prevention plans should be documented for each consumer and developed mutually between the consumer and staff. This plan supports symptom monitoring by outlining specific signs of decomposition and implements a recovery plan that empowers the consumer toward self-sufficiency that may prevent or minimize relapse. Additionally, for consumers who express thoughts of harming themselves, **safety plans** should be developed.

Relapse prevention plans and safety plans may be documented in the consumer's chart as a separate document, or in existing documents where clinically appropriate (e.g., incorporated into the treatment/rehabilitation plan).

Group Schedule and Community Participation

Documentation should reflect that consumers are involved in operation of the 'household' (including formulation and monitoring of house rules, cooking, cleaning, menu planning and activity planning). Consumers are to be involved in community meetings daily in the CRT and weekly in the ART.

Programs are required to have a group calendar listing days, times, and specific activities offered. A list of group participants for each activity must also be maintained by the facility.

Discharge

The consumer's chart should reflect that discharge planning began at admission, and that the discharge date was collaboratively established.

A discharge summary must be prepared for each discharge and include the following:

- Reason for admission
- Any referral and follow up plans
- Progress made towards consumer's needs and what needs continue
- Outline of services provided
- Medication prescribed
- The reason and plan for discharge

Assistance with transportation must be provided, if needed, and documented.

Documentation of discharge medications or prescriptions is to be provided upon discharge to the appropriate program within two business days for CRTs, and five business days for ARTs.

In the event of an unplanned discharge due to serious danger or seriously or repetitively non-compliant behaviors, ensure the following:

- ✓ Document an assessment of safety needs and action(s) taken.
- ✓ Document all other available actions that have failed.
- ✓ Notify law enforcement and PG of imminent risk so a 5150 assessment can be done.

- ✓ Notify consumer's involved family members, CCL, and RUHS-BH as appropriate
- ✓ If the consumer was actively involved in another treatment program, notify that program immediately.

Social Rehabilitation Program Codes

Crisis Residential Treatment Service

Description

SERVICE CODES DAY RATE
3304NI (CRT)
3366NI (ART)

"Crisis Residential Treatment Service" means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

Medication Support

Description

SERVICE CODES BY PROCEDURE
99212MD (10 -19 Minutes)
99213MD (20 - 29 Minutes)
99214MD (30 - 39 Minutes)
99215MD (40 - 240 Minutes)

Pharmacologic management, including prescription use, and review of medication with no more than minimal psychotherapy. Evaluation of the need for medication prescribing, the clinical effectiveness and side effects, obtaining informed consent, medication education (including discussing risks, benefits, and alternatives, collateral involvement), treatment planning.

SCOPE OF PRACTICE: Psychiatrist, Physician Assistant, Nurse Practitioner

13.5 MENTAL HEALTH REHABILITATION CENTER (MHRC)

The Mental Health Rehabilitation Center (MHRC) operates as a 24-hour program offering intensive support and rehabilitation services for individuals aged 18 and older with mental disorders. This program is designed to assist those who would have otherwise been placed in a state hospital or another mental health facility, empowering them to develop the necessary skills for self-sufficiency and increased levels of independent functioning. The center also serves as a rehabilitation facility for patients transitioning from acute inpatient psychiatric hospitals, providing continued psychiatric care without the need for intensive services.

Additionally, the MHRC accepts individuals referred through the Felony Incompetent to Stand Trial (IST) Diversion Program, based on determinations and agreements by the Public Defender, District Attorney, and Superior Court, as recommended by RUHS-BH. This segment of the population includes individuals with not yet adjudicated legal charges, individuals found incompetent, and individuals diagnosed with mental disorders such as bipolar disorder, schizophrenia, schizoaffective disorder, or post-traumatic stress disorder, excluding certain personality disorders.

General provisions related to record keeping and communications still apply for MHRC programs. For more information, see Additional Record Keeping and Communication Considerations in Section 2.

Documenting MHRC Services

The entries and documents in a consumer's clinical record in total must reflect that interventions and supports required of MHRC programs were provided based on the needs identified in the assessment and the consumer's individual service plan. Documents such as acknowledgement forms, assessments, historical medical records, care plans, progress notes, monitoring logs, sign-in sheets, and group activity calendars are subject to review as evidence that the MHRC provided services as required.

Evidence must be available that the program provided:

- ✓ Structured services available day and evening, seven days a week.
- ✓ Each consumer received an average of 14 specific rehabilitation services hours and seven activity program hours per week.
- ✓ Interventions/activities addressed the following areas:
  - Self-Help Skills Training
  - Behavioral Intervention Training
  - Interpersonal Relationships
  - Prevocational Preparation Services
  - Discharge Planning

A written schedule of planned and varied activities should be visibly posted. Additionally, a current record of the type of frequency of activities provided and the names of consumers participating in each activity must be maintained.

Admission and Legal Forms

In addition to the required forms and disclosures provided upon admission to a mental health program (refer to Legal Forms and Other Required Forms in Section 2), as part of the informed consent process, a physician will verbally explain the consumer's right to refuse or accept medical treatment. This process also involves a written consent form signed by the consumer, confirming their acknowledgment of the information provided.

Please refer to Section 2: Legal forms and Other Required Forms for more information on Informed Consent, Notice of Privacy Practices, Telehealth Consents, Authorization to Release Information, and Informing Materials.

