Monterey County Behavioral Health Specialty Mental Health Services Documentation Manual

Summer 2024

A guide for serving people in care in accordance with our core values, while adhering to regulatory requirements and documentation standards.

Dedication and Acknowledgement

This guide is dedicated to the people who work one day at a time to guide others on the path to recovery. Together, recovery is possible.

We would also like to acknowledge the following staff who drafted this guide:

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Introduction

Welcome to the Monterey County Behavioral Health System!

Whether you are a county employee, a county contractor, or an employee of a community behavioral health organization contracted with the county, this guide is designed to help you do your job effectively. In the California behavioral health system, as you know, there are many regulations and requirements governing how services are provided to people in care. These regulations provide guidance on eligibility for funding, access to services, integration and coordination of services, billing for services, documentation of services, and much more.

If you are like the vast majority of people who work in our system as service providers, you did not take this job to primarily spend your time worrying about how to follow all these regulations. Your primary mission and values are – and should be – about providing the very best and most helpful services possible to the people in need that come to our door. The goal of this manual is to help you to do just that.

Our goal is to help you be the very best helper you can be, and to do your work in a way that is fully aligned with your values and ours, while at the same time helping you to understand and follow the necessary regulations in a way that supports and reinforces those values to the greatest extent possible.

We know this is a challenge for our whole system. But we believe we are up to the challenge. Please join us in making this a successful journey.

Core Values:

Every person who “comes to our door” in any part of the Monterey County system, is to be regarded as an important customer. We always need to remember the vulnerability experienced by people with behavioral health needs who take the risk of asking for help, of putting their lives in the hands of people like us, who they hardly know, and yet whose ability to provide effective help may mean the difference between happiness and despair, between life and death.

Many of those seeking our services have had bad experiences with behavioral health systems, including our own, in the past, and are especially vulnerable to being retraumatized by our own service system in the future. So whatever we do, whenever we do it, we always remember **people first**, and approach each person and family in

the spirit of the following core values:

- **Welcoming –** We purposefully welcome everyone, especially those who may have the greatest challenges, as priority customers.
- **Hopeful –** Our goal is to have everyone, especially those with the greatest challenges, to be inspired when they meet us with hope for a meaningful happy life (what some people term “recovery”)
- **Person and Family Driven –** Services are always provided in partnership with persons served to help them achieve their most important life goals, even when (especially when) there are safety needs that necessitate services being provided involuntarily. We always strive to work as empowered partners in the context of hopeful relationships.
- **Strength-based –** We recognize that everyone is using enormous strength every day to address each and every one of their challenges and that people are recurrently successful never ‘chronic re-lapsers”.
- **Trauma-informed –** We hold trauma the highest regard for the people we serve and are fully committed to never contributing to re-traumatization at our hands.
- **Cultural Humility –** We recognize that people come to us with their own culture(s), and it is our job to learn from them about how to fit our help within their culture(s), not the other way around.
- **Integrated (Co-occurring Capable) –** We understand that among the people we serve, co-occurring needs (mental health, substance use, physical health, intellectual and social needs) are an expectation, not an exception, so that everything we do is designed to help us provided “integrated care” to the people with complex needs who may have the hardest time making progress.

Monterey County is committed to these values, and we have a responsibility to realize them in all our services. Designing this manual to start with these values is an important step on our journey.

California Advancing and Innovating Medi-Cal

The California Medi-Cal system is undergoing a significant transformation to reform the program in service of improving the quality of life and health outcomes of Medi-Cal members. This person-centered approach, operationalized by the Department of Health Care Services (DHCS), through its California Advancing and Innovating Medi-Cal (CalAIM) initiative, streamlines processes and documentation in order to better address the needs of persons in care while improving access to and coordination among the delivery systems responsible for providing care. Monterey County Behavioral Health (MCBH) aims to provide Monterey County residents with access to equitable, integrated, cost-effective and high-quality behavioral health care.

The intent of this documentation guide is to support the implementation of DHCS guidance concerning care coordination efforts between Monterey County Behavioral Health, Drug Medi-Cal Organized Delivery System (DMC-ODS) and our Managed Care Plan (MCP) services delivery systems (e.g. screening, transition of care and service referrals), and the essential documentation requirements for specialty mental health services for clinical documentation and claims reimbursement.

This documentation manual will cover many relevant topics and concepts that support your work with children, youth, adults, and families. Aligned with CalAIM, readers will note the use of person-centered language, the focus on clinical treatment and a trauma-informed lens as key elements of the manual.

Note that regulations and guidelines may change frequently between the routine updates of this guide. Please be aware that from time-to-time MCBH Quality Improvement may therefore issue updates and/or clarifications to information found in this manual via QI Newsletters, Policy Clarification Memos, MCBH QI website (www.qi.mtyhd.org) and/or other accessible modes of communication. The updates and/or clarifications are official MCBH communications and will be incorporated into this guide as appropriate.

Social Determinants of Health

Health care systems are intended to help people improve or maintain their health and wellness within their community. For this to happen, people need to have the ability to access not just physical health care, but quality behavioral health care, in a way that is responsive to their particular needs and situation, respects their choices and authentically centers their voice.

We know from research that care is not always accessible, available, or responsive in an equitable way. Research further shows that access to and engagement in quality health care is affected by a number of factors, including race, ethnicity, socioeconomic status, and other social determinants. Social determinants of health (SDOH) play a huge part in people's health and wellness. SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Per the CDC,

SDOH are grouped into five domains:

1. **Economic stability (ability to access and maintain food, clothing, shelter, and mobility as well as other basic needs within their community)**
2. **Education (opportunities to learn and build skills)**
3. **Health care access and quality (to prevent and treat illness and injury)**
4. **Neighborhood and built environment (safe, free from pollutants and access to nature)**
5. **Social and community context and connectedness**

SDOH contributes to health disparities and inequities simply by limiting access to fundamental resources aimed at supporting health and wellness. For example, if behavioral health services are offered in one part of town that is difficult to get to, those who live far away or have transportation challenges may not receive the services they need in a timely fashion. Or perhaps the same clinic does not employ direct service staff who speak the language or understand the culture of the person seeking care. This again impacts a person in care's ability to access care that meets their individualized needs. Lastly, we have witnessed the harsh realities of inequities revealed by the COVID-19 pandemic, with stark differences in outcomes including mortality seen along racial/ethnic lines, socioeconomic status, and educational attainment.

Although there are efforts aimed at addressing health disparities, there is still a lot of work to be done. As practitioners, we have a responsibility to look within our organizations and advocate for changes that help reduce or eliminate disparities within

health systems. Through this diligent attention, systems can transform to best meet the needs of the people they are intended to serve. One of the monumental ways that CalAIM supports our systems in addressing health disparities is in the acknowledgement of the impact of trauma on health and wellness. We can streamline access to treatment services, especially for youth, when a substance SUD is suspected but not yet diagnosed, or due to trauma. Details on this access criteria will be addressed later in this material, as it cues practitioners that treatment services can be initiated while assessment is occurring concurrently.

Understanding Medi-Cal Programs

In California, the Department of Health Care Services (DHCS) is the state agency responsible for the administration of the state's Medicaid program. In California, we refer to Medicaid as "Medi-Cal." The Medi-Cal program is a mix of federal and state regulations serving over 13 million people, or 1/3 of all Californians.

Medi-Cal behavioral health services are "carved out", meaning that they are delivered through separate managed care delivery systems, each of which is responsible for delivering different sets of services to individuals depending on their care needs. To keep it simple, we will look at the three managed care plans; Mental Health Plans (MHP) operated by county behavioral health departments, Drug Medi-Cal Plans (DMC or DMC-ODS) administered respectively by the state or the county, and Managed Care Plans (MCP) physical healthcare plans. The MCPs, which are operated by either publicly run or commercial entities, also administer the Non-Specialty Mental Health Services (NSMHS) benefit.

All three plan types discussed here - MHPs, DMC-ODS and MCPs administer and deliver an array of services to Medi-Cal members. Given the complexity of the systems, it can be difficult for individuals seeking services to understand which plan would best treat their behavioral health care needs and where/how to access SMHS, DMC or NSMHS.

Mental Health Plans

Specialty Mental Health Services (SMHS) are managed locally by county Mental Health Plans (MHPs). Monterey County Behavioral Health is Monterey County's MHP. Fifty-six county MHPs are contracted with DHCS to administer the Medi-Cal SMHS benefit. In addition to managing the benefit, MHPs directly deliver and/or contract with Community-Based Organizations (CBOs) or groups/individual providers to deliver an array of services designed to meet the needs of individuals with Medi-Cal who have significant and/or complex care needs. This array includes highly intensive services and programs,

including therapy, community-based services, wraparound, and intensive case management programs. The term “case management” is used at different points since this service type is defined in federal regulations for SMHS. However, it is important to remember that each person in care is not a “case” to be managed, but rather a human being with care needs.

SMHS are provided to persons with mental health conditions that require intervention to support the person’s ability to safely participate in their communities and achieve wellbeing. The Medi-Cal populations served by Monterey County Behavioral Health include low-income individuals across the lifespan. Individuals living at or below federal poverty levels can experience complex psychosocial issues, such as being unhoused, being involved in the child welfare system, being justice-involved, or having experienced trauma, to name a few examples. In short, Monterey County Behavioral Health serve some of the most vulnerable individuals living in our state.

Drug Medi-Cal Organized Delivery System

Monterey County Behavioral Health opted into the Drug Medi-Cal Organized Delivery System (DMC-ODS) in July 2018 and currently contracts all substance use disorder services with Community-Based Organizations. Monterey County Behavioral Health CBOs provide their resident Medi-Cal persons in care with a range of evidence-based SUD treatment services in addition to those available under the Drug Medi-Cal (DMC) program. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care. To receive services through the DMC-ODS, a person must be enrolled in Medi-Cal and meet the criteria for DMC-ODS services.

Managed Care Plans

Monterey County’s Managed Care Plan is Central California Alliance for Health.
Managed Care Plans (MCPs) are responsible for the majority of medical (physical health care) benefits and NSMHS for individuals. The MCPs provide mental health services to those with less significant or complex care needs, and therefore may provide lower frequency/intensity of mental health services. MCPs cover medication evaluation and treatment, group and individual therapy, psychological testing, and long-term skilled nursing services as well as prescription medications, including psychotropic medications.

Compliance Plan

The intent of the Compliance Plan is to clarify responsibilities for actions within MCBH, and to provide standards by which members of the workforce will conduct themselves. The Compliance Plan particularly supports the integrity of all health data submissions, as evidenced by accuracy, reliability, validity, and timeliness. The plan applies to all MCBH staff, volunteers, trainees, and providers working in county owned or operated sites. It is also intended to communicate compliance standards and expectations to all external individual or organizational contracted providers, including SUD providers, and to all other entities providing services on the behalf of Monterey County.

The Compliance Plan outlines the elements of the MCBH Compliance Program that all MCBH staff and contracted providers are required to follow. Details regarding the specific requirements of each element may be found in various policies and procedures that are included within the plan document itself or by reference. The Monterey County Compliance Plan can be found on the QI Website at www.mtyhd.org/qi or by calling our Quality Improvement Office at (831) 755-4545.

The principal statutes impacting our billing and cost claiming practices are the Federal False Claims Act, Civil Money Penalties Act, Federal Managed Care Regulations, HIPAA, the Balanced Budget Act of 1997, and the Medicare/Medicaid Fraud and Abuse and Anti-Kickback Statutes. These include the Stark Amendments related to physician referrals.

By signing the Provider Attestation, the provider is confirming that they have reviewed and understand the Monterey County Behavioral Health Compliance Plan and Code of Conduct and their role in reporting activity/conduct that may be in violation of the Code of Conduct, including, but not limited to:

- Billing or reimbursement regulations; fraudulent transactions
- Conflict of Interest
- Falsification of documents
- Documentation irregularities
- Any limitations or inabilities that affect the provider’s ability to perform any of the position’s essential functions, with or without accommodation
- A history of loss of license or felony conviction
- A history of loss or limitation of privileges or disciplinary activity
- A lack of present illegal drug use
- The application’s accuracy and completeness

Attestation of Compliance Plan

Staff MUST sign the attestation located in the electronic health record, Avatar (search Compliance Attestation), or on paper. Paper copies shall be immediately submitted to MCBH Quality Improvement at 415QI@co.monterey.ca.us. Attestations MUST be renewed at minimum every three years.

Fraud, Waste, and Abuse Defined

Behavioral health care fraud, waste, and abuse affects everyone. So, let's make sure you know what it is, how to spot it, and how to help us prevent it.

What is it exactly?

Well, **fraud** is when someone intentionally lies to a health care benefit program to get money. **Waste** is when someone overuses behavioral health services carelessly. And **abuse** happens when best practices aren't followed, leading to expenses and treatments that aren't needed:

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. §1347).
- **Waste** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Compliance Hotline

Local Contact Number: 831-755-4018 Anonymous Contact Number: 1-866-262-8618
Compliance E-mail: healthcomplianceoffice@co.monterey.ca.us

A compliance hotline is in place for those times when a person prefers not to, or is unable to approach a supervisor, with a question concerning activity or behaviors that may be in violation of Code of Conduct. These may include, but not limited to:

- Billing and reimbursement regulations, fraudulent transactions
- Misuse of federal or state funds
- Person in care confidentiality
- Conflict of interests
- Sharing passwords to access electronic health record
- Misuse of MCBH funded or supported property, facilities, and equipment

Information will remain confidential, and the caller may remain anonymous. All employees of Monterey County Behavioral Health and its contracted providers are expected to abide by, at a minimum, but not limited to the policies and procedures rules outlined in the MCBH Compliance Plan.

Electronic Signature

Monterey County utilizes the Avatar Electronic Health Record system. Each staff member is assigned a unique username and password to access Avatar. The username and password assigned to you should never be shared and should solely be used for business operations necessary to provide care. Staff may claim for services and must be credentialed in accordance with MCBH credentialing policies. Credentialing is important because it ensures compliance standards are met, and the unique user identification is used as the individual's signature equivalent. As such when a staff member submits forms and/or "finalizes" documents in Avatar, this function serves as a legal signature for that individual. All providers using Avatar must adhere to the Monterey County Policies and Procedures pertaining to electronic signature and health record documentation (MCBH Policy 129).

Provider Application and Validation for Enrollment (PAVE)

The Federal Cures Act (42 CFR 438.602(b)) requires states to screen, enroll and periodically re-validate all network providers of managed care organizations, including County Mental Health Plans.

All Specialty Mental Health Services (SMHS) practitioners within specific licensed disciplines must enroll in the DHCS Provider Application and Validation for Enrollment (PAVE) portal. In addition, once enrolled in PAVE, prescribers must register in the Medi-

Cal Rx Provider Web Portal.

The following eligible practitioners must enroll into the PAVE System

- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Professional Clinical Counselors
- Licensed Psychologists
- Nurse Practitioners
- Occupational Therapists
- Medical Doctors and Osteopaths (DO)
- Physician Assistants
- Registered pharmacists, pharmacists
- Speech Therapists

Note: Any discipline not listed above does not need to enroll in PAVE. This includes but is not limited to Psychiatric Technicians, Clinical Nurse Specialists, and Registered Nurses. Students and trainees do not need to enroll in the PAVE System.

Medi-Cal Rx Provider Web Portal

California State Executive Order N-01-2019 states the Medi-Cal pharmacy benefits will now be administered through the fee-for-service delivery system for all Medi-Cal persons in care (generally referred to as “Medi-Cal Rx”). DHCS will utilize the Medi-Cal Rx Provider Web Portal. All prescribers must be enrolled in the Medi-Cal Rx Provider Web Portal to submit prior authorization treatment requests and view prescription history.

The secure Medi-Cal Rx Provider Web Portal includes key functions for providers and prescribers such as:

- Prior authorization information and submittal instructions
- Person In Care eligibility look up
- Prescription history
- Web claims submission, activities, and inquiries

(MCBH QI Memo: Provider Application and Validation for Enrollment)

Utilization Review

Monterey County Behavioral Health conducts an array of performance-monitoring activities throughout our operations. These activities include utilization management and utilization review of the person's health record.

State regulations and MCBH specify that person health records, regardless of format (electronic or print) go through the utilization review (UR) process. The UR process is meant to ensure the following: all planned clinical services are appropriate to address the person's behavioral health needs; comply with all State, Federal and Behavioral Health regulations; and maintain the integrity of the person's health records in accordance with documentation standards.

We have established a Utilization Review process with an aim to review 10% of all Monterey County Behavioral Health records per fiscal year. The Quality Improvement (QI) team oversees the UR processes. The UR process includes licensed staff members from the QI Team. Compensation to the QI Team to conduct utilization management activities does not provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any person. The roles of these reviewers are critical as they provide clinical oversight and function as a "check and balance" system.