Prior to admission each consumer shall be screened for tuberculosis by RUHS ITF. Upon transfer to the MHRC, test results must be included in the consumer's record. Staff should also include the height and weight of each consumer being admitted to the MHRC and continue to record their weight once a month thereafter.

An **admission agreement** is required for each consumer. This agreement outlines the services to be provided, as well as the expectations and rights of the consumer concerning program rules, consumer empowerment, and involvement in the program. The agreement is intended to be signed by the consumer or their authorized representative, with a copy provided when the signature is obtained.

Evaluation and Assessment

State regulations require the following regarding assessments upon admission to the MHRC:

Within **72 hours** of admission:	An **evaluation performed by a physician**, including a written report of a physical examination (unless a physical has been completed within 30 days prior to admission).
Within **15 days** of admission:	An **initial written assessment** of each consumer (unless a similar assessment has been done by the referring agency within 30 days prior to admission) including at least the following: ✓ Health and psychiatric histories. ✓ Psychosocial skills. ✓ Social support skills. ✓ Current psychological, education, vocational and other functional needs and/or limitations. ✓ Medical needs, as reported. ✓ Self-control and symptom management. ✓ The signature of a licensed mental health professional.
Within **30 days** of admission:	A **comprehensive individual mental health evaluation** signed by a licensed mental health professional upon completion.

RUHS-BH highly encourages using a standard domain-based format for assessments. See Section 4 Assessment and Diagnosis for more information on Assessment Domains.

The requirement and guidelines related to maintaining a Problem List also applies to MHRC. Please refer to Section 6 for more information.

Individual Service Plan

The written **Individual Service Plan** is required to be prepared within 30 days following admission by the program director or a staff member who is a licensed mental health professional, and it will include, but not be limited to, the following:

- ✓ Statement of specific treatment/rehabilitation needs and goals
- ✓ Measurable objectives with time frames, which should be reviewed monthly
- ✓ Staff and consumer's responsibilities achievement of objectives

- ✓ Anticipated length of stay needed to accomplish identified goals
- ✓ Methods to evaluate the achievement of these goals

The service plan will be approved by the program director or a licensed mental health professional and signed by the consumer.

Consumers should be involved in an ongoing review of progress towards goal attainment and in the planning and evaluation of their treatment/rehabilitation goals. In addition to documenting that objectives were reviewed monthly, there will be a review and updating of the individual service plan as necessary but at least quarterly, and more often if there is a change in the consumer's condition.

Documentation of the quarterly review will include:

- ✓ A reevaluation which will be a summary of the progress of the consumer in the rehabilitation program.
- ✓ The appropriateness of identified needs, consumer goals and objectives, and the success of the plan.
- ✓ That the consumer was present at the quarterly review, and if agreed to by the consumer, family members and other involved individuals.

Placement Review

At least every four months, the MHRC in conjunction with the RUHS-BH designee will reassess each consumer to determine the need for continued placement of the consumer in the mental health rehabilitation center.

Progress Note Requirements

A **weekly progress note** in the form of a general review of weekly progress written by staff providing rehabilitation services to the consumer is required. Progress notes

should clearly provide information regarding the type of services being provided, the consumer's level of involvement in treatment activities, and progress towards goals.

At least quarterly, and more frequently if needed, there should be one progress note specific to the leisure and activity needs of the consumer.

Each note should have the signature of the person providing the service (or electronic equivalent) and professional degree/licensure/job title.

Restraint and Seclusion

Restraint and seclusion shall not be used except when necessary to prevent immediate injury to the consumer or others, and only when there is no less restrictive method to prevent injurious behavior. Documentation must conform to requirements set forth by CCR, Title 9 Sections 784.36 and 784.38 and be readily available for review upon request.

Transfers and Discharge

If a consumer is **transferred** to another facility or setting, staff are required to document the following in the consumer record:

- Date and time
- Written statement of the reason for the transfer
- Condition of the consumer
- Informed written or telephone acknowledgment of the transfer by the consumer or legal representative (except in an emergency)

Prior to discharge, there will be a written **discharge summary** prepared by the staff, including the following:

- An outline of services provided
- Reason and plan for discharge
- Goals accomplished
- Referral follow-up plans

A **written aftercare plan** should be documented and provided to the consumer upon discharge.

MHRC Service Codes

Mental Health Rehabilitation Center

Description

This is a 24-hour program, licensed by the State Department of Mental Health, which provides intensive support and rehabilitation services designed to assist persons 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning.

SERVICE CODES
BILLABLE:
152
NON-BILLABLE:
236NB*
**Bed hold*

SCOPE OF PRACTICE: Multidisciplinary Team

SECTION 14: APPENDICES

APPENDIX A: SUMMARY OF SERVICE CODES

SERVICE TYPE	CODE	SCOPE OF PRACTICE
DIRECT SERVICES		
ASSESSMENT		
Assessment (15 minutes)	**90791CA***	• Psychiatrist • Psychologist-Licensed/ Waivered/Intern • Clinician-Licensed/Registered/ Waivered • Registered Nurse • Professional Student Intern
Assessment-Katie A (15 minutes)	**90791KTACA*+**	
***Note:** *Over 15 minutes, staff will use 'add-on' code G2212 for additional time.* **+**PSI unable to conduct assessments for Pathways to Wellness consumers.*		
PSYCHOLOGICAL TESTING		
Psychological Evaluation	**96130**	• Psychiatrist • Psychologist-Licensed/ Waivered/Intern
Test Administration Scoring	**96136**	
THERAPY		
Individual 16-37 Minutes	**90832CA**	• Psychiatrist • Psychologist-Licensed/ Waivered/Intern • Clinician-Licensed/Registered/ Waivered • Registered Nurse • Professional Student Intern
Individual 38-52 Minutes	**90834CA**	
Individual 53-60 Minutes	**90837CA***	
Client & Family 26-50 minutes	**90847CA***	
***Notes:** *For Individual therapy over 60 minutes or Client and Family therapy over 50 minutes staff will use 'add on' code G22212 for additional time.*		
CRISIS SERVICES		
Crisis (minimum 15 minutes)	**90839CA**	• All Staff within Scope except Certified and Non-Certified Peers
CASE MANAGEMENT		
Brokerage	**520**	• All Staff except Certified Peers
Family Brokerage	**590**	
MENTAL HEALTH SERVICES		
Mental Health Services	**360**	• All Staff except Certified Peers
GROUP MH SERVICE		
Skill-Building/Parent Group	**363**	• All Staff except Certified Peers
CERTIFIED PEER SERVICES		
Certified Peer MH Therapeutic Activity	**621**	• Certified Peers
Certified Peer ICC Therapeutic Activity	**621ICC**	
Certified Peer IHBS Therapeutic Activity	**621IHBS**	
Certified Peer MH Engagement	**622**	
Certified Peer ICC Engagement	**622ICC**	
Certified Peer MH Education Groups	**623**	
Certified Peer MH Education Co-Staff Groups	**623C**	

SERVICE TYPE	CODE	SCOPE OF PRACTICE
KATIE A./ICC SERVICES		
Case Management	**520ICC**	• All Staff except Certified Peers
Case Management Family	**590ICC**	
Service Plan Review	**530ICCR**	
KATIE A./IHBS SERVICES		
Intensive Home-Based Services	**360IHBS**	• All Staff except Certified Peers
MEDICATION SERVICES (PRESCRIBERS)		
ASSESSMENT - E&M		
New Patient 15-29 Minutes	**99202CA**	• Psychiatrist • Physician Assistant • Nurse Practitioner
New Patient 30-44 Minutes	**99203CA**	
New Patient 45-59 Minutes	**99204CA**	
New Patient 60-74 Minutes	**99205CA***	
Established Patient 10-19 Minutes	**99212CA**	
Established Patient 20-29 Minutes	**99213CA**	
Established Patient 30-39 Minutes	**99214CA**	
Established Patient 40-54 Minutes	**99215CA***	
Note: **For assessment with new patient over 74 minutes or assessment with established patient over 54 minutes staff will use 'add on' code G2212 for additional time.*		
MEDICATION SERVICES (MD)		
Established Patient 10-19 Minutes	**99212MD**	• Psychiatrist • Physician Assistant • Nurse Practitioner
Established Patient 20-29 Minutes	**99213MD**	
Established Patient 30-39 Minutes	**99214MD**	
Established Patient 40 minutes and above (no add on code needed)	**99215MD**	
NON-FACE-TO-FACE		
Established Patient (All durations)	**99215NF**	• Psychiatrist • Physician Assistant • Nurse Practitioner
MEDICATION SERVICES (NURSES)		
MEDICATION THERAPY		
Established Patient (All durations)	**99215MT**	• Registered Nurse • Licensed Vocational Nurse • Psych Tech
NON-FACE-TO-FACE		
Established Patient (All durations)	**99215NF**	• Registered Nurse • Licensed Vocational Nurse • Psych Tech

APPENDIX B: SERVICE LOCATION CODES

CODE	LOCATION	DESCRIPTION
1	Office	Services are provided in a location, other than a hospital, skilled nursing facility, correctional facility, public health clinic or facility supplying residential care, where the mental health professional routinely provides assessments, diagnosis, and mental health treatment on an ambulatory basis. This place of service/site location code is applicable for all services rendered in the clinic site. Medicare services can only be billed using the 'Office' location.
2	Field	Services are provided in an unspecified location away from the clinician's usual place of business, except for Correctional Institutions, Inpatient, or Residential Care for adults and children.
3	Phone	Services are provided by telephone contact with the consumer, not involving video conferencing.
4	Home	Services are provided at a location, other than a hospital or other facility, where the consumer receives care in a private residence.
5	School	Services are provided in any facility that has the primary purpose of education.
6	Satellite	Services are rendered at a clinic's satellite site.
7	Crisis Field	N/A
8	Correctional Facility	Services are provided in a correctional facility, including adult or juvenile detention facilities.
9	Inpatient/ IMD/MHRC/PHF/SNF	Services are provided in a facility that primarily provides diagnostic, therapeutic, and rehabilitative services. Includes hospitals, Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs), Psychiatric Health Facilities (PHFs), and Skilled Nursing Facilities (SNFs).
10	Homeless/ Emergency	Services are provided in a facility specifically designed to provide shelter to the general homeless population.
11	Faith Based +	Services are provided in a location owned or leased by a faith group.
12	Health Care/ Primary Care ++	Services are provided by the consumer's primary care or general health care provider, or in the clinic or facility of a health care provider, including emergency room and public health clinics.
13	Age-Specific Community Center +	Services are provided in a location owned or leased by an age-specific community center, such as a senior center, or a teen drop-in center.