SMHS Utilization Review Tools

All QI Reviewers use a SMHS Utilization Review Tool to ensure the following:

- Monitoring and reporting of fraud, waste, and abuse
- Persons receive a quality assessment
- Problem list/treatment plan and services are consistent with documentation requirements and best practices
- Ensure services meet medical necessity standards
  Each of these tools review required elements of a person's chart including admission information, assessment, problem list/treatment planning and progress notes, but is also nuanced to include specific service delivery requirements.

Clinical Supervisory Tool

In the spirit of transparency, the Clinical Supervisory Tool reflects the same areas of focus as the SMHS Utilization Review Tools. The most significant difference between the two review tools is that although the SMHS Utilization Review Tool and Clinical Supervisory tool are used to review assessment, problem lists/treatment plans,

progress notes/ medical necessity and quality of care, the Clinical Supervisory tool allows for the direct supervisor to provide real-time feedback to the supervisee.

Quality Action Plans

Utilizing a SMHS Utilization Review Tool, the QI reviewers organize feedback sessions to provide Utilization review findings to the program leadership through a Quality Action Plan (i.e. supervisor, managers, directors). Program leadership is responsible for reviewing and responding to the action plan items as applicable. Additionally, information from utilization reviews is used to review overall program or system trends when considering performance improvement projects. The QI team takes information from UR findings into consideration when exploring training needs of County and Community Provider staff members.

Additionally, MCBH recognizes the importance in providing information about review findings to staff. Below are some common methods for providing feedback outside of the formal Utilization Review Process:

1) The Supervisor may use the UR Supervisory Tool as part of their administrative supervision by reviewing a chart and providing direct feedback to the staff member as an opportunity for further coaching and support.
2) The Quality Improvement Team may complete a Quality Improvement Action Request--QIAR (MCBH Policy 493) which provides detailed information on identified issues including action steps to address the concerns. The QIAR is usually emailed to the individual staff member and their immediate Supervisor.

Quality Assurance for Community Based Partners

Collaboration between Monterey County Behavioral Health and contracted Community Based Partners is paramount to comply with State or Federal laws and regulations and in accordance with contractual agreements with the Department of Health Care Services (DHCS) and other entities, for the service provision of specialty mental health services and/or substance use disorder treatment services.

It is the responsibility of each contracted Community Based Partner to implement and monitor a quality assurance program to monitor adherence of documentation and service delivery in accordance with State and Federal laws. Each Provider is responsible for monitoring of service delivery monthly. Providers may monitor with more frequency, but no less than monthly. Timeliness of these procedures is necessary to maintain the integrity of the health record as well as avoid disallowances, when applicable.

The contracted Community Based Partner Quality Assurance Manager or designee is responsible for monitoring and reviewing of person records to monitor the integrity of the delivery of services. Monthly, using the electronic health record, Avatar, the contracted Community Based Partner Quality Assurance Manager or designee will run and review the compliance reports from the list provided by our QA team. The list for each Provider is dependent on the contractual agreements. Monterey County Quality Improvement staff will monitor the adherence of monthly submission of the Provider QA Compliance Report.

More details about Quality Assurance for Community Based Partners activities are described in the *Quality Assurance (QA) Compliance Manual for Mental Health and Substance Abuse Disorder Providers* located on the QI website (www.mtyhd.org/qi).

Admission

Monterey County Behavioral Health (MCBH) receives referrals from a variety of resources. Referrals for services may be by self-referral, mental health unit, Community Providers, from other counties, or the larger community. MCBH services are voluntary. All individuals who seek behavioral health services from MCBH are entitled to receive, at minimum, an assessment to determine their need and whether MCBH services might meet those needs or whether a referral is warranted to better serve the individual/family. In order for MCBH to begin the process for determination of the needs of the person who is requesting services, we must first begin with establishing an electronic health record. The intention with establishing a health record for the individual is that it will create a unique record of the individual's request for services, the outcome of the request, as well as provide information on MCBH's responsiveness to the request for services. The initiation of a health record does not, in any way, guarantee the person will receive all or some of their mental health services from MCBH. It means the individual/family has requested mental health services and we are responding to the request.

Access Call Log

There are times when an individual seeking services for themselves or a loved one will contact MCBH for support with accessing information on services. These contacts with individual not receiving care from MCBH should be documented within Avatar. The "Unknown Caller" client account in Avatar may be used to document a request for services (via telephone or in person) by someone who does not already have an open MCBH health record. To access this in Avatar, use the Unknown Caller form (client ID 815864). A clinical progress note using this method shall be entered under "Episode 1" using a nonbillable (330CA) code to document services rendered to the individual. It is not necessary to open a new episode to document the services rendered. The documented notes within the "Unknown Caller" client account may be viewed collectively by running the "765 Call Log Notes" report. The use of the "Unknown Caller" and Call Log reports are permissible for use by Access to Treatment programs, Crisis Team, and to document services provided by the "Officer of the Day" from various programs for individuals who do not already have an open health record in Avatar. Access to Treatment teams shall use "Unknown Caller" client account to document ALL initial requests for service. The Crisis Team member shall use "Unknown Caller" client account to document a telephone call or in-person interaction for an individual who is not currently opened to MCBH services. For programs using "Officer or SW of the Day" functions, use "Unknown Caller" client account to document a telephone call or in-person interaction for an individual who is not currently opened to MCBH services. In

the event the individual already has an open health record with MCBH, all services shall be documented in the open episode.

Opening an Episode

All other programs are expected to open an episode within the program in order to document the services provided. During the assessment period, a program may claim for mental health services in accordance with medical necessity standards and within MCBH policies. In order to begin documentation and claiming for service provided to an individual, the practitioner must first "OPEN" an episode prior to providing services. A program episode is considered opened in AVATAR when the following forms have been completed:

- Admission
- Admission Part 2 (Bundle):
    - Client and Services Information (CSI)
    - Admission Diagnosis AND ICD-10 code set (this must be entered before any billing is submitted)
    - Client Relationships
    - Case Coordinator
    - Onset of Services

All MCBH staff are expected to discuss important issues related to treatment options along with risks and benefits in order to support the individual/family in making an informed decision about their treatment. At the onset of services, the practitioner is expected to discuss and/or provide the following documents to the individual/family:

EVERYONE	**WHEN APPLICABLE**
Informed Consent	Minor Consent
Notice of Privacy Practices	Authorization to Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information-GENERAL (as indicated)
Consumer Rights	Authorization to Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information for Multi-Disciplinary Teams (when applicable)
MCBH Problem Resolution Process	Unlicensed Clinician (when applicable)
Authorization for Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information WITHIN Monterey County	Electronic Communication Consent (when applicable)

Behavioral Health	
Authorization to bill private insurance or Medicare	Treatment Plan Participation Consent (Required for FSP Programs only)
Offer a copy of "Guide to Medi-Cal Mental Health Services"	
Advance Directives	
Telehealth Consent Acknowledgement	

Care Coordination – Timeliness of Admission

The Case Coordinator is responsible for ensuring timeliness of service delivery. Meaning, the Case Coordinator is responsible for making sure that all forms are completed within the designated timelines. The following forms need to be completed at the start of an initial assessment/intake or for episodes where the person in care was previously closed for services for 365 days or longer*:*

- Onset of Services
  - Informed Consent
  - Notice of Privacy Practices
  - Consumer Rights
  - MCBH Problem Resolution Process
  - Authorization for use, exchange, and/or disclosure of confidential behavioral health information WITHIN Monterey County Behavioral Health*
  - Authorization to bill private insurance or Medicare
  - Offer a copy of "Guide to Medi-Cal Mental Health Services"
  - Minor Consent (if applicable)
  - Authorization to use, exchange, and/or disclosure of confidential behavioral health information (as indicated)
- New Client form
- CalAIM Assessment
- Child Assessment of Needs and Strengths (CANS) (as applicable)
- PSC-35 (as applicable)
- ACES/PEARLS (Pediatric Early Adversity and Related Life Effect Screen)
- Diagnosis (ICD-10 code set)
- Monterey County Treatment Plan (when applicable)
- Problem List
- Medication Consent (when applicable)
- Special Considerations (if applicable)
- Case Coordinator form
- Client Relationships
- UMDAP - Uniform Method of Determining the Ability to Pay*
- Unlicensed Clinician form (at the start of services provided by an unlicensed, but licensed eligible clinician) (MCBH Policy 144)

- Telehealth Consent Acknowledgement Form
- Treatment Plan Participation Consent Form (FSP programs only0

*Note: Information gathered for completion of UMDAP should be collected for present timeframe moving forward. Meaning, there is no need to complete UMDAP information for years in which the individual was closed to prior episodes.

In order to comply with claiming (billing), the health record must include an admission diagnosis prior to claiming any service. The diagnosis (ICD-10 code set) is informed by assessment. Additionally, the health record must also include the following prior to claiming for services.

- Case Coordinator
- Onset of Services
- CSI information

In the event the chart is out of compliance, claiming for services will not be allowed, services will automatically be moved to a non-billable service code, and the progress note will continue to remain as part of the health record. In order to meet documentation expectation standards, all applicable documents listed above must be completed (as applicable).

Care Coordination – Annual Renewal of Services

On an annual basis, the Case Coordinator is responsible for the annual evaluation of the individual's needs, which include the evaluation of medically necessary services, renewal of services, maintaining the accuracy of the health record, and ensure all necessary documents are completed in a timely manner. Of note is that many of the documents previously completed at onset of services **do not** need to be collected again during the annual review/renewal of services, with the **exception** of the Authorization for Use, Exchanges, and/or Disclosure of Confidential Behavioral Health Information (General Release of Information) that have expired and Medication Consents (medical staff only). It is, however, good practice to review the limits of confidentiality and risks and benefits with the individual as often as clinically relevant.

The Case Coordinator is responsible for the completion of the following forms, which may be completed **up to 30 days prior to the anniversary month**:

- Update Client Data
- Annual Plan Bundle:
    - CalAIM Assessment
    - Child Assessment of Needs and Strengths (CANS) (as applicable)
    - PSC- 35 (as applicable)
    - Diagnosis ICD-10 code set (make sure to select "update" option)
    - Monterey County Treatment Plan (when applicable)
    - Treatment Plan Participation Consent (FSP programs only)

    - Problem List
    - Authorization to use, exchange, and/or disclosure of confidential behavioral health information (as indicated-if expired)
    - Special Considerations (if applicable)
    - Client Relationships
    - Unlicensed Clinician form (at the start of services provided by an unlicensed, but licensed eligible clinician)
- UMDAP
- MD Bundle (medical staff only, if applicable)

Care Coordination – Transfer of Services

Transfer of services means that the responsibility of providing services to an individual/family has been transferred to a different program. If the services are transferred from one program to another program (with no break or closure of services in the process of transfer), most onset of services documentation **do not** need to be completed again, except for the Authorization for Use, Exchanges, and/or Disclosure of Confidential Behavioral Health Information that have expired and Medication Consents (medical staff only). As always, it is good practice to review the limits of confidentiality and risks and benefits with the individual for the services they will receive as often as clinically relevant.

The receiving MCBH program takes on the Care Coordination responsibilities and should do the following as soon as possible:

- Discuss risks and benefits of their particular program services with the individual/family and ensure that the individual/family clearly understand these risks and benefits before beginning services
- The individual's informed consent should then be documented clearly in a progress note in their health record
- Admission form
- Admission Part 2 (Bundle) form which includes the Client and Services Information (CSI)
- Diagnosis ICD-10 code set (must be completed before claiming any service)
- Case Coordinator form
- CalAIM Assessment (update if applicable)
- Treatment Plan (when applicable – must update with current provider and treatment goals; non-current treatment goals must be closed by prior transfer)
- Problem List (update as applicable)
- Unlicensed Clinician form (at the start of services provided by an unlicensed, but licensed eligible clinician)

Note: Please extend a level of professionalism when transferring services to another program by ensuring the integrity of the person in care's record is up to date. In the

event the person in care's annual plan renewal is due at the time of the transfer; it is clinically appropriate for either the existing or the receiving program to complete the annual renewal of services documents. This should be coordinated.

Informed Consent

Informed consent to is fundamental in both ethics and law. People have the right to receive information and ask questions about recommended treatments so that they can make well-informed decisions about care.

All persons in care should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in a person's preferences and encourage shared decision making. Adults, including those receiving mental health services, have the right to give or refuse consent to medical, diagnostic or treatment procedures. California Health and Safety Code § 7185.5(a) states that "the legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care..." California Code of Regulations, Title22 § 70707(b)(6) provides that a patient has a right to "participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment."

The range of services provided shall be discussed prior to admission with the prospective person or an authorized representative so that the program's services are clearly understood (CCR, Title 9 § Section 532.3). Behavioral Health has an obligation to inform people of the risks and benefits of treatment. At the onset of services, it must be ensured that people understand the content of not only the Informed Consent form but of all the onset of services documentation prior to the person agreeing to services and signing these forms. This includes ensuring that minors who are able to consent for their own services without a parent are fully educated about the similarities and differences in the types of services they can receive. In addition, although persons in care are not asked to re-sign Informed Consent forms when they transfer from program to program, it is important that all persons in care are informed of the specific risks and benefits of each service when they initially transfer.

An important part of Informed Consent is the person's capacity to consent. A person is deemed to have legal capacity to consent to treatment if he/she has the ability to understand the nature and consequences of the proposed health care, including its significant benefits, risks, and alternatives (including doing nothing), and can make and communicate a health care decision. A person's lack of mental capacity to consent to medical care may be temporary or it may be permanent, and the provider should determine capacity on a case-by-case basis whenever consent is sought. For example, a person who is clearly under the influence of drugs or alcohol may lack capacity temporarily, but could provide consent at a later time, when not so impaired. If there are any questions regarding a person's ability to consent, staff should consult with their supervisor and/or Quality Improvement.

Minor Consent

This section provides guidance regarding consent for health care services for minors receiving services from Monterey County Behavioral Health. The terms health care and medical care include assessment, care, services, or referral for treatment for general medical conditions, mental health issues, and substance use disorders. As with adults consenting for their own services, minors who can consent for their own services have the fundamental right to consent to or refuse medical treatment (MCBH Policy 320).

Generally speaking, minors need the consent of their parents to receive mental health services unless the minor has the right to consent to care under minor consent laws (see “Circumstances That Allow for Minor to Consent to Their Own Services”). Only one parent is necessary to provide consent unless we are aware of evidence that the other parent has objected. Adoptive parents have the same rights to consent as natural parents.

In the case of divorced parents, the right to consent rests with the parent who has legal custody. If the parents have “joint legal custody” usually either parent can consent to the treatment unless the court has required both parents to consent. In most situations, we can presume that either parent can consent unless there is evidence to contrary. Some teams prefer to obtain consent from both parents. This is not a legal requirement, but this is acceptable within MCBH as long as it does not pose a significant detriment or cause harmful delay to the treatment of the person in care.

A parent or guardian who has the legal authority to consent to care for the minor child has the right to delegate this authority to other third parties (aged 18 and older). For

example, the parent may delegate authority to consent to medical care to the school, to a coach, to a stepparent, or to a baby-sitter who is temporarily caring for the minor while the parent is away or at work. A copy of the written delegation of authority should be scanned into the Electronic Health Record.

In some cases, a “surrogate parent” is raising a minor child. If this adult is a qualified relative (often the grandparent, an aunt or uncle, or older sibling) who has stepped into the role of parent because the biological parents are no longer willing or able to care for the minor, he or she should fill out the **Caregiver's Affidavit** form which is used widely throughout California.

These identified “Caregivers” who have "unofficially" undertaken the care of the minor are authorized by law to consent to most medical and mental health care and to enroll these children in school. Once they have completed the Caregiver's Affidavit form (which is then scanned into the Electronic Health Record), they may consent to medical or mental health care for the minor child; however, if the parent(s) returns, the "Caregiver's" authority is ended, and once again the parent has authority to consent to or refuse care for the child. A Caregiver’s Affidavit does not have to be renewed and can remain in effect until the parent returns, or until the minor turns 18.

The court has the power to authorize medical and mental health treatment for abandoned minors and for minors who are dependents or wards of the court (for example, youth in foster care or juvenile hall). Furthermore, the court may order that other individuals be given the power to authorize such medical and mental health treatment as may appear necessary if the parents are unable or unwilling to consent. In some circumstances a court order is not necessary. For example, under certain circumstances, a police officer can consent to medically necessary care for a minor who is in "temporary custody."