+ Field Use Only
++ Office Based Service Only
+++ Video Conference Only

CODE	LOCATION	DESCRIPTION
14	**Consumer's Job Site +**	Services are provided at the consumer's site of employment.
15	**Licensed Care-Adults +**	Services are provided in a location supplying 24-hour non-medical care for adults, not including inpatient hospital, Psychiatric Health Facilities, (PHFs), Skilled Nursing Facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs), or homeless/emergency shelters.
16	**Mobile Unit +**	Services are provided consistent with the concept of a Mobile Clinic. Mobile clinics provide services to individuals in rural or outlying areas where services are otherwise inaccessible. The concept of mobile services is in contract to services provided at other community locations that are reached by vehicle.
17	**Non-Traditional Service Location +**	Services are provided in the community, but not a school, faith-based location, homeless/emergency shelter, health-care center, or the consumer's job site. Examples include a community mental health center, a park bench, on the street, under a bridge, in an abandoned building, etc.
18	**Urgent Care**	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
19	**Residential Care-Children +**	Services are provided in a location supplying 24-hour non-medical care for children, other than inpatient hospital, or Psychiatric Health Facility (PHFs). Includes Community Treatment Facilities (CTFs) and family foster homes.
20	**Telehealth at Client Home +++**	Services are provided so that the clinician can meet via video or web camera while consumer is at home. Also known as "Telemedicine".
21	**Juvenile Hall-Awaiting Placement**	Services are provided in a Juvenile Detention Facility. The minor is on a "Placement Order" from the court and is waiting for a placement opening.
29	**Telehealth Not at Client Home+++**	Services are provided so that the clinician can meet via video or web camera while consumer is out in the field. Also known as "Telemedicine".

+ Field Use Only
++ Office Based Service Only
+++ Video Conference Only

APPENDIX C: Z55-65 SOCIAL DETERMINANTS OF HEALTH CODES

NOTE: *Codes subject to change per ICD-10 updates.*

CATEGORY	Z CODE	
Problems Related to Education and Literacy	Z55.0	Illiteracy and low-literacy level
	Z55.1	Schooling unavailable and unattainable
	Z55.2	Failed school examinations
	Z55.3	Underachievement in school
	Z55.4	Educational maladjustment and discord with teacher and classmates
	Z55.5	Less than a high school diploma
	Z55.6	Problem related to health literacy
	Z55.8	Other problems related to education and literacy
	Z55.9	Problems related to education and literacy, unspecified
Problems Related to Employment and Unemployment	Z56.0	Unemployment, unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
	Z56.3	Stressful work schedule
	Z56.4	Discord with boss and workmates
	Z55.5	Uncongenial work environment
	Z56.6	Other physical and mental strain related to work
	Z56.81	Sexual harassment on the job
	Z56.82	Military deployment status
	Z56.89	Other problems related to employment
	Z56.9	Unspecified problems related to employment
Occupational Exposure to Risk Factors	Z57.0	Occupational exposure to noise
	Z57.1	Occupational exposure to radiation
	Z57.2	Occupational exposure to dust
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
	Z57.4	Occupational exposure to toxic agents in agriculture
	Z57.5	Occupational exposure to toxic agents in other industries
	Z57.6	Occupational exposure to extreme temperature
	Z57.7	Occupational exposure to vibration
	Z57.8	Occupational exposure to other risk factors
	Z57.9	Occupational exposure to unspecified risk factor
Problems Related to Physical Environment	Z58.6	Inadequate drinking-water supply
	Z58.81	Basic services unavailable in physical environment
	Z58.89	Other problems related to physical environment

CATEGORY	Z CODE	
Problems Related to Housing and Economic Circumstances	Z59.00	Homelessness unspecified
	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
	Z59.10	Inadequate housing, unspecified
	Z59.11	Inadequate housing, environmental temperature
	Z59.12	Inadequate housing, Utilities
	Z59.19	Other inadequate housing
	Z59.2	Discord with neighbors, lodgers and landlord
	Z59.3	Problems related to living in residential institution
	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.811	Housing instability, housed, with risk of homelessness
	Z59.812	Housing instability, housed, homelessness in the past 12 months
	Z59.819	Housing instability, housed, unspecified
	Z59.82	Transportation insecurity
	Z59.86	Financial Insecurity
	Z59.87	Housing instability, material hardship due to limited financial resources, not elsewhere classified
	Z59.89	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems Related to Social Environment	Z60.0	Problems of adjustment to life-cycle transitions
	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty
	Z60.4	Social exclusion and rejection
	Z60.5	Target of (perceived) adverse discrimination and persecution
	Z60.8	Other problems related to social environment
	Z60.9	Problem related to social environment, unspecified
Problems Related to Upbringing	Z62.0	Inadequate parental supervision and control
	Z62.1	Parental overprotection
	Z62.21	Upbringing away from parents, child in welfare custody
	Z62.22	Upbringing away from parents, institutional upbringing
	Z62.23	Upbringing away from parents, child in custody of non-parental relative
	Z62.24	Upbringing away from parents, child in custody of non-relative guardian
	Z62.29	Other upbringing away from parents
	Z62.3	Hostility towards and scapegoating of child
	Z62.6	Inappropriate (excessive) parental pressure
	Z62.810	Personal history of physical and sexual abuse in childhood