In situations where an adult other than the parent or guardian is providing consent, (unless it is an emergency) care must be taken to establish their legal authority to consent to care before treatment begins. Often this requires identification of the minor's status as well as the ability or inclination of the natural parents to provide consent. A copy of the court order delegating this authority (to a foster parent, for example) should be scanned into the Electronic Health Record before care is provided. For those treatments for which a minor can legally provide his or her own consent, no court order or other authorization is necessary when treating a dependent or ward.

In rare situations, a court may summarily grant consent to medical or mental health treatment upon verified application of a minor aged 16 or older who resides in California if consent for medical care would ordinarily be required of the parent or guardian, but the minor has no parent or guardian available to give the consent. A copy of the court order should be obtained and scanned in the minor’s Electronic Health Record before

treatment is provided pursuant to the order.

Consent from the parent is not required if the minor is involuntarily held for a 72-hour assessment and treatment pursuant to Welfare and Institutions 324 Code 5585.2 or 5150 et seq.

Circumstances that Allow for Minors to Consent to Their Own Services

Minors generally need a parent to consent to healthcare services because minors suffer automatic legal incapacity due to their young age. However, there are certain minors who can consent for their own services. These minors are minors who are treated as "adults" under the law for purposes of medical consent which includes:

1. Emancipated minors
2. Self-sufficient minors
3. Minors seeking *sensitive services*

These minors do not suffer automatic legal incapacity due to their young age but must still display legal capacity. As with adults, legal capacity to consent to services indicate an ability to understand the nature and consequences of the proposed health care, including its significant benefits, risks, and alternatives; make a health care decision; and communicate this health care decision. Emancipated minors include:

1. Minors 14-years-of-age and older who have been emancipated by court order
2. Minors who are serving in the active US military forces; and
3. Minors who are married or who have been married

Before providing services to these minors, staff should obtain a copy of their emancipation card or court order, a copy of their military ID card, or a copy of their marriage certificate and scan these documents into their Electronic Health Record. Self-sufficient minors are defined by law as minors aged 15-years-of-age and older who are living separate and apart from their parents and who are also managing their own financial affairs regardless of their source of income. Even though self-sufficient minors can consent to outpatient mental health services such as therapy, rehabilitative counseling, and case management, the law is not clear whether or not self-sufficient minors can consent to psychotropic medication treatment. Staff should consult with their supervisor and/or Quality Improvement if psychotropic medication treatment is part of the services being sought by a self-sufficient minor.

Minors seeking certain *sensitive services* may be legally authorized to provide their own consent to those services. The minor also controls whether or not the parent will have access to records generated as a result of receiving those services. When minor consent applies, sensitive services should not be provided over the minor's objection. In other words, *even if the parent provides consent, non-consent by the qualified minor presents ethical issues and provision of care should be delayed until consultation using*

the chain of command can be obtained on a case-by-case basis.

Minors 12-years or older may consent to medical care and counseling related to the diagnosis and treatment of a substance related problem. Since the law deems such minors to be legally competent to consent to such care, parents or guardians have no legal authority to demand drug testing of their minor children who are 12 or older. The law requires providers to involve the minor's parent or legal guardian in the care, unless to do so would be inappropriate. The decision and reasons to involve, or not involve, the parent/legal guardian, as well as staff efforts to involve them, needs to be recorded in the Electronic Health Record.

Assembly Bill 665 aligns previously existing California laws, Family Code 6924(b) and Health and Safety Code section 124260. The first law states that minors 12 years of age or older may consent to behavioral health treatment or counseling on an outpatient basis, or to residential shelter services, if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. The second law states the provider need only determine that the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient mental health services.

The attending professional person should clearly document that any required "qualifying" criteria have been met if services are provided pursuant to either of these provisions of the law.

When outpatient behavioral health care or residential shelter services are provided, the laws state that it shall include the involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, **after consulting with the minor**, determines the involvement would be inappropriate. The professional person must state in the record, whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful, or the reason why, in the professional person's opinion and consultation with the minor, it would be inappropriate to contact the minor's parent or guardian. Note: 42 CFR requires proper **written consent** from the minor before involving the parent/guardian who is receiving "Part 2" SUD services.

It needs to be reiterated that even though a minor 12-years-of age or older can provide their own consent for sensitive services related to substance use and mental health, mental capacity to provide consent and informed consent is still required. If a minor who otherwise qualifies for minor consent lacks mental capacity, and insists that there not be parental involvement, staff should consult with their supervisor and Quality Improvement so that appropriate steps may be taken.

Note: Psychotropic medication treatment is **not** one of the sensitive services that a minor can consent for. Parent/guardian consent is required if psychotropic medications are prescribed. Parent/guardian consent for psychotropic medication is also needed if

voluntary inpatient mental health facility services are provided. Further, the minor consent laws do not authorize a minor to consent to convulsive therapy or psychosurgery.

<table>
<tr><th colspan="2">Minor Consent (Ages 12+)</th></tr>
<tr><th>With Parent/Caregiver Involvement</th><th>Without Parent/Caregiver Involvement</th></tr>
<tr><td>Seeking one or more of the following
Outpatient mental health treatment
Substance use disorder treatment
Minor has no objections to parent or guardian involvement</td><td>Seeking one or more of the following
Outpatient mental health treatment
Substance use disorder treatment
In opinion of treating professional:
Minor mature enough to participate intelligently in the aforementioned services
After consulting with the minor determines the involvement of parent or guardian would be inappropriate</td></tr>
<tr><th colspan="2">Next Steps (i.e. Intake Paperwork, Documentation, etc.)</th></tr>
<tr><th>With Parent/Caregiver Involvement</th><th>Without Parent/Caregiver Involvement</th></tr>
<tr><td>Minor must sign all consents (“Informed Consent”) & authorizations (“WITHIN” & “GENERAL”)
Some parents or caregivers may also like to sign alongside minor, this is acceptable
Complete “GENERAL” to authorize communication with parents or caregiver</td><td>Minor must sign all consents (“Informed Consent”) & authorizations (“WITHIN” & “GENERAL”)
In addition, minor must also sign “Minor Consent”
Document in chart the reason why it would be inappropriate to contact the minor’s parent or guardian and the consultation had with the minor
Email 415-QA@countyofmonterey.gov with chart number
Gather information from minor, such as, an alternate mailing address where correspondence from MCBH can be mailed</td></tr>
</table>

Advance Directives

It is important to note Monterey County Behavioral Health (MCBH) values and upholds the right and freedom of the individual person to decide every aspect of their life, including end of life decisions. MCBH recognizes and accepts all instruments that protect and safeguard this right and the freedom of the individual to decide, including their right to have an Advance Directive. Persons in care will not be discriminated

against based on whether they execute an Advance Directive. Information on advance directives shall be offered to the person in care upon the initial start of service for those 18 years and older and for emancipated minors (MCBH Policy 471).

Telehealth Consent Acknowledgement

MCBH offers telehealth or telephone as a modality to help individuals stay healthy while living in their communities, and to provide individuals with timely access to specialty mental health and substance use disorder services. Telehealth involves the use of an audio and video component. If a visit is provided through telehealth (synchronous audio or video) or telephone, MCBH staff and contracted providers are required to confirm consent for the telehealth or telephone service, in writing or verbally at least once prior to initiating applicable health care services via telehealth to a Person In Care receiving Medi-Cal. Consent to include:

- An explanation that persons in care have the right to access covered services that may be delivered via telehealth through an in person, face-to-face visit;
- An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Person In Care receiving Medi-Cal without affecting their ability to access covered Medi-Cal services in the future;
- An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted;
- The potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

Confidentiality

The confidentiality of medical, psychiatric, and substance abuse information is protected by State and Federal statutes, rules, and regulations. The statutes, rules, and regulations require that staff members protect a person in care's personal health information (PHI) and that staff members obtain informed consent from the person in care in order to disclose any PHI information prior to doing so, except under specific conditions as indicated by the law. Only staff members who are directly involved in the person's treatment may access the health record for treatment purposes. It is never permissible for staff members to access a person's health record to satisfy a curiosity for their own purpose, even when the person in care is related to the staff member. The electronic medical record stores information on who has accessed the medical record as part of the audit trail. Additionally, the health record will prompt a "reason for accessing the record" whenever an individual who is not directly involved in person's care attempts to access a record This requires the staff member to clearly indicate the reason for accessing the record. This audit record is necessary to safeguard the person's confidentiality as well as to provide an "account of disclosure" if requested by the person in care, or legal entities via subpoena/court order. All applicable federal, state, and local laws, and county confidentiality policies shall be followed when an unauthorized access/breach of information has been discovered (MCBH Policy 322).

MCBH recognizes that there may be times when a staff may access a person's health record in error. As an example, staff may have incorrectly entered the person's medical record number and opened a person's chart before realizing this error. When a person's record is accessed in error, it is important to complete the "Accidental/Incorrect Client Access" form in AVATAR. This form will record the error in accessing the person's health record should a reason ever need to be given to the person in care or legal entities.

General Authorization to Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information

All information and records obtained in the course of providing services to an individual shall be considered confidential. A person in care or authorized representative who consents to the release of any information about their health record must read and sign the "**General Authorization to Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information**" previously referred to as "Release of Information." The Authorization, once signed, may be valid for a designated period of time or for an event (i.e., until the end of services). The person in care or authorized representative must

state who may provide the information, who the information may be released to, the purpose for which the information may be used, what specific information may be released, and when the authorization will expire. A person in care may decide to revoke the authorization at any time and may do so by submitting the request verbally or in writing to any staff member. The authorization will at that time be revoked, making it invalid. If at a later time the person in care decides to reactivate the authorization, a new authorization must be completed as indicated above.

Within Authorization for Disclosure of Confidential Behavioral Health Information

All information and records obtained in the course of providing services shall be confidential. A person in care or authorized representative shall be informed of and asked to sign the "**Authorization to Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information within Monterey County Behavioral Health System**" ("WITHIN") at the onset of service. The "WITHIN" Authorization informs the person in care of the use of an integrated electronic health record and its usefulness in providing coordinated care. The "WITHIN" is completed once in the treatment course, at onset of services, and remains valid unless revoked or the person in care has closed all Behavioral Health services for **longer than 365 days**. The signed "WITHIN" Authorization permits Monterey County Behavioral Health System to view health information and communicate among its programs and contracted provider programs.

The "WITHIN" Authorization **does not** permit the disclosure outside of its Behavioral Health System. In order to authorize any disclosures outside of the Monterey County Behavioral Health System, a "Authorization for Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information-GENERAL" shall be completed. If after an explanation of the use of the "WITHIN" form the person in care or caregiver refuses to sign the "WITHIN" document, you must immediately contact our Quality Improvement Department at (831) 755-4545 to request the record to be blocked. Blocking a record will restrict information that is shared.

Revoking and Authorization to Use, Exchange, and/or Disclose Information

A person in care may *withdraw* consent or REVOKE a previously signed Authorization at any time during their course of treatment (CCR, Title 9, Section 854), and may do so by submitting the request verbally or in writing to any staff member. In the event the person in care asks to revoke a release of information, the behavioral health staff *must* complete the "revoke" section of the release of information form, being careful to enter a reason for revocation and notifying necessary team members of this request. For authorizations completed on paper, staff must print the authorization, write "revoke"

across the page and scan back into the EHR in the appropriate section.

Special Considerations for Minors

For minors who are eleven (11) years of age or younger, the authorized representative may authorize the release of information. For minors who are treated as "adults" under the law for purposes of medical consent (emancipated and self-sufficient minors) and minors seeking sensitive services for which they are qualified to provide their own consent under the law, the minor must authorize the release of information, even to their own parents or guardians (MCBH Policy 320).

The minor is in control of their health information. A minor has a right to view the information in their medical record but must complete the designated request of information document (a verbal release of records will NOT be accepted). Records request may be done by visiting the Monterey County Behavioral Health Quality Improvement office located at 1611 Bunker Hill Way, Suite 120, Salinas, CA 93906 (831) 755-4545. A designated staff member of the Quality Improvement team will review the request to ensure a proper and timely response to person in care's request.

Note: When information is disclosed, it is necessary to complete the "Account of Disclosure" form in the EHR in order to keep track of the disclosure of information.

Subpoena/Court Order's

All subpoenas for Monterey County Behavioral Health (MCBH) staff **shall be personally served** upon the individual when the subpoena seeks the personal appearance of an individual staff member to testify in a court hearing.

All subpoena/court orders seeking release of health records shall be delivered to the Quality Improvement (QI) office at 1611 Bunker Hill Way, Suite 120, Salinas, CA 93906 (831) 755- 4545.

All subpoenas originating from the Public Guardian's office shall be delivered to the Quality Improvement (QI) office at 1611 Bunker Hill Way, Suite 120, Salinas, CA 93906 (831) 755-4545.

For subpoenas/court orders for MCBH **Contracted Providers**:
All subpoenas/court orders must be served at the program or provider's site. When the contracted program or provider has questions regarding subpoena/court order, the program or provider should seek its own legal counsel. MCBH Quality Improvement Records Technician will only provide technical assistance.

Response to Subpoena/Court Order's
To respond to a subpoena/court order requiring an MCBH staff to appear and testify in

court, MCBH staff who are served with a subpoena/court order shall:

1. Notify supervisor and/or manager about the subpoena as soon as possible
2. Notify QI team via telephone or by email to 415-QA@co.monterey.ca.us
3. Collaborate with a QI team member for guidance to address subpoena

Note: Never *ignore* a subpoena/court order no matter how improper it may appear to be. Immediately notify a supervisor, a program manager, and/or QI staff. If legal advice is required, county staff may contact County Counsel. Noncompliance with a subpoena/court order may constitute a contempt of court and result in a bench warrant for your arrest and/or a fine.

QI staff is responsible for responding and processing subpoenas/court orders seeking release of health records, in accordance with applicable regulations. QI staff take all necessary steps required to respond to and process subpoenas/court orders, including, but not limited to the following:

1. Log the date of receipt, the check amount (when applicable), and actions by QI team staff
2. Determine the validity of the subpoena/court order
3. Determine the validity of the authorization for disclosure of health information
4. Respond to subpoenaing parties regarding improper subpoenas/court orders
5. Notify County Counsel of subpoena
6. Prepare medical records for court
7. Coordinate with program staff regarding proper subpoena/court orders, if applicable
8. Provide staff support to address subpoena, if applicable (MCBH Policy 314)

Restraining Orders

On rare occasions, a Person In Care may have a restraining order with provisions that would restrict the restrained party from accessing records or information pertaining to the health information of a minor child. If a Person In Care or authorized representative presents staff with a restraining order with this provision, please refer to the appropriate Protocol (located on the QI website).

Use of Emails to Transmit PHI and PII

The use of emails to transmit Protected Health Information (PHI) and Personally Identifiable Information (PII) among staff members, contracted providers, and business associates are as follows:

> The use of email to conduct business is commonplace. For this reason, *additional considerations* must be made when sending Personal Health Information (PHI) and Personally Identifiable Information (PII) using electronic forms of communication.

Specifically, the focus here is for use of email to transmit PHI and PII between staff members, contracted providers, and business associates, as permitted by law. Monterey County Health and Behavioral Health policies require all staff, employees, volunteers, students, and business associates to comply with all applicable federal and state confidentiality laws, including laws pertaining to confidentiality and privacy of physical health, mental health, HIV, substance use disorders and/or other sensitive services records. If PHI/PII must be transmitted using email, all MCBH staff may do so only through secure remote access or via encrypted/otherwise secure portable devices approved by Monterey County Health Department.

When sending PHI/PII using email, consider the following:

- Whether it is necessary for the email to disclose PHI/PII and, if so, whether the email must disclose the extent of the PHI/PII being transmitted
- Use only the minimum necessary PHI/PII in your email communications
- Limit patient identifiers where practicable, especially where the information is specifically protected by state law or could be used to perpetrate identity theft
- Use non-descriptive person in care data on the subject line; use of individual's PHI in the subject line is not permissible
- Double check email address before your click on send, reply, or reply all
- Be aware of the risk that an email address could be incorrectly typed or auto filled
- If you receive an email, before selecting "reply all" ensure there are not personal email addresses listed
- Ensure this confidentiality statement is on your email signature:
    - Confidentiality Notice: This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution of this message is prohibited and may be against the law. If you are not the intended recipient, please contact the sender by replying to the original email and destroy all copies (electronic and print) of the original message.

MCBH does not authorize the use of personal emails to conduct business, especially the transmission of Personal Health Information (PHI) and/or Personally Identifiable Information (PII). If PHI/PII must be transmitted using email, all MCBH staff may do so only through secure remote access or via encrypted/otherwise secure portable devices approved by Monterey County Health Department. PHI/PII may only be disclosed as permissible by law.

All emails containing PHI/PII must be sent using encryption methods. This includes emails transmitted within Monterey County Health Departments, including between Behavioral Health programs, as well as treatment providers and community business associates. Again, disclosures are only permissible as permitted by law.