CATEGORY	Z CODE	
Problems Related to Upbringing (Continued)	Z62.811	Personal history of psychological abuse in childhood
	Z62.812	Personal history of neglect in childhood
	Z62.813	Personal history of forced labor or sexual exploitation in childhood
	Z62.814	Personal history of child financial abuse
	Z62.815	Personal history of intimate partner abuse in childhood
	Z62.819	Personal history of unspecified abuse in childhood
	Z62.820	Parent-biological child conflict
	Z62.821	Parent-adopted child conflict
	Z62.822	Parent-foster child conflict
	Z62.823	Parent-step child conflict
	Z62.831	Non-parental relative-child conflict
	Z62.832	Non-relative guardian-child conflict
	Z62.833	Group home staff-child conflict
	Z62.890	Parent-child estrangement NEC
	Z62.891	Sibling rivalry
	Z62.892	Runaway (from current living environment)
	Z62.898	Other specified problems related to upbringing
	Z62.9	Problem related to upbringing, unspecified
Other Problems Related to Primary Support Group, Including Family Circumstances	Z63.0	Problems in relationship with spouse or partner
	Z63.1	Problems in relationship with in-laws
	Z63.31	Absence of family member due to military employment
	Z63.32	Other absence of a family member
	Z63.4	Disappearance and death of a family member
	Z63.5	Disruption of family by separation and divorce
	Z63.6	Dependent relative needing care at home
	Z63.71	Stress on family due to return of family member from military deployment
	Z63.72	Alcoholism and drug addiction in family
	Z63.79	Other stressful life events affecting family and household
	Z63.8	Other specified problems related to primary support group
	Z63.9	Problem related to primary support group, unspecified
Problems Related to Certain Psychosocial Circumstances	Z64.0	Problems related to unwanted pregnancy
	Z64.1	Problems related to multiparity
	Z64.4	Discord with counselors

CATEGORY	Z CODE	
Problems Related to Other Psychosocial Circumstances	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances
	Z65.4	Victims of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities
	Z65.8	Other specified problems related to psychosocial circumstances
	Z65.9	Problem related to unspecified psychosocial circumstances

APPENDIX D: APPROVED ACRONYMS

Numbers	
3M	3 Month Quarterly Assessment
A	
AB 1299	Assembly Bill 1299 (re: Presumptive transfer)
AB 2627	Assembly Bill 2627 (re: IEP mental health services)
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assessment and Consultation Team
ADA	Americans with Disabilities Act
AIU	Adolescent Inpatient Unit
AMFT	Associate Marriage & Family Therapist (registered with BBS)
AOD	Alcohol and Other Drugs
AOT	Assisted Outpatient Treatment (aka Laura's Law)
APCC	Associate Professional Clinical Counselor (registered with BBS)
APS	Adult Protective Services
ART	Adult Residential Treatment/Aggression Replacement Therapy
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Organization
ASOC	Adult System of Care
ACSW	Associate Clinical Social Work (registered with BBS)
B	
B&C	Board and Care
BBS	Board of Behavioral Sciences
BHC	Behavioral Health Commission
BMH	Banning Mental Health
BOS	Board of Supervisors
BRRIIM	Brief Risk Reduction Interview & Intervention Model
C	
CalAIM	California Advancing and Innovating Medi-Cal
CalMHSA	California Mental Health Services Authority
CalOMS	California Outcomes Measurement System
CalWorks	California Work Opportunity and Responsibility to Kids
CANS	Child and Adolescent Needs and Strengths
CAP	Corrective Action Plan
CARES	Community Access, Referral, Evaluation and Support
CASA	Court Appointed Special Advocates
CAST	Children's Authorization Services Team
CATT	Community Assessment Transportation Team
CBAT	Community Behavioral Assessment Team
CBCL	Child Behavior Checklist Outcome Measure
CBDC	Cois M. Byrd Detention Center
CBHDA	California Behavioral Health Directors Association

CBT	Cognitive Behavioral Therapy
CCL	Community Care Licensing
CCP	Client Care Plan, Consumer Care Plan, or Cultural Competency Plan
CCR	California Code of Regulations or Continuum of Care Reform
CDC	U.S. Centers for Disease Control and Prevention
CDL	California Driver's License
CFR	Code of Federal Regulations
CFT	Child and Family Team
CFTM	Child and Family Team Meeting
CHC	Community Health Center
CIHBS	California Institute for Behavioral Health Solutions
CMS	Centers for Medicare and Medicaid Services
CMT	Contract Monitoring Team
COS	Crisis Outpatient Services
CPS	Child Protective Services
CPSS	Consumer Peer Support Services
CRT	Crisis Residential Treatment
CSD	Children's Services Division
CSEC	Commercial Sexual Exploitation of Children
CSI	Client Service Information
CSOC	Children's System of Care
CSSOC	Crisis Support System of Care
CSSR-S	Columbia Suicide Severity Rating Scale
CSU	Crisis Stabilization Unit
CTS	Children's Treatment Services
CURES	Controlled Substance Utilization Review and Evaluation System
D	
DAS	Drug, Alcohol Services
DATAR	Drug and Alcohol Treatment Access Report
DD	Developmentally Disabled or Delayed
DHCS	Department of Health Care Services
DJJ	Department of Juvenile Justice
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal-Organized Delivery System
DMH	Department of Mental Health
DPSS	Department of Public Social Services
DRC	Day Reporting Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
E	
EAP	Employee Assistance Program
EAS	Employee Assistance Services
EBP	Evidence Based Practice
ECM	Enhanced Case Management
ED	Emergency Department
EFC	Extended Foster Care
EHR	Electronic Health Record

ELMR	Electronic Management of Records
EMS	Emergency Medical Services
EQRO	External Quality Review Organization
ER	Emergency Room
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ETS	Emergency Treatment Services
F	
FAP	Family Advocate Program
FAPE	Free and Appropriate Public Education
FFA	Foster Family Agency
FFP	Federal Financial Participation
FFS	Fee for Service
FNL	Friday Night Live
FQHC	Federally Qualified Health Center
FSA	Family Services Association
FSP	Full Service Partnership
FTM	Family Team Meeting
G	
GA	General Assistance
GIFT	Graduate Internship, Field, and Traineeship Program
H	
HCFA	Health Care Finance Agency
HHOPE	Homeless Housing Opportunities, Partnership & Education Program
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HUD	Housing and Urban Development
I	
IA	Interagency Agreement
ICC	Intensive Care Coordination
ICD	International Classification for Disease
ICF	Intermediate Care Facility
ICPM	Integrated Core Practice Model
ICT	Intercounty Transfer
IDC	Intensive Day Care
IDT	Intensive Day Treatment
IDP	Impaired Driver Program
IEHP	Inland Empire Health Plan
IHBS	Intensive Home-Based Services
IHSS	In-Home Supportive Services
ILOS	In Lieu of Services
ILS	Independent Living Skills
IMD	Institute of Mental Disease
INMH	Indio Mental Health Services
IOT	Intensive Outpatient Treatment
IP	Implementation Plan
ISF	Interagency Services for Families

ISFC	Intensive Services Foster Care
ISP	Individualized Service Plan
ISRC	Integrated Services Recovery Center
ITF	Inpatient Treatment Facility
ITFC	Intensive Therapeutic Foster Care
J	
JBDC	John J. Benoit Detention Center
JH	Juvenile Hall
JOT	Justice Outreach Team
JWC	Jefferson Wellness Center
K	
KET	Key Event Tracking
L	
LCSW	Licensed Clinical Social Worker
LEP	Limited English Proficient
LGBT	Lesbian, Gay, Bisexual, and Transgendered
LGBTQI	Lesbian, Gay, Bisexual, Transgendered, Questioning, Intersexed
LMFT	Licensed Marriage & Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPCC	Licensed Professional Clinical Counselor
LPHA	Licensed Practitioner of the Healing Arts
LPS	Lanterman-Petris-Short
LTC	Long Term Care
LVN	Licensed Vocational Nurse
M	
MAP	Misdemeanor Alternative Placement
MAT	Medication Assisted Treatment
MCE	Medical Care Evaluation
MCMCP	Medi-Cal Managed Care Plan
MCMT	Mobile Crisis Management Team
MCP	Managed Care Plan
MCPSSC	Medi-Cal Peer Support Specialist Certification
MCRT	Mobile Crisis Response Team
MDFT	Multi-Dimensional Family Therapy
MEDS	Medi-Cal Eligibility Determination System
MHC	Mental Health Court
MHP	Mental Health Plan
MHRC	Mental Health Rehabilitation Center
MHS	Mental Health Services
MHSA	Mental Health Services Act (aka Proposition 63)
MHUC	Mental Health Urgent Care
MOU	Memorandum of Understanding
MVCHIPS	Moreno Valley Children's Interagency Program
MSW	Masters of Social Work (not registered with the BBS)
N	

NAMI	National Alliance for the Mentally Ill
NOABD	Notice of Adverse Beneficiary Determination (formerly NOA – Notice of Action)
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Notice of Privacy Practices
NPS	Non-Public School
NTP	Narcotic Treatment Program
O	
OA	Older Adults
OAS	Older Adult Services
ODS	Organized Delivery System
OHC	Other Health Coverage
OIG	Office of Inspector General
OP	Outpatient Program
OT	Occupational Therapy or Outpatient Therapy
OTP	Opioid Treatment Program
P	
P&P	Policy and Procedures
PAF	Partnership Assessment Form
PAIR	Pets Assisting In Recovery
PAP	Patient Assistance Program
PCIT	Parent Child Interaction Therapy
PCN	Position Control Number
PCP	Primary Care Physician
PEI	Prevention and Early Intervention
PFI	Payer Financial Information
PG	Public Guardian
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Plan (for an individual) or Performance Improvement Project (for the department)
PL	Problem List
PN	Progress Note
PO	Purchase Order
POC	Plan of Care, Person of Color, or Plan of Correction
PSI	Professional Student Intern
PSRSC	Peer Support and Resource Service Center
PSS	Peer Support Specialist, Peer Support Partner, or Parent Support Partner
PSTP	Parent Support & Training Program
PU	Parents United
Q	
QI	Quality Improvement or Qualified Individual
QIC	Quality Improvement Committee
R	