Providing Responsive Care

Access to Treatment Criteria

This section describes the criteria for accessing specialty mental health services (SMHS) through Monterey County Behavioral Health. While we will be discussing the technical criteria, we encourage practitioners to continue to review the information from the perspective of the person in care with empathy and centering the person's voice regarding their health care decisions.

The criteria we will discuss in this section are for two distinct age cohorts:

1. Individuals aged 21-years and older
2. Individuals under 21-years of age

Each of these cohorts have distinct criteria due to their developmental needs. It is important to point out early that a person may begin to receive clinically appropriate services, so long as the person would benefit from the SMHS services, even before a diagnosis has been fully articulated and a final determination has been made.

Overview of criteria for persons aged 21 years and older (BHIN 21-073)	**Overview of criteria for persons under 21 years of age** (BHIN 21-073)
• 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. • AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), or a suspected disorder that has not yet been diagnosed.	• The person is experiencing homelessness, and/or is interacting with the child welfare or criminal justice system • OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder. • 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 there is no presence of impairment. • AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), or a suspected that has not yet been diagnosed.

No Wrong Door

SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the person meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the person does not meet criteria for SMHS. MCBH must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the person does not meet criteria for SMHS or meets the criteria for NSMHS.

Likewise, MCBH must not disallow reimbursement for NSMHS services provided during the assessment process if the assessment determines that the person does not meet criteria for NSMHS or meets the criteria for SMHS.

Monterey County Behavioral Health and CBO programs and providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a person's treatment when a diagnosis has yet to be established.
- In cases where services are provided due for a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS-approved ICD-10 diagnosis code list, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

Concurrent NSMHS and SMHS

Persons in care may concurrently receive NSMHS via a FFS or MCP provider and SMHS via MCBH provider when the services are clinically appropriate, coordinated and

not duplicative. When a person meets criteria for both NSMHS and SMHS, the person should receive services based on individual clinical need and established therapeutic relationships. MCBH must not deny or disallow reimbursement for SMHS provided to a person in care on the basis of the person also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated, and not duplicative.

Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a person in care on the basis of the person also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated, and not duplicative.

Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MCBH to ensure person in care's choice. MCBH must coordinate with MCPs to facilitate care transitions and guide referrals for persons in care receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the person. Such decisions should be made via a person centered shared decision-making process.

- Persons in care with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from MCBH provider, as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a person in care may only receive psychiatry services in one network, not both networks; a person in care may only access individual therapy in one network, not both networks).
- Persons in care with established therapeutic relationships with a MCBH provider may continue receiving SMHS from the MCBH, even if they simultaneously receive NSMHS from an FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

DHCS has developed a set of statewide screening tools to facilitate screenings and care transitions for the SMHS, NSMHS and FFS systems (BHIN 22-011).

Prior Authorization

While CalAIM "No Wrong Door" policy has changed the way that persons enter services in order to increase access to needed treatment, select services within Monterey County Behavioral Health *still require* prior authorization; for example, certain residential

and SUD programs. This process ensures that persons in care are linked with the correct level of care at the correct time. As the prior authorization process is program-specific for services requiring prior authorization, information on completing needed documentation and timelines for submission can be found in referral and extension requirements for these programs.

Timely Access to Services

Monterey County Behavioral Health (MCBH) and its contracted providers receive referrals for mental health and substance use services from a variety of resources. Services may be requested by the individual or authorized representative, by referral from inpatient hospitals, community providers, or other institutions.

All individuals who seek behavioral health services from MCBH are entitled to receive, at minimum, an assessment to determine their needs and whether MCBH services might meet those needs or whether a referral is warranted to better serve the individual/family.

As such, MCBH, along with its contracted providers, must comply with standards of timely access to care and network adequacy standards set forth by the Medicaid Managed Care Final Rule (MCBH Policy 148). These rules apply to SMHS services for initial assessment appointments and treatment appointments.

Definitions

- New Person
    - SMHS: An individual who has never received care in our systems or if received care in the past, all outpatient episodes are closed for longer than 365 days.
    - DMC-ODS: Any person requesting services who is not currently open to a DMC-ODS program.
- Non-urgent request: Refers to routine appointments for non-urgent conditions.
- Urgent request: Refers to cases in which a person or provider indicates, or MCBH determines, that the standard timeframe could seriously jeopardize the person in care's life or health or ability to attain, maintain, or regain maximum function.

Specialty Mental Health Services (SMHS)

New person requesting Outpatient Mental Health Services:

- Non-Urgent: Offer appointment within 10 business days from request
- Urgent: Offer appointment within 48 hours of request, 96 hours for service requests that require prior authorization

New person requesting Outpatient Psychiatry services:

- Non-Urgent: Offer appointment within 15 business days from request
- Urgent: Offer appointment within 48 hours of request

Substance Use Disorder Services (DMC-ODS)

New Person requesting Outpatient/Residential Services:

- Non-Urgent: Offer appointment within 10 business days from request
- Urgent: Offer appointment within 48 hours of request, 96 hours for service requests that require prior authorization (i.e., Residential)

New person requesting Opioid Treatment Services:

- Non-Urgent: Offer appointment within 3 business days from request
- Urgent: Offer appointment within 48 hours of request

New persons requesting mental health or substance use disorder services may be self-referred via telephone or by walking into a designated MCBH clinic or applicable contract provider or, received by referral from an authorized representative or agency. A record must be created to document receipt of the new person's request for mental health or substance use disorder services.

- The intention of establishing a health record is to create a unique record of the individual's request for services, the outcome of the request, as well as provide information on MCBH's responsiveness to the request for services.
- The initiation of a health record does not, in any way, guarantee the individual requesting services will receive all or some of their mental health services and/or SUD services through MCBH and or its contractors. It means the individual or authorized representative has requested mental health and/or SUD services and MCBH and its contractors are responding to the request.
- All new requests for services must be documented in the person in care's record. This form is used to document the date of request, type of service requested, if the request is urgent or not, the date of offered appointments, the date of accepted appointments and reason for closure of this series of events (MCBH QI Memo: New Client Form). These elements must be recorded via:
    - SMHS Providers: New Client From

Maintaining accurate and up to date scheduling:

- All MCBH licensed/licensed eligible clinicians and prescribers will maintain their scheduling calendar in the electronic health record to accurately reflect availability of appointments.
    - Scheduling mechanisms are up to the discretion of subcontracted providers. All applicable contracted providers must maintain a scheduling calendar to accurately reflect availability of appointments.
- If a person is screened and eligible for SMHS or SUD services, an appointment must be offered within the established timeliness standards.
    - If an appointment is not available within the timeliness standards, the next available appointment must be offered.

Delivery System	Type of Service	Non- Urgent Services	Urgent Services
SMHS	Psychiatry	Within 15 business days from request to appointment	Within 48 hours of the request
SMHS	Outpatient services with a non-physician mental health care provider where prior authorization is not required	Within 10 business days from request to appointment	Within 48 hours of the request
SMHS	Outpatient services with a non-physician mental health care provider where prior authorization is required	Within 10 business days from request to appointment	Within 96 hours of the request
DMC-ODS	Opioid Treatment Services (OTP's)	Within 3 business days from request to appointment	Within 48 hours of the request
DMC-ODS	Outpatient SUD Services, excluding opioid treatment programs (OTP's) where prior authorization is not required	Within 10 business days from request to appointment	Within 48 hours of the request
DMC-ODS	Outpatient SUD Services excluding opioid treatment programs (OTP) where prior authorization is required	Within 10 business days from request to appointment	Within 96 hours of the request

Monitoring Timeliness for New Persons in Care

In order to comply with Medicaid Managed Care Final Rule, the Department of Health Care Services (DHCS) is requiring collection of additional information related to timeliness to care for individuals who request mental health services. This requirement impacts county run and contracted provider programs. The additional data elements aim to assess timeliness standards for services and monitors 10-day access for non-urgent appointments and 48 hours for urgent appointments. DHCS refers to these additional items as "New Client." This data will examine the timeliness and trajectory of a new person entering services and start of treatment following the assessment.

The additional data elements will be submitted to DHCS along with the submission of other CSI data on a monthly basis. The "New Client" data elements are completed for new persons in care. In brief, the data elements are:

- Initial request for services
- Initial offered and accepted appointment for assessment
- Offered and accepted appointment for treatment following assessment
- Reason for Closure of "New Client"

The reason for closure for this purpose is to documents at what point the person has completed the series of events for admission and treatment (scenarios are provided below):

01 = Person In Care did not accept any offered assessment dates
02 = Person In Care accepted offered assessment date but did not attend initial assessment appointment
03 = Person In Care attended initial assessment appointment but did not complete assessment process
04 = Person In Care completed assessment process but declined offered treatment dates
05 = Person In Care accepted offered treatment date but did not attend initial treatment appointment
06 = Person In Care did not meet medical necessity criteria
07 = Out of county/presumptive transfer
08 = Unable to contact (e.g. deceased or unresponsive)
09 = Other

Person and Family Centered Care

As a Behavioral Health System, Monterey County is committed to delivering person and family driven care. Person-centered care has been recognized as a best practice in mental health. Person-centered care involves putting the person in care in the driver's seat of the care they are receiving.

When serving children, Monterey County Behavioral Health strives to be a family driven system of care that fosters resiliency. The chart below demonstrates some differences between "traditional care" and "person/family driven care" services.

Traditional Care	Person/Family Driven Care
Practitioner Based	Person/Family Directed
Problem Based	Strength Based
Professional Dominance	Skill Acquisition
Cure and or Amelioration	Quality of Life
Dependence	Empowerment
Reactive	Preventative and/or Wellness
Professional Supports	Natural Supports

Resiliency

Resilience refers to the personal qualities of optimism and hope, personal traits of effective problem-solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. Children who encounter negative experiences at home, at school, and in the community may find that mental health treatments may teach good problem-solving skills, optimism, and hope that will help build and enhance resiliency. MCBH ensures that:

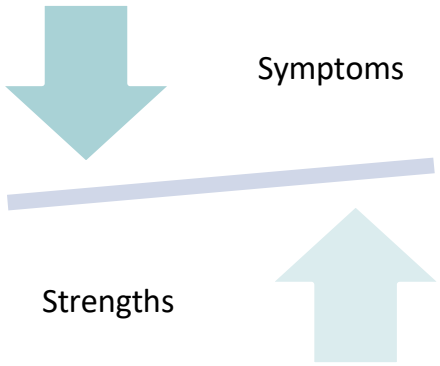
1. Families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
2. Families and youth, practitioners and administrators embrace the concept of sharing decision-making and responsibility for outcomes.
3. Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.
4. Families and family-run organizations engage in peer support activities to

reduce isolation, gather, and disseminate accurate information, and strengthen the family voice.

5. Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports.
6. Providers take the initiative to change practice from provider-driven to family-driven.
7. Administrators allocate practitioners, training, support, and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
8. Community attitude change efforts focus on removing barriers and discrimination created by stigma.
9. Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families.
10. Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.

Strengths

Monterey County Behavioral Health's goal is to reduce symptoms by increasing strengths and coping skills in order to help people live a meaningful life in the community.



What are strengths? Environmental factors that will increase the likelihood of success such as:

- Community supports, family/relationships, support/involvement, work, etc. may be unique to racial, ethnic, linguistic, and cultural (including lesbian, gay, bisexual and transgender) communities
- Identifying the person's best qualities/motivation
- Strategies already utilized to help (what worked in the past)
- Competencies/accomplishments interests and activities (i.e., sports, art identified by the person in care and/or the provider)

- Motivated to change
- Support system (e.g. friends, family)
- Employed or does volunteer work
- Skills/competencies (e.g. vocational, relational, transportation savvy, activities of daily living)
- Talents (e.g. intelligent, artistic, musical, sports)
- Possesses knowledge of their disorder
- Values medication as a recovery tool
- Has a spiritual program (i.e. connected to a church or spiritual-community)
- Good physical health
- Adaptive coping skills (e.g. help seeking behaviors, strong self-advocate)
- Capable of independent living

Practitioners use the information from the assessment on strengths (including cultural strengths) to identify the individual/family attributes and skills. Identify resources that will be particularly significant to supporting the person in care in achieving their goals.

When considering strengths, it is beneficial to explore other areas not traditionally considered “strengths,” such examples include: an individual’s most significant or most valued accomplishment, what motivates them, educational achievements, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, personal heroes, most meaningful compliment ever received, etc.

Lastly, it is important to take the time to acknowledge the value of the individual’s existing relationships and connections. If it is the individual’s preference, significant effort should be made to include these “natural supports” and unpaid participants as they often have critical input and support to offer to the treatment team. Treatment should complement, not interfere with, what people are already doing to keep themselves well, ultimately drawing support from friends and loved one. MCBH has created a document, AB 1424, which may be used by family members or support persons, completed in advance of a crisis event, and used to provide first responders with critical collateral historical information on the person in care which will support with overall continuity of care. While it is not a required form, it is a helpful tool that encourages our overall value of family centered care for the people we serve.

Screening Tools

Persons needing care may access care in several different ways including self-referral, getting a referral from another behavioral health practitioner, or a primary health care provider, etc. No matter how a person initiates care, the person can expect to receive timely behavioral health services whether from the MHP with MCBH or the MCP with Carelon through CCAH. If we keep the person's care needs at the forefront of treatment decisions, there is no wrong door by which the person may enter. The goal is to ensure that individuals seeking care have access to the right care in the right place at the right time, regardless of what door they come to initially.

Screening is used as the first step in getting the person connected with the right care system. When an individual seeks care, the standardized "Screening Tool" created by The Department of Health Care Services (DHCS) is used to understand the person's behavioral health needs, symptoms, and distress and get them to the provider that best matches their needs. The screening tools do not replace the need for an assessment, which will come later.

The Adult Screening Tool is used for individuals 21 and older. The Youth Screening Tool is used for individuals under the age of 21 with distinct versions for when a youth is seeking services on their own (Youth Response) and when a parent/caregiver is seeking services on behalf of a youth (Adult Response).

These screening tools are intended to be used by the MCBH and Carelon service delivery systems by a diverse workforce and were designed for use by clinical and non-clinical staff (e.g., Social Worker III) to determine the best place for a person to start care (Carelon, MCBH, or SUD Provider delivery system). The screening tools are not required for use with persons who contact Contracted Providers directly to seek mental health services, as they may begin receiving assessment and clinically appropriate services without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy (BHIN 22-01).

Description of the Screening Tools

The screening tools are intentionally brief, as they are completed in one encounter in order to determine which service delivery system is a more appropriate fit. The screening tools identify initial indicators of a person's behavioral health needs as described below.

1. **Safety:** Information about whether the person needs immediate attention and the reason(s) a person is seeking services.

2. Information about whether the person is currently receiving treatment, with a distinct set of questions for adults and youth.	
a. **Adults: Clinical Experiences** Information about if they have sought treatment in the past, and their current or past use of prescription mental health medications.	b. **Youth: System Involvement** Information about whether they have been involved in foster care, child welfare services, or the juvenile justice system.
3. **Life Circumstances:** Information about challenges the person may be experiencing related to school, work, relationships, housing, or other circumstances.	
4. **Risk:** Information about suicidality, self-harm, emergency treatment, and hospitalizations.	

The Adult and Youth Screening Tools SHALL NOT replace:

- MCBH's protocols for emergencies or urgent and emergent crisis referrals.
- MCBH's protocols that address clinically appropriate timely, and equitable access to care.
- MCBH clinical assessments, level of care determinations, and service recommendations.
- MCBH requirements to provide EPSDT services.

Administration of the Screening Tools

Screening tools may be completed by clinicians and non-clinicians via in person, by phone, or by video conference. The screening tool questions shall be asked in full using the specific wording provided in the tools and in the specific order the questions appear in the tools, to the extent that the person is able to respond. Services provided prior to determination of whether Non-SMHS or SMHS access criteria are met (i.e., during the screening phase) are covered and reimbursable, even if the later assessment ultimately indicates the person does not meet criteria for SMHS. An appropriate ICD-10 diagnosis code is required to ensure claims related to the screening and care coordination are reimbursed timely and accordingly.

Special Circumstances Requiring Referral

Referral coordination shall be provided by MCBH under the following circumstances and should include sharing the completed screening tool and follow up to ensure a person was

connected to services as appropriate.