R&B	Room and Board
RCF	Residential Care Facility
RCOE	Riverside County Office of Education
RLC	Recovery Learning Center
ROCKY	Resilient Outcomes in the Community for Kids and Youth
ROI	Release of Information
RPD	Riverside Police Department
RPDC	Robert Presley Detention Center
RSO	Riverside Sheriff's Office
RU	Reporting Unit
RUHS-BH	Riverside University Health System – Behavioral Health
S	
SA	Substance Abuse
SABG	Substance Abuse and Prevention Treatment Block Grant
SAPT	Substance Abuse Prevention and Treatment
SCAR	Suspected Child Abuse Report
SCF	Smith Correctional Facility
SD/MC	Short-Doyle/Medi-Cal
SDC	Special Day Class
SDOH	Social Determinants of Health
SED	Seriously/Severely Emotionally Disturbed
SMART	Specialty Multidisciplinary Aggressive Response Team
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SNF	Skilled Nursing Facility
SNOMED	Systematized Nomenclature of Medicine
SOC	System of Care
SOGIE	Sexual Orientation and Gender Identity Expression
SpEd	Special Education
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Social Security Insurance
SSP	Social Services Planner (formerly County Social Worker)
START	Substance Use Treatment and Recovery Team
STC	Special Terms & Conditions
STD	Short Term Disability
STRTP	Short Term Residential Treatment Program
SUD	Substance Use Disorder
T	
TANF	Temporary Assistance for Needy Families
TAR	Treatment Authorization Request
TAY	Transitional Age Youth
TBS	Therapeutic Behavioral Services
TCIT	Teacher-Child Interaction Training
TCM	Targeted Case Management
TCon	Temporary Conservatorship

TDD	Telecommunications Device for the Deaf
TDM	Team Decision Making
TFC	Therapeutic Foster Care
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
TOPSS	Transforming Our Partnerships for Students Success
TRAC	Therapeutic & Residential Assessment & Consultation (Team)
U	
UM	Utilization Management
UMDAP	Universal Method for Determining Ability to Pay
UR	Utilization Review
URC	Utilization Review Committee
V	
VA	Veteran's Administration
W	
WA	Wraparound
WET	Workforce Education & Training
WM	Withdrawal Management
WPC	Whole Person Care
WRAP	Wellness Recovery Action Plan or Wraparound Program
Y-Z	
YHIP	Youth Hospital Intervention Program
YOC	Youth Opportunity Center
YTEC	Youth Treatment and Education Center

APPENDIX E: APPROVED ABBREVIATIONS

Revised abbreviations approved for use in RUHS-BH Clinical Records.

Numbers	
1:1	One-on-one meeting with person
24/7	24 hours a day/7 days a week
5150	Involuntary hospitalization
5250	Involuntary hospitalization (14-day hold)
5270	Involuntary hospitalization (30-day hold)
5585	Involuntary hold of a child
A	
a.c.	Before meals (*ante cibum*)
AA	Alcoholics Anonymous or African-American*
Abd	Abdominal
ADL	Activities of daily living
AEB	As evidenced by
AH	Auditory hallucinations
AI/AN	American Indian/Native American*
AIMS	Assessment of Involuntary Movement Scale
AKA	Also known as
AMA	Against medical advice
Amb	Ambulatory
AOx3/AOx4	Alert and oriented to person, place, time (and situation)
API or AAPI	Asian/Pacific Islander* or Asian American and Pacific Islander*
Appt	Appointment
ASAM	American Society of Addiction Medicine
ASAP	As soon as possible
ASL	American Sign Language
Avg	Average
AWOL	Away without leave/Absent Without Official Leave
B	
B&C	Board and care
b.i.d.	Twice daily (*bis in die*)
b/c	Because
BCG	Bacille Calmette-Guerin
Benzos	Benzodiazepines
BHS	Behavioral Health Specialist
BHSS	Behavioral Health Services Supervisor
BIB	Brought in by
BIPOC	Black, Indigenous, and People of Color
Blk	Black*
BP	Blood pressure
Bx	Behavior
C	

c.u.	Chronic undifferentiated
Clt	Client
cm	Centimeters
Cont	Continued
CT	Clinical Therapist
Cx	Canceled, cancel
D	
d/c	Discontinued, Discharged
DD	Developmentally Disabled or Delayed
Do, d/o	Disorder
DOB	Date of birth
DOC	Drug of choice
DT, DTs	Delirium tremens ("the shakes" from alcohol withdrawal)
DTO	Danger to others
DTS	Danger to self
DUI	Driving under the influence
DV	Domestic Violence
Dx	Diagnosis
E	
e.g.	For example
ECT	Electro Convulsive Therapy
ED	Eating Disorder
EH	Emergency Housing
EPS	Extra pyramidal symptoms
ETOH	Alcohol
F	
F	Female
f/u	Follow Up
FA	Family Advocate
Fil	Filipino*
FOI	Flight of ideas
FOO	Family of origin
Fr	From
G	
GD	Gravely disabled, Grave disability
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GMC	General medical condition
Grp	Group
GU	Genitourinary
H	
h.s.	Bedtime (hour of sleep)
H/I, HI	Homicidal Ideation
h/o	History of
HBV	Hepatitis B virus
HepB	Hepatitis B

Hisp	Hispanic*
HPI	History of present illness
hr	Hour
ht	Height
HTN	Hypertension
Hx	History
I	
i.e.	That is
ILS	Independent Living Skills
IM	Intramuscular
IPV	Intimate partner violence
IV	Intravenous
IVDU	Intravenous drug use
J	
(none)	
L	
L	Left
lb	Pound
LD	Left deltoid
LLQ	Left lower quadrant
LOA	Looseness of association
LOS	Length of stay
LPS	Lanterman-Petris-Short
LSD	Lysergic Acid Diethylamide
LUOQ	Left upper outer quadrant
LUQ	Left upper quadrant
M	
M	Male
MAR	Medication administration record
Max	Maximum
MD	Medical Doctor
MDMA	Methylenedioxymethamphetamine (Ecstasy)
Med	Medical
Med eval	Medical evaluation
Meds	Medication
Meth	Methamphetamine
mg	Milligram
MH	Mental health
Min	Minimum
ml	Milliliters
MOU	Memorandum of Understanding
MSE	Mental Status Examination
N	
N/A	Not applicable
N/C	No call
N/S	No show