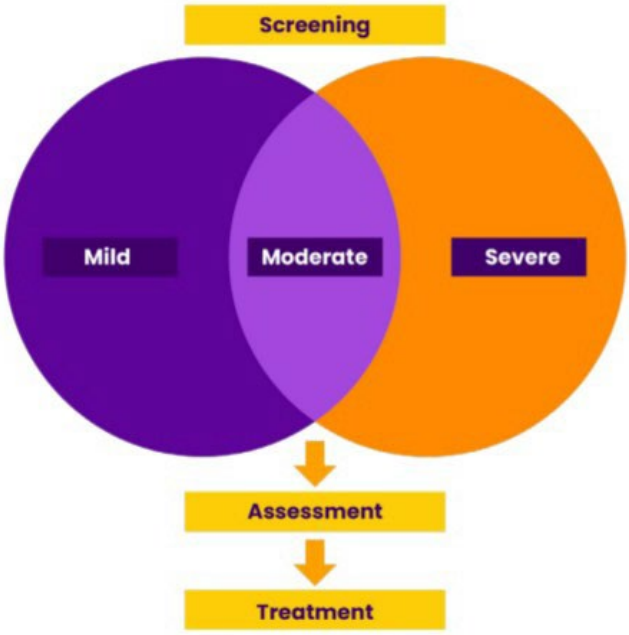
- If a person responds affirmatively to the question related to suicidality, or other serious risk factors are identified (danger to self, danger to others, etc.), MCBH must immediately complete a risk assessment (or connect person seeking services to emergency services if warranted) after the screening is complete.
- If a youth responds affirmatively to a question related to SMHS access criteria, they shall be referred for an assessment and medically necessary services (BHIN 21-073).
- If a person responds affirmatively to the question related to substance use, they shall be offered a referral to MCBH for SUD assessment. The person may decline this referral without impact to their mental health delivery system referral.
- If a youth or adult on their behalf indicates there is a gap in connection to primary care, they shall be offered linkage to CCAH for a primary care visit.

Screening Tool Scoring System

The Screening Tool will generate a score at the bottom of the form:

- If score is 0-5, then refer to Carelon.
    - If the Screening Tool score yields a referral to Carelon, MCBH shall coordinate the person's referral, including sharing the completed Adult or Youth Screening Tool and following up to ensure the person has been connected with a provider. The person in care shall be engaged in the process and appropriate consents obtained as needed.
    - If the Screening Tool score yields a referral to Carelon and in certain circumstances, clinical judgement indicates that the person should remain with MCBH for an assessment, staff shall ensure the completion of the Disposition portion of the Tool.
- If score is 6 or above, then refer to MCBH.
    - If the Screening Tool score yields a referral to MCBH, the person must be offered and provided a timely clinical assessment and an additional screening is not required.

The Screening Tool is built into the existing Avatar EHR system. Please refer to QI Memo CalAIM Implementation 007 for further instructions on how to complete the Transition of Care Tool.



Following Administration of the Screening Tools

Once the screening tool has been administered, there may be a referral for an assessment with MCBH or with Carelon. Once a person is referred, they shall receive an assessment to develop a clinical understanding regarding the person's care needs, including diagnosis, and to confirm the appropriate treating system and what services are medically necessary. Persons seeking care shall be engaged in the process and appropriate consents should be obtained in accordance with accepted standards of clinical practice.

Because humans are complex, the assessment may take more than one session to fully determine the overall care needs. For many individuals and/or in some circumstances, assessment also includes the collection of information from collateral sources including, but not limited to, family members, prior service providers and/or system partners. While the assessment is in process, the person in care may also receive clinically appropriate treatment services simultaneous to the assessment services.

Clinically appropriate services include prevention, screening, assessment, and treatment services (e.g. therapy, rehabilitation, collateral, case management, medication support) and are covered and reimbursable under Medi-Cal even when:

1. Services are provided prior to determination of a diagnosis, during the assessment process, or prior to determination of whether SMHS access criteria

are met (Welfare & Institutions Code 14184.402(f));

a) While a mental health diagnosis is not a prerequisite for access to covered services and while a person may access necessary services prior to determining a diagnosis, a provisional diagnostic impression and corresponding ICD-10 code (BHIN 22-013) must be assigned to submit a service claim for reimbursement. There are ICD-10 codes LPHAs may use prior to the determination of a diagnosis – if there is a suspected disorder within the LPHA's scope, "Other Specified" or Unspecified" ICD-10 codes are available. Additionally, the code Z03.89 "Encounter for observation for other suspected diseases and conditions ruled out" may be used.
b) As appropriate, LPHAs may use ICD-10 codes Z55-Z65 "Persons with potential health hazards related to socioeconomic and psychosocial circumstances (BHIN 22-013).

2. The person in care has a co-occurring mental health condition and substance use disorder (SUD); or
3. Non-specialty mental health services (NSMHS) and specialty mental health services (SMHS) are provided concurrently, if those services are coordinated and not duplicative.

We should note that the responsibilities for covered services by each of the service delivery systems remains in place, with each delivery system responsible for providing covered services per its contract with DHCS. This remains true even when persons in care are receiving services from multiple delivery systems, as each delivery system has separate and distinct services for which it provides coverage.

Assessment

The goal of an assessment is to understand the person's needs and circumstances, in order to recommend the best care possible and help the person recover. The assessment must be completed under the guidance of an LPHA. It may be acceptable in some instances other qualified staff or other qualified staff to offer support to the person in care during the assessment process and/or may share information with the treatment team through collaboration. During an assessment, the person completing the assessment develops a clinical understanding regarding the person's care needs, determines an accurate diagnosis, confirms the appropriate treating system, and what services are medically necessary to support the person in their goals so they can thrive in their community. For some individuals, completing an assessment may include collecting information from collateral sources including, but not limited to, family members and other natural support persons, prior service providers and/or external system partners. While the assessment is in process, the person in care may simultaneously receive additional clinically appropriate treatment services (such as therapy, rehabilitation, case management, medication support, etc.). These services are reimbursable under Medi-Cal even when:

1. The services are provided prior to determination of a diagnosis, during the assessment process, or prior to determination of whether SMHS access criteria are met;
    a. Remember that while a mental health diagnosis is not a prerequisite for access to covered services and while a person may access necessary services prior to determining diagnosis, an ICD-10 code must be assigned to submit a service claim for reimbursement.
2. The person in care has a co-occurring mental health condition and substance use disorder (SUD); or
3. Non-specialty mental health services (NSMHS) and specialty mental health services (SMHS) are provided concurrently, if those services are coordinated and not duplicative.

Many different tools or tests are available to assess different aspects of a person's functioning, such as tools to assess trauma, depression, suicide risk, and mental status. While the use of tools is often left to the discretion of the assessing practitioner, it is the practitioner's responsibility to use the tool for its intended purpose and to have the appropriate training for administration and scoring of the tool. Note that some tools must be completed by clinicians, while others may be completed by other types of staff, including MHRS or other qualified staff. Information or results from the tools utilized should be included as part of the assessment.

DHCS requires practitioners to complete an assessment for the determination of

behavioral health needs. While all persons shall receive a mental health assessment to best determine their individual needs, there are different assessments to meet this requirement, based on age and type of service being sought.

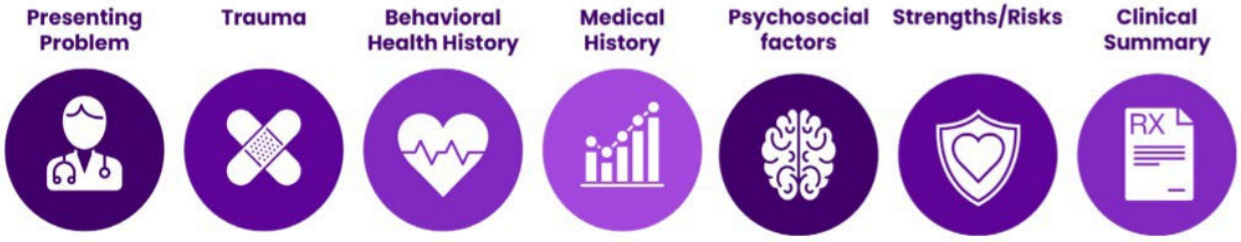
Central to the completion of a comprehensive assessment is collaboration with the person in care. Centering the voice of the person in care and remaining curious and humble about the person's experiences, culture and needs during the assessment process is crucial to building this collaboration. When assessments are conducted in this manner, they function as an important intervention and relationship building opportunity. Focusing on strengths, culture, and resiliency, in addition to challenges, creates a setting where the person in care feels seen as a whole person. Assessments must be approached with the knowledge that one's own perspective is full of assumptions, so that staff maintain an open mind and respectful stance towards the person in care.

Curiosity and reflection indicate humility and a deep desire to truly understand the person in care and to help them meet their needs. A key outcome of the assessment process is the generation of shared agreement on the strengths and needs of the person in care, as well as how to best address those needs. The assessment process generates a hypothesis, developed in collaboration with the person in care, that helps to organize and clarify service planning.

Assessment Domain Requirements

The assessment contains universally required domains that should not vary from MHP to MHP or CBO to CBO. Below is information on the standardized domains comprising the assessment for understanding the person's care needs. While each of the domains are required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the person's current and historical need is accurately documented. Include the perspective of the person in care and, whenever possible, use their quotes within the document.

Below are the domain categories, key elements, and guidance on information to consider under each domain. The information in the outline below is not meant to be an exhaustive list. The practitioner should always consider the person within the context of their developmental growth and their larger community, including cultural norms or expectations when completing and documenting an assessment. Information within the assessment should come from the person seeking care, in their own words whenever possible. Particularly for children/youth and those with disabling impairments, this may also include information from collateral sources.



Presenting Problem/Chief Complaint (Domain 1)

Domain 1 focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint.

- Presenting Problem (Current and History of) – The person's and collateral sources' descriptions of problem(s), history of the presenting problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.
- Current Mental Status Exam (MSE) –A standard assessment tool used by practitioners to assess the basic functioning of a person in care. An MSE is completed in the initial assessment and updated at least annually. The assessment categories include mood, cognition, perception, thoughts, behaviors, insight, and judgement.
- Impairments in Functioning – The person and collateral sources identify the impact/ impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning. Functioning should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.

Trauma (Domain 2)

Domain 2 involves information on traumatic incidents, the person in care's reactions to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care — it is not necessary in every setting to document the details of traumatic incidents in depth.

- Trauma Exposures – A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.).
- Trauma Reactions – The person's reaction to stressful situations (i.e., avoidance

of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.

- Trauma Screening - The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}), indicating elevated risk for development of a mental health condition.
- Systems Involvement – The person's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.

Behavioral Health History (Domain 3)

Domain 3 focuses on history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/ abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

- Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.
- Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.
- Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addiction Treatment [MAT]), length of treatment, and efficacy/ response to interventions.

Medical History and Medications (Domain 4)

Domain 4 integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides important context for understanding the needs of the people we serve.

- Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.
- Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.

- Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21-years-old or younger).

Psychosocial Factors (Domain 5)

Domain 5 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

- Family - Family history, current family involvement, significant life events within family (e.g., loss, divorce, births).
- Social and Life Circumstances – Current living situation, daily activities, social supports/ networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community.
- Cultural Considerations – Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) and/or Black, Brown, Indigenous, and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practices.

Strengths, Risk and Protective Factors (Domain 6)

Domain 6 explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Practitioners should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing.

- Strengths and Protective Factors – personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships.
- Risk Factors and Behaviors – behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/ planning/intent, aggression, inability to care for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used.
- Safety Planning – specific safety plans to be used should risk behaviors arise, including actions to take and trusted individuals to call during crisis.

Domain 7 provides practitioners an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

- Clinical Impression – summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below).
- Diagnostic Impression – clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified).
- Treatment Recommendations – recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care.
    - If including targeted case management (TCM)/intensive care coordination (ICC) services as the treatment recommendations, the Domain 7 requirements shall also include the following:
        - Specifies the goals and actions to address the medical, social, educational, and other services needed
        - Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals
        - Identifies a course of action to respond to the assessed needs
        - A **transition plan** once a person in care has achieved the goals

OR

    - The above requirements shall be imbedded in the narrative of every progress note using the right-click template

Additional Assessment Requirements

Adverse Childhood Experiences (ACE) & Pediatric ACEs and Related Life-events Screener (PEARLS): Adverse Childhood Experiences (ACEs) are traumatic experiences that children experience before the age of 18 that can have lasting impacts on their mental health, physical health, and general well-being. By screening for ACEs, providers can better determine the likelihood a person is at increased health risk due to a toxic stress response, which can inform treatment and encourage the use of trauma-informed care. Detecting ACEs early and connecting people to interventions, resources,

and other supports can improve the health and well-being of individuals and families. Based on the age of the person in care, it is required to complete one or the other (PEARLS: 0-17; ACES: 18+).

Both the ACEs and PEARLS may be completed collaboratively but shall **NOT** be completed without the person in care and/or their parent/caregiver. If completed collaboratively, these shall be completed by Licensed, Licensed-Eligible, or SWIII staff (MCBH), as well as by SMHS Contracted Providers. Both tools are available in Avatar and may also be printed from the QI website. The printable forms should be paired to the appropriate age and recipient(s), and/or be provided to the caregiver and/or child/youth, and then transcribed (manually entered) into Avatar (the results). Note: Staff need not worry about the syntax (i.e. you/your child, etc.) of the forms, as all of the questions on each version are the same.

- Prior to the administration and interpretation of these tools, staff may complete the 3-hour training online at www.acesaware.org.
- ACE:
    - Completed for those ages: 18+
    - Completed by the person in care
    - Frequency
        - At least once as part of the initial assessment for all persons in care
        - In the case the person in care refuses to complete the questionnaire, document refusal in a progress note and attempt at a later date
        - By definition, ACEs occur in childhood and therefore do not change, however, a person's comfort with disclosure may change over time, so re-screening may be considered upon clinical discretion
        - At the annual update after person in care's 18th birthday, administer the ACEs
- PEARLS
    - Completed for those ages: 0-17:
        - Ages: 0-11 - Completed by the parent/caregiver on behalf of person in care
        - Ages: 12-17 - Completed by either the parent/caregiver AND/OR person in care
            - This version contains two additional questions in Part 2
            - Best practice for BOTH parent/caregiver and person in care to complete
            - When these yield different scores, the higher score should be used
        - Frequency
            - At least once as part of the initial assessment for all persons in care
            - Periodic re-screening as appropriate and medically necessary

Child and Adolescent Needs and Strengths (CANS): is a multi-purpose tool that supports decision-making, including level of care and service planning, which allows for the monitoring and outcome of services. MCBH also requires the use of this tool for persons in care ages 6-20. The CANS must be completed as part of the initial assessment, updated every 6 months from date of initial completion, and at the time of discharge. CANS may be administered by any staff on the treatment team. To note, Services to Education programs are also required to complete the CANS-EI at onset and discharge.

Pediatric Symptom Checklist (PSC): A 35-item parent/caregiver-report psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-35 is completed by a parent, guardian, or caregiver for persons in care ages 3 through 18. PSC-35 must be completed as part of the initial assessment, updated every 6 months from date of initial completion, and at the time of discharge.

Columbia Suicide Severity Risk Scale (C-SSRS): Supports suicide risk screening through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, determine the severity and immediacy of that risk, and gauge the level of support that the person needs. C-SSRS must be completed at onset as part of the initial assessment and updated annually thereafter.

Stanley Brown Safety Plan: Provides people who have experienced a crisis or intense levels of stress with a specific set of coping strategies and resources to use in order to decrease the risk of harmful behaviors. The Stanley Brown Safety Plan must be completed at onset as part of the initial assessment and updated annually thereafter.

Other Requirements

- MCBH requires staff and contracted providers to use the CalAIM Assessment.
- The time period for practitioners to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, practitioners shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice but no later than 365 days after date of care coordination.
- Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the person does not meet criteria for SMHS.
- The assessment shall include the practitioner's recommendation – and the determination of eligibility for medically necessary services. The problem list and progress note requirements identified later in this guide shall support the medical necessity of each service provided.
- The diagnosis, Mental Status Exam (MSE), medication history, and assessment

of relevant conditions and psychosocial factors affecting the person's physical and mental health must be completed by a provider, operating in their scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan (BHIN 22-019; BHIN 21-071; BHIN 21-073, BHIN 23-068).

- Appropriate Screening Tools:
    - SUD Screening Tool: must be administered to all beneficiaries requesting substance use disorder services from Monterey County Behavioral Health or directly with a DMC ODS Provider. This tool is sufficient to determine a preliminary level of care placement for beneficiaries within the DMC- ODS System. Medical necessity is not required to be established prior to receiving treatment within the DMC-ODS system of care.
    - Children's System of Care Screening Tools: MCBH is obligated to provide Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) to all children and youth under the age of 21 eligible with full scope Medi-Cal and who meet medical necessity criteria and need these services. ICC, IHBS, and TFC services will now require the applicable screening tool to be completed for any child/youth prior to rendering the service(s) and/or currently receiving these services.
    - Full Service Partnership (FSP) Eligibility Screening Tool: The FSP Eligibility Screening Tool identifies qualifying criteria that justify placement in an FSP level of care for children/youth (0-15), transition age youth (16-25), adults (26-59), and older adults (60+).
    - Screening Tool for Crisis Residential Services: This tool screens in/out persons in care who may be eligible for crisis residential services to ensure they are appropriately placed in the safest and least restrictive level of care.
    - Screening Tool for Adult Transitional Residential Services: This tool screens in/out persons in care who may be eligible for Adult Transitional Residential Services, to ensure that individuals are appropriately placed in a safe and least restrictive level of care.
    - Screening Tool for Day Rehabilitation Services: This tool screens in/out persons in care who may be eligible for Day Rehabilitation services, to ensure they are appropriately placed in a safe and least restrictive level of care.
    - Screening Tool for Day Treatment Intensive Services: This tool screens in/out persons in care who may be eligible for Day Treatment Intensive services to ensure they are appropriately placed in a safe and least restrictive level of care.

Definition of Medical Necessity

All Medi-Cal services provided to persons in care need to meet the standard of being "medically necessary". The definitions of medical necessity are somewhat different, based upon the age of the person in care (BHIN 21-073).

Medical Necessity	
Individuals aged 21 and older	Individuals under 21 years of age
A mental health service is considered "medically necessary" when it is "reasonable and necessary to protect life, to prevent significant illness or significant disability, to alleviate severe pain."	A service is "medically necessary" if it is necessary to correct or ameliorate a mental illness or condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition. Mental health services considered "medically necessary" fall under the Early and Period Screening, diagnostic and Treatment (EPSDT) Services. .

Diagnosis

Information for the determination of a diagnosis is obtained through a clinical assessment and may include a series of structured tools. Information may come directly from the person in care or through other means, such as collateral information or health records. A diagnosis captures clinical information about the person's mental health needs and other conditions based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Diagnoses are determined by the case coordinator and other practitioners commensurate with their scope of practice. Diagnoses are used to communicate with other team members about the person's mental health symptoms and other conditions and may inform level of distress/impairment. Moreover, and most importantly, diagnoses may help the treatment team advise the person in care about treatment options.

As a person in care begins services with behavioral health, all persons must have an "Admission" diagnosis with an ICD-10 code set. Each new service episode of care includes an admission diagnosis. This diagnosis and an ICD-10 must be present in order to submit claim for services. On the admission diagnosis, the diagnosis date defaults to the admission date of the service episode. Do not change this date. The start date of the diagnosis must be the admission date of the specific service episode. Once entered, do not edit the admission diagnosis. A diagnosis with a DSM 5 and ICD-10 code set must be updated at least once annually (MCBH Policy 129). However, an "Update" diagnosis may be completed at any time in the course of treatment.

Diagnoses should not remain static. For example, the person's clinical presentation may change over time and/or the practitioner may receive additional information about the person's symptoms and how the person experiences their symptoms(s) and conditions. As a practitioner, it is your responsibility to document all diagnoses, including preliminary diagnostic impressions and differential diagnoses, as well as to update the person in care's health record whenever a diagnostic change occurs.
While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SMHS, the responsibilities of MCBH related to CCAHs remain unchanged. For example, MCBH is not required to provide Applied Behavior Analysis (ABA), a key intervention in the treatment of Autism Spectrum Disorder (ASD), as that responsibility still lies with the CCAH. However, a person in care who has ASD is able to additionally receive treatment from MCBH if their service needs require it and are not duplicative (BHIN 21-043).

Providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established (BHIN 22-013):

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by a Licensed

Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

- **ICD-10 code Z03.89**, “Encounter for observation for other suspected diseases and conditions ruled out,” may be used by an LPHA or LMHP during the assessment phase of a person’s treatment when a diagnosis has yet to be established.
- In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS approved ICD-10 diagnosis code list 1, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code (BHIN 22-013). For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.”

Stages of Change

While the assessment, diagnosis, and problem list are necessary to understanding the person's overall care needs, equally as important is the consideration of the stage in which the person is in their recovery. The Stages of Change framework supports practitioners in meeting the person where they are. Their readiness for change offers empowerment to the person. This framework lends itself to the identification of evidence-based interventions compatible with each stage of change and supports the conceptualization of change as a continuum. Change is not considered a linear process and should be evaluated throughout the course of care.

Moreover, a person may be in different stages of change relative to each issue. Movement from stage to stage may vary per person and may, at times, move backwards in addition to forwards through the stages. Some persons may move faster than others, while others may plateau in one stage for a longer period. A practitioner may take this opportunity to engage the person in understanding the situation.

We should note, relapse or reversion in symptoms, behaviors and/or functioning is a normal part of the change process. When relapse occurs, practitioners should take time to evaluate the situation alongside the person in care and continue to encourage and explore pros and cons of changes.

Stage	Description	Potential Behaviors
Precontemplation	This is the period prior to any action towards change. The person has not yet begun to think about change. Person is not aware they hove o problem.	Seeking services due to pressure of others (i.e., parent, partner, employer, courts). Place responsibility of problems on other factors or persons.
Contemplation	Person is aware they have a problem. During this period, the person begins to consider the possibility of change and begins to evaluate the benefits of making change. Not fully dedicated to taking action.	Considerations of the pros and cons of change are weighed. Action may take place if pros outweigh cons. Planning may take place the next few months.
Preparation	Person begins planning to make changes to what they are most committed to. Adjustments begin toward making change.	Person is future thinking and focused on their commitment.
Action	Specific changes to aspects of life that are contributing to undesired situation or problem. Changes may be behavioral or environmental. Changes may include decreasing unhealthy behaviors or increasing healthy ones.	Person is actively modifying their behaviors and is committed to change.
Maintenance	Actively working to sustain previously changed behaviors.	Person is committed to maintaining changes. Requires strong commitment of the person to avoid reverting to previous behaviors. Person has strong supports, including community connectedness.

Care Coordination

Treatment Teams

While the precise composition of teams varies in each individual situation, it is not uncommon to have treatment teams with some combination of psychiatric social workers, social workers, behavioral health aids, support staff, partner providers, medical staff and others who work with the person in care.

It is critical that treatment teams include the person in care and center their voice and priorities as the treatment team collaborates to support the person in care in meeting their goals. Teaming should be a seamless part of treatment and all members should work collaboratively to ensure that work is highly coordinated and aligned across providers.

Doing this well takes intentional partnership, information-sharing, and focus. Treatment teams are highly encouraged to use consensus building decision making techniques and to solicit and explore viewpoints across the team. The case coordinator is the primary support for the person in care.

Responsibility of the Case Coordinator

Monterey County Behavioral Health uses a Care Coordination (Coordinator) model for its delivery of services to the person in care/family in an effort to support the person in care/family's recovery. The Case Coordinator plays an integral part in supporting the person in care/family's access to medically necessary services and avoids duplication of services by working in conjunction with other staff and providers to support person in care/family's recovery. It is important to point out that the Case Coordinator is not solely responsible for the direct delivery of all mental health services to the person in care; instead, the Case Coordinator is responsible for coordinating care among service providers to meet the mental health needs of the person in care/family. Further, the Case Coordinator is responsible for ongoing assessment of the person in care's mental health needs and medical necessity.

As noted above, there may be a variety of service providers involved in the delivery of services. For this reason, we have included a "Supporting Staff" form in AVATAR which is used to communicate which staff members are supporting the person in care's recovery. Once a Supporting Staff member has been added, the designated person in care will display on the "My Clients" widget for the given Supporting Staff member. This option, in no way, waives the person's confidentiality. Thus, we must all continue to adhere to all policies regarding confidentiality of protected health information. Please note: The Case Coordinator is responsible for removing "supporting staff" members

from the supporting staff list once the supporting staff member is no longer part of the person in care's treatment team.

As the Case Coordinator you are responsible for maintaining communication and collaboration with treatment providers as well as maintaining the accuracy and integrity of the medical record by adhering to documentation standards and timelines. The Case Coordinator role also includes reviewing and updating the diagnosis, maintaining the treatment plan, and contributing to the problem list. When services are denied or modifications to the services are made, the Case Coordinator is responsible for communicating of these needs with other staff and/or service providers.

Reminder: The Case Coordinator may review the list of persons in care on their caseloads using the 201 Caseload report. Supporting Staff may use the 218 Other Support Staff report for a list of persons in care on their caseload.

Original Date of Coordination

The date on which the person in care is first opened to an outpatient "coordinated care" episode is considered the original date of coordination. This date is important because it informs the case coordinator about the treatment cycle, annual reassessment period, and helps MCBH comply with State and Federal regulations for the delivery of services. The original date of coordination (also referred to as "anniversary month"), can be found in the green-colored widget in the chart overview section of the individual's medical record.

Please note, on rare occasions, there may be times when the original date of coordination seems inaccurate, questions arise about this date, or there may be a clinically relevant reason for special considerations for modification of this date. In those instances, the case coordinator may submit the "Error Reporting" form indicating the error or reason for the change request along with supporting evidence for the request. The request will be reviewed by a QI clinical staff member, and a decision will be made regarding the request. The QI team may contact the case Coordinator for further information prior to making a decision.

Note: Some persons in care may have had other services prior to this admission that are not considered coordinated outpatient episodes, this list of programs include, and are not limited to: ZADP, FFS, MHSA-Clinic Integration, CHS, DRS, certain Access Programs (when treatment is not provided), ER Crisis, ER Mobile Crisis, MHU, JJ Juvenile Hall, AS Vet Court, Prop 47 MILPA, SUD Programs, TARs, and Pre-Admission. These do not impact the date of coordination.

UMDAP

Monterey County Behavioral Health (MCBH) uses the Uniform Method of Determining the Ability to Pay (UMDAP) as a sliding scale of liabilities based on the person's and/or financially responsible parties' ability to pay for the cost of mental health services provided. The UMDAP establishes a process for collecting the person's financial information, billing for financial liability, and/or collecting payment for services. This information is used to assess the person in care/family's and/or the financially responsible party's annual liability. The person in care/financial responsible party are responsible for payment of actual cost of care, inclusive of all other resources such as Medi-Cal and third-party payers, up to their annual liability. The UMDAP information is obtained during the intake process and is renewed, at least, on an annual basis by completing the "Family Registration" forms in Avatar.

MCBH will not withhold services from anyone based on their past due balance or inability to pay. Note: Please refer to the Avatar User Guide for instructions on completing the UMDAP form.

Special Considerations

During the course of assessment and treatment, there may be information shared and/or observed by the practitioner that is deemed pertinent for all staff to be aware of, in order to safely engage the person in care in services. The "Special Considerations" form is used to communicate to the treatment team any special circumstances related to the person in care's treatment. The Special Consideration form will allow the practitioner to include information regarding an active "Safety Plan" as well as "other" considerations.

The Safety Plan section shall be used to communicate the active safety plan that is in place to help support the person in care's needs. The Safety Plan section will display at the top of the "client notifications" (green widget) section of the chart overview. The Safety Plan will provide an opportunity for the treatment team to quickly view and understand the active safety plan and provide information on how to best support the person in care during this time. The form will allow the practitioner to enter a start and end date for the Safety Plan; only one "active" Safety Plan at a time is permitted.

The "other" Special Considerations section will allow the practitioner to enter other important information or considerations related to the person in care's treatment. This section may include information about person in care's language needs, hearing deficits, gender identity preferences, mobility considerations, etc.

Both, the Safety Plan and Other Considerations, will display in the "client notification" widget (green widget) section of the chart overview. When an "active" Safety Plan has

been identified, the information about the safety plan will display on the top of the “client notification” widget. The information on “other” considerations will display at the bottom of the notification widget.

Co-Occurring Treatment

Co-Occurring treatment, also known as dual diagnosis treatment, refers to an integrated approach to addressing both mental health and substance use disorders that present simultaneously. Co-occurring treatment recognizes that mental health and substance use disorders often coexist and interact, influencing each other's severity and progression.

Co-Occurring treatment is based on understanding that treating one condition while ignoring the other can lead to incomplete recovery and an increased risk of relapse. By providing co-occurring treatment, providers can deliver comprehensive and coordinated care that addresses both the mental and substance use aspects of the well-beign of a person in care.

Under CalAIM, the No Wrong Door policy aims to ensure that people have access across the right care at the right time. No Wrong Door specifies that clinically appropriate SMHS are covered and reimbursable even when the person in care has a co-occurring substance use disorder. Similarly, clinically appropriate and covered DMC and DMC-ODS services are covered by DMC and DMC-ODS plans even when the person in care has a co-occurring mental health disorder. Co-occurring diagnoses can interact and influence each other, leading to more complex treatment. By recognizing and understanding the interplay between co-occurring diagnoses, providers can provide more effective treatment tailored to the person in care's needs.

The Complex, Unstable, and Bidirectional Nature of Co- Occurring Disorders

Providers working with people who have co-occurring disorders often want to know which disorder developed first. The answer is not always clear because the temporal nature of Co-Occurring Disorders can be inconsistent and nuanced. In some cases, a mental disorder may obviously have led to the development of a substance use disorder example would be someone with long-standing major depressive disorder who starts using alcohol excessively to cope and develops alcohol use disorder. In other instances, substance use clearly precipitated the mental disorder—such as when someone develops a cocaine-induced psychotic disorder. In many cases, it will be uncertain which disorder occurred first.

Furthermore, Co-Occurring Disorders can be bidirectional. For some people, there may be a third condition that is influencing both or either of the two comorbid disorders (e.g.,

HIV, chronic pain). Environmental factors, like homelessness or extreme stress, can also affect one or both disorders. Thus, even when it is clear which disorder developed first, the causal relationship may be unknown. Regardless of the temporal-causal relationship between a person's substance use disorder and mental illness, the two are likely to affect, and possibly exacerbate, one another. This means that both need to be treated with equal seriousness.

Treatment Planning

Overview

A treatment plan is a document, co-created by the person in care and the case coordinator that outlines the steps needed to achieve particular goals or outcomes. Monterey County Behavioral Health is committed to providing person-centered care. This commitment is shown when mental health practitioners engage persons in the development of a meaningful treatment plan. The treatment plan is the primary way we empower persons in care to develop a plan to achieve their recovery and resiliency goals. The treatment planning process supports persons in understanding what they can expect from the behavioral health services we provide and their own role in their recovery. Monterey County Behavioral Health embraces the obligation of providing persons with the most effective treatment and use of evidenced-based care available to help persons reach their personal goals and thrive in their community.

Research clearly shows the importance of practitioners investing time to support persons in care in making educated decisions about the care they receive. Without developing person friendly treatment plans, research shows we fail to retain the person in care who feels they have not developed a shared vision of success with their practitioner. A treatment plan should be like a roadmap to success. We join with persons in care to develop an understanding of where they are and where they want to arrive, then we plot out a map of how we as mental health providers can help reach their goals.

As you start to develop a treatment plan, don't focus on what is a problem, goal, objective, or intervention. Start first with why are we treatment planning? Our real reason for completing a treatment plan is the opportunity to develop a shared vision of success with persons in care and their families. At least once a year we have the chance to join with our persons in care to ask; why are you here, what do you want, and how can we help you get it? If we find ourselves unable to ask or answer these questions, then we need to look closely at medical necessity – are the services we are providing necessary for this person? All services need to be medically necessary and must be treating symptoms of an identified diagnosis. It is the responsibility of the case coordinator to work with the person in care and any providers to ensure that the person receives agreed upon services that will help reduce the barriers/impairments resulting from their mental health condition.

Program goals should be consistent with the person's/family's goals as well as the diagnosis and assessment. The person in care's participation and understanding of all elements of the plan is essential and participation must be documented in the plan development progress note.

Treatment Plans

The use of a Problem List has largely replaced the use of treatment plans, except where federal requirements mandate a treatment plan be maintained.

A Treatment Plan shall be completed for the following **Service Types and/or Programs**:

- Children's Crisis Residential Programs
- Community Treatment Facilities
- Enhanced Care Management
- Mental Health Rehabilitation Centers
- Full-Service Partnership (FSP) Individual Services and Support Plan (ISSP) (Note: These are any programs that have names ending in 'FSP' in Avatar)
- Peer Support Services
- Short-Term Residential Therapeutic Programs
- Social Rehabilitation Programs which include: Short-Term Crisis Residential Treatment; Transitional Residential Treatment; and Long Term Residential Treatment
- Therapeutic Behavioral Services

Components of a Treatment Plan

Treatment Plan Dates

Treatment Plan "Start", and "End" dates coincide with the "original date of coordination." The Treatment Plan dates run for the course of one year. As an example: If the original date of coordination is February 15, 2022, then the initial Treatment Plan (MCBH 2022) dates are 2/15/2022 - 1/31/2023. This initial treatment plan will be "finalized." This means the plan can no longer be edited, so a "draft" plan will need to be created to add/update goals. In the event that the person in care is opened for services with another program during this same year (let's say another episode opened on 5/3/22) the adjunct program will enter treatment goals onto the "draft" plan.