NFP	Not following plan
NKA	No known allergies
NKDA	No known drug allergies
noc	Nocturnal, night
norm	Normal
NOS	Not otherwise specified
NSSI	Non-suicidal self-injury
O	
OA	Office Assistant
OD	Overdose
OH	Olfactory hallucinations
Ox3/Ox4	Oriented to person, place, time/ and situation
oz	Ounce
P	
p.o.	By mouth (*per os*)
p.r.n.	As needed (*pro re nata*)
PCP	Primary care physician
PHN	Public Health Nurse
PO	Probation Officer (aka DPO)
PP	Parent Partner
PPD	Purified Protein Derivative for Tuberculosis Test
preg	Pregnant, pregnancy
PSC	Personal Service Coordinator
PSS	Peer Support Specialist
Psych eval	Psychiatric evaluation
pt	Patient
Q	
q	Every (*quaque*), each
q.h.s.	Every bedtime (*quaque hora somni*)
q.i.d.	Four times a day (*quater in die*)
R	
R	Right
R/O	Rule-out
RD	Right deltoid
re	Regarding or about
Rehab	Rehabilitation
RLQ	Right lower quadrant
ROI	Release of information
RTC	Return to clinic
RTIS	Responding to internal stimuli
RUOQ	Right upper outer quadrant
RUQ	Right upper quadrant
Rx	Medical prescription
S	
S/A	Substance abuse or suicide attempt
S/I	Suicidal ideation

S/P	Status post
SFA	Senior Family Advocate
SIB	Self-injurious behavior
SPP	Senior Parent Partner
SPSS	Senior Peer Support Specialist
stat	Immediately
STI	Sexually transmitted infection
SUD	Substance use disorder
Sx	Symptoms
T	
t.i.d.	Three times a day (*ter in die*)
T/C	Telephone call
TB	Tuberculosis
TBI	Traumatic brain injury
TCon	Temporary conservatorship
TD	Tardive dyskinesia
TH	Tactile hallucinations
THC	Tetrahydrocannabinol (marijuana/cannabis)
TX	Treatment
U	
UA	Urinalysis
UDS	Urine drug screen
URI	Upper respiratory infection
UTI	Urinary tract infection or under the influence
V	
VH	Visual hallucinations
VM	Voicemail, voice message
Vol	Voluntary
W	
w/	With
w/i	Within
w/o	Without
Wht	White*
WNL	Within normal limits
wt	Weight
Y-Z	
x	times (example: 3x a day)
yo	Years old
yr	Year
MDFT Specific	
Adol D	Adolescent domain
Bar T Tx	Barrier to treatment
C&P	Compliment & praise
CSU	Create a sense of urgency
E&S	Encouragement & support
ECS	Enhance communication skills

EFLC	Enhance feelings of love & commitment
ETF	Express thoughts and feelings
Fac C	Facilitate change
Fac D	Facilitate discussion
Fac SE	Facilitate self-examination
Fac SR	Facilitate self-reflection
Fam D	Family domain
Mon Att	Monitor attendance
Mon Bx	Monitor behavior
OHPP	Out of home probation placement
PaD	Parent domain
PRI	Parental Reconnection Intervention
Pro SA	Pro-social activities
PSS	Problem solving skills
Sel E	Self evaluation
Stg 1	Stage 1
Stg 2	Stage 2
Stg 3	Stage 3
Stg 4	Stage 4
ThA	Therapeutic alliance
WIT	Whatever it takes
YAM	You are the medicine
PCIT Specific	
BE DIRECT	**B**e specific with commands **E**very command positively stated **D**evelopmentally appropriate **I**ndividual rather than compound **R**espectful and polite **E**ssential commands only **C**hoices when appropriate **T**one of voice is neutral
BD	Behavioral Descriptions
CBCL	Child Behavior Checklist Outcome Measure
CDI	Child Directed Interaction/The 1st Phase of PCIT/Relationship Enhancement
DC	Difficult Child Indicator
DECA	Devereux Early Childhood Assessment Outcome Measure
DPICS	Dyadic Parent-Child Interaction Coding System
ECBI	Eyberg Child Behavior Inventory Outcome Measure
ID	Informational Descriptions
LP	Labeled Praise
Mastery Criteria	(DPICS July 2009) LP = 10 BD = 10 R – 10 QCC = 3 or less
PCIT	Parent Child Interaction Therapy
PDI	Parent Directed Interaction/ The 2nd Phase of PCIT/Discipline Strategies

PRIDE	Praise, Reflection, Imitation, Description, Enthusiasm
PSI	Parent Stress Index Outcome Measure
R	Reflections
QCC	Questions, Commands and Critical Statements
UP	Unlabeled Praise
5/2/5	Time out sequence
5/5/5	Fifteen minute behavioral observation conducted at pre, mid, and post treatment

*Abbreviations for race recognized by State Department and other public agencies

APPENDIX F: REVISION LOG

Revision Date	Change Description	Page #