All goals will show the date the goals were created. These dates coincide with the dates for which the person in care receives services within the program(s). In our example above, the individual goals for the adjunct program would reflect the 5/3/2022 date.

Please note: As the person in care achieves their particular goals or is no longer interested in working on a particular goal, it is the responsibility of each program to close out the program's treatment goals by entering the date the goal was closed and/or completed on the treatment plan.

It is important to "finalize" the treatment plan and then generate a "draft" plan which will function as a "living document." The draft plan can be updated throughout the course of

treatment to accurately reflect the needs and goals of the person in care/family. This includes updating the dates on the specific Problem, Goal, Objectives, and Interventions for those goals which the person in care intends to continue to work on achieving.

Treatment plans are required to be completed at onset and updated annually and/or whenever clinically indicated. In the example above, an updated Treatment Plan is required for the plan year 2/1/2023 -1/31/2024 and must be completed before 2/1/2023.

My Life Goals/Aspirations (In Person's Own Words)

This statement is located at the beginning of the treatment plan, and it is intended to be a space where the person in care's goals are freely stated. This space may indicate the person's desired outcome of successful treatment. This is the reason the person is seeking treatment. Overall goals are broad life goals, such as returning to work or graduating from high school. The overall goal is meant to be a global objective that reflects the person's intent and interests. The overall goal should be clear to the person in care and the treatment team, and it should reflect the person's preferences and strengths. These goals have a special place in a system committed to recovery and resiliency – they should speak to the person in care's ability to manage or recover from their illness and achieve major developmental milestones. Reminder: Treatment plans written in both, English and the person's/family's preferred language, support the person in care by increasing understanding of treatment and encourage participation goal attainment.

My Challenges/Barriers (Problem)

This is a statement of the behavioral signs and symptoms of the primary diagnosis and other barriers and/or challenges in the individual's life domains. This statement is the focus of treatment. Remember: The problem is not the diagnosis--the problem is the symptoms, of the diagnosis, that prevent the person in care from living the life they want.

It may take time to build an understanding with our persons in care about the symptoms/challenges/barriers they may be experiencing. However, as part of the informed consent process, the practitioner joins with the person in care (and possibly their family) to share their clinical perspectives. Working with the person in care, the practitioner and the person can develop a shared understanding of the problems that can benefit from treatment. Our role as practitioners is to help our persons in care understand how the symptoms of the diagnosis might be interfering with reaching their goals.

My Hopes/Goals (In Person's Own Words)

Goals build upon the strengths, preferences, and needs of the person in care. Goals should embody hope. Practitioners need to be mindful that identifying a goal to a practitioner can be frightening to a person, child or family. Sharing one's aspirations with another can make people feel vulnerable. A practitioner starts the person in care thinking about their goals by asking the "Miracle Question." - If you woke up tomorrow and all was well, what would that look like?

A goal is always stated in the persons own words and should relate to a quality of life goal. For example: I want a car, I want to go back to school to get my BA degree, I want a girlfriend/boyfriend, I want to get off of SSI and be self-sufficient. The goal is the development of new skills/behaviors and the reduction, stabilization or removal of the barrier/problem. Individual goals are generally related to important areas of functioning affected by the person in care's mental health condition, such as living situation, daily activities, school, work, social support, legal issues, safety, physical health, substance abuse, and psychiatric symptoms. The assessment must clearly document how a particular goal reflects the person in care's mental health condition:

- A goal should be a shared vision of success
- Goals express the hopes and dreams of the persons in care
- Goals identify the hoped-for destination to be arrived at through the services provided

Person-Centered goals:

- Ideally expressed in the words of the individual, their family and/or other supportive individuals
- Easily understandable in the persons in care's preferred language
- Appropriate to the person's culture; reflect values, traditions, identity, etc.
- Consistent with desire for self-determination and self-sufficiency and may be influenced by culture, tradition, and sense of community
- Written in positive terms
- Consistent with abilities/strengths, preferences and needs
- Embody hope/alternative to current circumstances

Writing too many goals can make a treatment plan overwhelming and unwieldy to both practitioner and the person in care. If we are able to consolidate goals, the treatment plan can have greater focus and clarity.

My Action Step (Objectives)

Objectives are the smaller accomplishments or the steps the person in care/family will need/want to make in order to achieve their goal. The objectives are used to address an already identified issue in the psychosocial assessment and the challenge statement.

They are specific to a mental health barrier or functional impairment. It may include specific skills the person in care will master and/or steps or tasks the person in care will complete to accomplish the goal. Objectives should be specific, observable, and/or quantifiable and are related to the assessment and diagnosis. Objectives need to be:

- Appropriate to the setting/level of need/stage of change.
- Responsive to the person or family's individual abilities and challenges.
- Appropriate for the person's age, development, and culture.
- Quantifiable and time limited.

Objectives should be specific, observable, and quantifiable enough so that both, you and the person in care, are likely to agree on the point in time when the objective/goal is achieved. The focus of the objective is the actual demonstration of new skills and/or abilities. Additionally, not all objectives should be based on a year timeline. The person in care's annual plan may involve planning for one year but the timeframe of an objective should be specific to the person's needs.

The person in care should have enough time to work through meeting their objectives, but not make it so long that the person/family has little opportunity for smaller successes along the way.

Supports (Interventions)

Interventions are the things the practitioners will do in order to assist the person in care to meet his/her objectives and eventually the life goal(s). These interventions are mental health interventions and relate back to the challenge/problem statement. They answer the five W's:

- Who: Clinical discipline of practitioner (e.g., case coordinator, practitioner, etc.)
- What: Modality/Service provided
- When: Frequency/intensity/duration
- Where: Location
- Why: Purpose/intent/impact

The interventions are why we receive reimbursement from Medi-Cal. Interventions define the concrete strategies/actions that will be utilized to assist the person/family in

meeting the objectives. All proposed interventions must meet medical necessity criteria.

Keep in mind that you can have multiple interventions (different service types) for the same problem/goal/objective cluster. Service types often include: medication services, group counseling, individual counseling, case management, and for the full service partnership persons in cares, intensive case management. Each intervention needs to be specific and non-duplicative.

Components of a Good Treatment Plan

- Clinically Relevant: The plan clearly outlines needs identified in the assessment.
- Culturally Relevant: The plan should consider all types of cultural issues to arrive at a meaningful understanding of the person in care's worldview. These considerations include ethnicity but are expanded to include family of origin, traditions and holidays, religion/spirituality, education, work ethic etc. Whenever possible, the plan should be written in English followed by person in care/family's preferred language.
- Person-Centered: The plan should be written in a way that is culturally sensitive and personally relevant. The plan is developed in collaboration with the person in care and uses language that is understandable and is acceptable to the person.
- Real: A good treatment plan meets and reflects where the person in care is in their lives/recovery. Remember, start where the person is.

Linking Services to Treatment Plan (Applicable to FSP Programs)

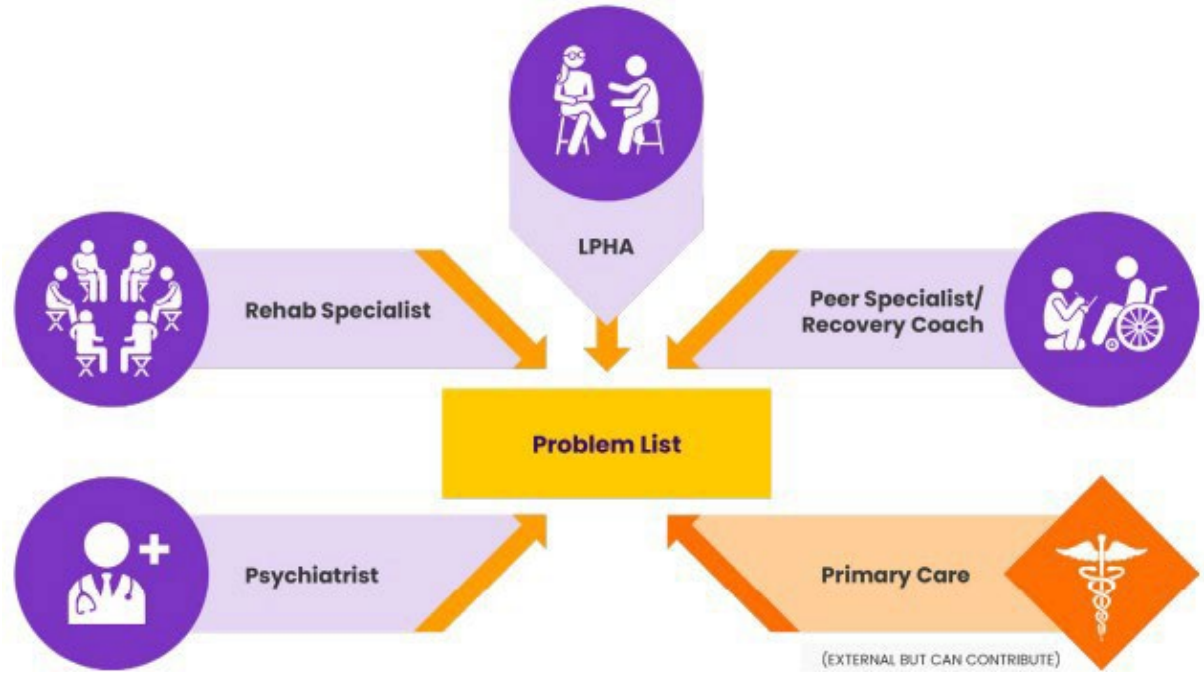
ALL service codes with the exception of Non-Billable, Assessment, Treatment Planning, and Crisis Intervention service codes, MUST link to the person's treatment plan.

Problem List

All persons in care shall have a problem list (BHIN 22-019 and BHIN 23-068). The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. This may include:

- Mental health diagnosis
- Substance use diagnosis
- Social determinants of health (Z55-Z65)
- Other Z codes
- Physical health conditions

A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list. The providers responsible for the person's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by Mental Health Rehabilitation Specialists, Peer Support Specialists, and other treatment team members acting within their scope. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues. As seen in the image below, a person in care may have several people contribute to a Problem List.



When used as intended, treatment teams can use the problem list to quickly gain

necessary information about a person's concerns, how long the issue has been present, the name of the practitioner who recorded the concern, and track the issue over time, including its resolution. The problem list is a key tool for treatment teams and should be kept up to date to accurately communicate a person's needs and to support care coordination.

DHCS has identified a list of priority SDOH codes to facilitate the collection of reliable SDOH information for the Medi-Cal population. You may find this list at the end of this guide.

Problem List Requirements

The problem list shall be updated on an ongoing basis to reflect the current presentation of the person in care.

The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any.
    - Include diagnostic specifiers from the DSM if applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the person in care and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Providers shall add or remove problems from the problem list when there is a relevant change to a person's condition.

Monterey County Behavioral Health and its contracted providers shall ensure that all persons in care have a problem list created at intake, annually, and whenever there is a new problem or illness identified.

Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a person, and to support claiming for services. Inconsistencies in either can lead to poor coordination of care across teams and treatment as well as inadequate documentation of the medical necessity of services, which can lead to rejected claims. The responsibility of ensuring that a person's problem list is accurate belongs primarily to the care coordinator.

Evidence Based Practices

Monterey County Behavioral Health supports and encourages the use of Evidence-Based Practices (EBP) as well as Promising Emerging Practices (PEP) in the treatment of persons in care to support resiliency, recovery, and wellness (MCBH Policy 130). EBP's have demonstrated, through research and practice, to be an effective modality in treating different types of mental health illnesses. EBP is the integration of 1) the best available research; 2) clinical expertise; and 3) the context of the person in care's characteristics, culture, and preferences. An evidence-based practice has been, or is being, evaluated and meets the following criteria:

- Has some quantitative and qualitative data showing positive outcomes but does not yet have enough research or replication to support generalized positive public health outcomes.
- Has been subject to expert/peer review that has determined that a particular approach or strategy has a significant level of evidence of effectiveness in public health research literature.

There are other practices that show promise in the treatment of different types of mental illnesses. These are called Promising Emerging Practices (PEP). They include those practices for which the scientific evidence is building, and which address a widely held need or gap in our service system. Monterey County has integrated a list of EBP and PEP into the clinical progress notes to encourage use and identification of those practices that are likely to help with each person in care's recovery and wellness. The core EBP used by Monterey County Behavioral Health (Motivational Interviewing, Dialectical Behavior Therapy, and Cognitive Behavioral Therapy) are described below. While these represent core EBP within Monterey County, the organization also recognizes that there are other EBP in use, which are reflected in the Avatar EBP menu for completion of progress notes.

List of Evidence Based Practices

- Motivational Interviewing (MI): A goal-directed, person in care-centered counseling style for eliciting behavioral change by helping persons in care to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change. Therefore, the examination and resolution of ambivalence becomes its key goal.
- Dialectical Behavioral Therapy (DBT): A cognitive-behavioral treatment approach using 2 key characteristics: (1) a behavioral, problem-solving focus blended with acceptance-based strategies; and (2) an emphasis on dialectical processes. It emphasizes balancing behavioral change, problem-solving, emotional regulation with validation, mindfulness, and acceptance.

- Cognitive Behavioral Therapy (CBT): A form of psychotherapy in which the therapist and the person in care work together as a team to identify and solve problems. CBT is used to help persons in care overcome their difficulties by changing their thinking, behavior, and emotional responses.
- Parent-Child Interaction Therapy (PCIT): A treatment program for young children (ages 2-7) with externalized behaviors that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child while encouraging prosocial behavior and discouraging negative behavior.
- Attachment-Based Family Therapy (ABFT): A psychotherapeutic model with a foundation in attachment theory. It is based on the belief that strong relationships within families can buffer against the risk of adolescent depression or suicide and help in the recovery process; to help children develop a healthy sense of self, trust in others, and better capacity for independence and affect regulation.
- Family Psychoeducation: A treatment modality designed to help individuals with mental illness attain as rich and full participation in the usual life of the community as possible. The focus is on informing families and support people about mental illness, developing coping skills, solving problems, creating social supports, and developing an alliance between persons in care, practitioners, and their families or other support people.
- Seven Challenges: A treatment for adolescents with drug problems. The goals are to motivate a decision and commitment to change and to support success in implementing the desired changes. Help youth think through their own decisions about their lives and their use of alcohol and other drugs teaching youth to identify and work on the issues most relevant to them. Helps address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems.
- Aggression Replacement Training (ART): The intervention program for aggressive young children and adolescents in K-grade 12. The program aims to improve psychological skill competence, anger control, and moral reasoning and social problem-solving skills.
- Brief Strategic Family Therapy (BSFT): Therapy designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve prosocial behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school.
- Attachment-Based Dyadic Therapy: Therapeutic model designed to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate

affect. It also aims at improving the child's cognitive, behavioral, and social functioning.

- Matrix: An intensive outpatient treatment approach for stimulant abuse and dependence where persons in care learn about issues critical to addiction and relapse. They receive direction and support, become familiar with self-help programs, and are monitored for drug use by urine testing.
- Seeking Safety: A present-focused treatment for persons in care with a history of trauma and substance abuse focusing on coping skills and psychoeducation. It follows 5 key principles: (1) safety as the overarching goal; (2) integrated treatment; (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes.
- Eye Movement Desensitization & Reprocessing (EMDR): A one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning.
- Intensive Community Team (ICT): A team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness.
- Triple P (Positive Parenting Program): A system of parenting interventions for families with children ages 0-8, which seeks to strengthen parenting skills and prevent dysfunctional parenting. The goal is to prevent child maltreatment and emotional, behavioral, and developmental problems.
- Intensive Family Preservation and Reunification Services (HOMEBUILDERS): Provides intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care to prevent the unnecessary out-of-home placement of children. Staff use intensive, on-site intervention, and to teach families new problem-solving skills to prevent future crises. The program provides crisis intervention and skill building, involves the family in the child's treatment, and broadens the continuum of care so that children are able to avoid the trauma and stigma of psychiatric hospitalization or residential treatment.
- Child & Family Traumatic Stress Intervention (CFTSI): is a brief early intervention model (for children and adolescents 7-18 and their caregiver) that is implemented soon after exposure to a potentially traumatic event. This model aims to improve children and adolescents impacted by traumatic stress, reduce posttraumatic stress symptoms, enhance emotional support through increased caregiver-child communication, teach/practice coping skills to reduce trauma reactions, identify and address concrete stressors and assess child’s need for long-term treatment.

Wellness Recovery Action Plan (WRAP)

Wellness Recovery Action Plan (WRAP) is described as a structured system that helps persons in care track uncomfortable feelings and behaviors and develop planned responses to reduce, modify or eliminate these feelings and behaviors. WRAP was developed by a group of individuals who were trying to find their own ways of effectively dealing with their mental health issues. A WRAP also acts as a plan that can tell others what a person in care needs when the individual feels so badly that they cannot make decisions for themselves and need support to stay safe. WRAP is used all over the world to support people with struggling with challenges including (but not limited to) trauma, depression, anxiety, substance abuse, post-traumatic stress disorder as well as physical health concerns such as diabetes. WRAP supports individuals with maintaining their wellness and taking control over their lives. WRAP is based on empowerment and personal responsibility and takes a holistic approach to recovery which encourages a focus on wellness and strengths rather than on what is not going well. WRAP trainings are provided by Monterey County Behavioral Health to introduce the WRAP system to practitioners and assist them with utilizing a WRAP with persons in care.

List of Promising Emerging Practices

- Joven Noble: A comprehensive indigenous-based youth leadership development program that supports and guides young men through their manhood "rites of passage" process. It also focuses on the prevention of substance abuse, teen pregnancy, relationship violence, gang violence and school failure.
- Xinachtli: A comprehensive indigenous-based youth leadership development program that supports and guides young women through their female "rites of passage" process. It also focuses on the prevention of substance abuse, teen pregnancy, relationship violence, gang violence and school failure.
- Cara y Corazon: A culturally-based family strengthening/community mobilization program that assists parents and other extended family to raise and teach their children in with a positive bicultural base.
- Applied Behavioral Analysis (ABA): A natural science approach to understanding student academic and social behavior; identifying those variables that educators can control that have an impact on student performance; starts from the assumption that by arranging for effective consequences to follow important educational behaviors -- either academic or social --F educators can influence the frequency of these behaviors.
- Thinking for a Change (T4C): An integrated, cognitive behavioral change program for offenders that includes cognitive restructuring, social skills development, and development of problem solving skills for adults and juveniles, both male and female; designed for delivery to small groups in 25 lessons.
- Cannabis Youth Treatment (CYT): The Cannabis Youth Treatment Series is a five-volume resource for substance abuse treatment professionals that provide a

unique perspective on treating adolescents for marijuana use. They include: 1) Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users; 2) Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement; 3) Family Support Network for Adolescent Cannabis Users; 4) The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users; and 5) Multidimensional Family Therapy for Adolescent Cannabis.

- Juvenile Sex Offender Treatment (JSORT)
- Trauma Focused Cognitive Behavior Therapy (TF-CBT): A psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy. It also may be provided in the context of a longer-term treatment process or in a group therapy format.

Payment Reform

The CalAIM Behavioral Health Payment Reform initiative is changing the way services are reimbursed. Payment Reform will move MCBH providers from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for people in care receiving Medi-Cal services. The go live date for many payment reform changes start 7/1/2023. This impacts any staff (county/contracted) claiming to Medi-Cal for services.

The goals of Payment Reform are to 1) Improve reporting and support data-driven decision making by disaggregating data on behavioral health services and 2) Align with other healthcare delivery systems and comply with Centers for Medicare & Medicaid Services (CMS) requirements for all state Medicaid programs to adopt CPT codes where appropriate.

Overview of Changes

- All service code descriptions will have a “CA” suffix and these shall be used 7/1/2023 moving forward (Note: continue to select the non “CA” suffix for any progress note with a date of service prior to 7/1/2023)
- Reimbursement rates are based on provider classification/category. Each staff will be assigned a specific practitioner category and corresponding taxonomy. Practitioner categories are based on education/certifications, job description, and/or licensure status and staff will be able to bill certain services based on their category.
- Progress Notes will now have Add-Ons which will be allowed for use for specific services and practitioner type including Extended Service, Interactive Complexity, Interpretation, Collateral, Psychotherapy for Medication Support (for psychiatry staff only), Crisis, Psychology, and Case Management (for psychiatry staff only) (See Add-On Codes Chapter for full description).
- Direct service, documentation, and travel time have been unbundled.
    - Direct service time is spent with the person in care for the purpose of providing a service and in some cases, direct service time is time spent with the members of the person’s care team, with family members or other supports, and other community support services.
    - Direct service duration does NOT include:
        - Travel time
        - Administrative activities
        - Chart review
        - Documentation
        - Utilization review
        - Quality assurance activities

    - Documentation time is the time it takes to document the service within the electronic health record. Documentation duration is specific to the time it takes for the provider to write a progress note or complete other forms of documentation on behalf of the person in care when the person in care is not present.
    - Travel duration is time spent traveling to and from your work location to provide a service to the client at their home or in the community (Note: if staff provide a service during the transportation of the person in care, that is a direct service and excluded from the total travel time).
- Lastly, there are new service codes available (See Service Components Chapter for full description).
    - Expanded Intensive Home-Based Services (IHBS)
    - Psychology
    - Service codes related to Family First Prevention Services Act (FFPSA) and Continuum of Care Reform (CCR) specific to youth receiving Short-Term Residential Treatment Program (STRTP) Services

Progress Notes

In previous sections, we explored the use of the screening tools, assessment, diagnosis, problem lists, and treatment plans to best identify the person's care needs and treatment options. Now, we will explore the use of progress notes for documenting services as providers work with individuals to address their needs. Progress notes have multiple functions.

First and foremost, progress notes are used as a basis for planning care and treatment among practitioners and across programs. Progress notes are communication tools; therefore, each progress note should be understandable when read independent of other progress notes. This means, documentation should provide an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided.

Secondly, progress notes are considered a legal record describing treatment provided for reimbursement purposes. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment. See Appendix for sample note narratives that provide sufficient documentation of the intervention.

Thirdly, individual progress notes may involve the use of specific Add-Ons to describe a service that is performed in conjunction with the primary service by the same practitioner. By "adding on" a code, the service reimbursement rates change and is more reflective of the specific service conducted by the staff/provider. These include Extended Service, Interactive Complexity, Interpretation, Collateral, Psychotherapy for Medication Support (for psychiatry staff only), Crisis, Psychology, and Case Management (for psychiatry staff only) (See Add-On Codes Chapter for full description).

Lastly, as noted earlier**,** progress notes are also used to communicate with other care providers. For these reasons, abbreviations should be avoided, unless universally recognized, to facilitate clear and accurate communication across providers and for when notes are used for legal or other reasons. Keep in mind that the person in care has legal privilege to their medical record and may review the medical record documentation. They should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

The following list are characteristics of a progress note that supports quality documentation. Consider the following characteristics when documenting:

Clear	Reliable
Consistent	Accurate/Precise
Descriptive	Timely

Required Progress Note Service Information

- The type of service rendered.
- The date that the service was provided to the person in care.
- Duration of the direct service, travel, and documentation.
- Location/place of the service. Note, the location of services refers to the location/place of the beneficiary while receiving the service, however, if the service is telehealth/telephone, use the telehealth/telephone option.
- A typed or legibly printed name, signature of the service provider and date of signature.
- A brief description of how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
    - For example, as clinically indicated, the brief description may include activities or interventions that occurred during the service event; issues discussed; and progress toward treatment goals or other treatment outcomes.
- A brief summary of next steps.
    - For example, as clinically indicated, next steps may include: planned action steps by the provider or by the person in care; collaboration with the person in care; collaboration with other provider(s); goals and actions to address health, social, educational, and other services needed by the member; referrals; and discharge and continuing care planning.
- Note: Monterey County Behavioral Health does not require a specific progress note format (i.e. FIRP, BIRP, SOAP), however requirement listed previously must be clearly documented in the progress note.

Group Progress Notes

The information above remains consistent for services provided in a group setting, with the following additional requirements:

- Each person in care that attended the group service must have a progress note.
- For groups facilitated by multiple providers, *each provider* will submit a progress note separately accounting for their own time and specific contribution.
- Group progress notes shall contain the information as noted above and modifications and additional information as noted below:
    - A brief description of the person in care's response to the service. For example, as clinically indicated, the individual note for a group service may

address the effectiveness of the intervention; progress or problems noted; group dynamics; or other information relevant to the person in care's participation, comments, or reactions during the treatment session.
    - The nature and extent of the information included may vary based on the service type and the person in care's clinical needs. Some notes may appropriately contain less descriptive detail than others. For example, a group note for a participant that chose not to speak during the group service may not include the same level of detail as a note for a group participant who engaged more actively, or a note for an individual counseling or therapy session.
    - Information about the specific involvement and specific amount of time of involvement of each provider in the group activity, including time spent traveling to/from the service and documenting the service.
    - Please note, due to confidentiality standards, a full list (or sign-in sheet) of group participants must not be kept in any single participant's personal health records, instead the MHP or practitioner must maintain the full participant list outside of any participant's health records.
- Group progress notes may involve the use of Add-Ons including Interactive Complexity, Interpretation, Collateral, and Extended Service (See Add-On section for further descriptions).

Progress Notes Timeliness

As noted above, each progress note should stand alone and be clear, complete, accurate, and free of jargon and local abbreviations. Documentation should be completed in a timely manner to support the practitioner's recall of the specifics of a service. Progress notes should never be completed in advance of a service. Below are timeliness expectations:

- Routine Outpatient Services: Documentation should be completed ***within 72 hours*** *from the date of service being provided*. If a note is submitted outside of the 72 hours, it is good practice to document the reason the note is delayed. Late notes should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations), stricter note completion timelines may be required by state regulation.
- Crisis Services: Documentation should be completed ***within 1 calendar day***.
- A Daily Note: Required for documentation of some residential services, day treatment, and other similar settings that ***use a daily rate*** for billing. Note: In these programs (i.e. Day Rehabilitation/Day Treatment Intensive/Adult Residential/Crisis Residential), weekly summaries are **no longer required**.

All person in care-related services must be entered **and** "finalized" in the Electronic Medical Records (EHR) within 72-business hours from when the service was provided. *Any other documents* related to a person in care (e.g., Suspected Child Abuse Reports

(SCAR), labs, etc.) must also be entered/scanned in the clinical record within 72-business hours. The intent of the 72-hour documentation policy is to establish a trend of timely documentation. All Behavioral Health direct service staff is expected to enter and finalize progress notes, in the EHR, ***a minimum of 90% compliance*** with the 72-business hour documentation standard. State regulations drive timeliness standards, which are based on the idea that documentation completed in timely manner has greater accuracy and makes needed clinical information available for best care of the person. State guidelines and auditors' practice established the 72-business hour documentation time frame utilized in Monterey County Behavioral Health.

However, perfection is not expected. QI recognizes that documentation cannot always be completed within 72-business hours. Situations may arise that prevent timely documentation, such as sickness, person in care crisis, or scheduling challenges. As with any trend's longevity, timely documentation is meant to be evaluated on a long-term basis. In cases where documentation is late, staff should document a brief reason for the **late entry**. The reason should be placed in the beginning of the progress note but should not be in extensive detail. For example, an entry such as "Late entry due to another person in care crisis" should suffice.

There are often questions on how the timeline expectation applies to services that occur at the end of the business day on Fridays or the day before a holiday. As mentioned, progress notes need to be completed within 72-business hours from when the service was provided.

The same rules apply for staff working alternative or modified schedules, the 72-hour business hours includes *all regular hours of operation* (excluding weekends and holidays) even if it coincides with a regularly scheduled day off that fall on a business day. For example, staff working four 10-hour days with Fridays off must consider that their regularly scheduled Friday off is still part of the calculations for the 72-business hour documentation standards.

There are some staffing classifications, such as new employees or interns, who require a reviewer or clinical supervisor to review the progress notes prior to finalization. Even in these instances, the 72-business hour standards apply. Generally, the practitioner completes a progress note, selects the "co-signature" option, and finalizes the progress note. This process sends the reviewer a "to do" message in their AVATAR inbox. The reviewer then reviews the progress note and provides the practitioner with feedback, if any. The use of supervision to provide feedback on progress notes is always encouraged, however, the feedback may be provided by e-mail or telephone.

Depending on the feedback, the practitioner has the option to "append" the progress note to include any necessary information regarding the service provided. If the progress

requires more than the use of the append option, please contact the QI Help Line for support.

The following reports are available to assist you:

- 309 72-Hour Compliance report (Clinician menu)
- 803 72-Hour Compliance team level report (Supervisor menu)
- 517 72-Hour Compliance program level report (Manager menu)

Unbundling of Services: Direct Service Time versus Documentation Time versus Travel Time

- **Direct service time is** (for the most part) spent **with the person in care** for the purpose of providing a service.
- In some cases, direct service time is time spent with person in care ***and*** the members of the person's care team, with family members or other supports, and other community support services (Collateral is an Add-On)
- In some cases, direct service time is time spent **only** with the members of the person's care team, with family members or other supports, and other community support services *without the person in care being present* (Collateral Rehabilitation 311CA/312/CA)
- Certain services such as: Case Management, Clinical Consultation, Psychiatric Evaluation of Records, and Collateral Services do *not* require the person in care to be present.
- Direct service duration does NOT include:
    - Travel time
    - Administrative activities
    - Chart review
    - Documentation
    - Utilization review
    - Quality assurance activities
- **Documentation duration is** the time it takes to document the service within the electronic health record.
- Documentation duration is specific to the time it takes for the staff to write a progress note or complete other forms of documentation on behalf of the person in care when the person in care is not present.
- **Travel duration is** time spent traveling to and from your work location to provide a service to the person in care at their home or in the community.***If staff provide a service during the transportation of the person in care, that is a direct service and excluded from the total travel time.

Compliance and Quality Assurance

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and/or abuse within the service provision and claiming system. Disallowances in audits will occur when there is evidence of fraud, waste, or abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote compliance. Additionally, never copy and paste notes into a person's medical record. Not only does this practice do a disservice to the individual's documented course of treatment; it is an unethical practice. Each note must clearly document the specific service provided.

Please ensure documentation is completed within the appropriate program under which you are providing the service. Generally, this means the program for which you, the practitioner, are assigned to in order to avoid issues with the submission of billing for services. Please note that County staff are not permitted to write process notes in a contracted Provider episode and vice-versa; contracted Provider staff are not permitted to write progress notes in a County episode. Doing so will have financial impact to the programs.

Append Progress Notes

The Append Progress Notes form in AVATAR may be used to include additional information to a progress note for added clarity, after the progress note has been finalized. The Append option does not permit changes to the original progress note. It simply appends or adds information to the progress note by including the "new" information to the end of the finalized progress note.

In addition, when there is an error in the content of the progress note, the progress note may be "appended" to reflect the accuracy of the services that were provided. For errors that are related to the accuracy for billing purposes, an "error report" must be submitted to make necessary corrections for the services billed.

Confidentiality In Progress Note Content

We must protect the person in care's confidentiality. The medical record is a legal document that may be subpoenaed by the court. Please observe the following standards in completing progress notes:

- Do not write another person in care's name (e.g., classmate, peer, etc.) in another person's chart.
- In the unusual circumstance when another person in care must be identified in the record (for example, when the other person in care received a Tarasoff warning), do not identify that individual as a behavioral health person, unless necessary.
- Names of family members/support persons should be recorded only when needed to complete intake registration and on financial documents. On progress

notes and most assessments, refer to the relationship - mother, husband, friend, but do not use names. Use a first name or initials of another person only when needed for clarification.

- Be judicious in entering any mental health diagnosis reported by a parent/spouse/other about themselves or family members/support persons. (Indicate “reported by...”).

Certain progress notes may be designated “**Restricted Disclosure**” by individual providers and their supervisors/managers. Designating a progress note as restricted disclosure alerts MCBH Quality Improvement staff to review the document and, if necessary, consult with the individual provider and/or their supervisor/manager prior to releasing the note as part of the person in care’s record request. Types of progress notes that may be designated “Restricted Disclosure” include but are not limited to:

- Progress notes documenting fulfillment of a mandated reporting obligation (e.g., suspected child abuse or elder abuse reporting) as disclosure of this information may reasonably endanger the reporting provider. This shall be documented as a non-billable note.
- Progress notes containing information that might reasonably endanger the life or physical safety of the person in care or another person.
- For minor persons, progress notes containing information that would have a detrimental effect on the provider’s professional relationship.

Mental Health Services

Monterey County Behavioral Health offers an appropriate range of specialty mental health services that is adequate for the anticipated number of persons in care that will be served by the MHP and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of persons that will be served. The range of Specialty Mental Health Services include:

1. Mental health services
2. Medication support services
3. Day treatment intensive
4. Day rehabilitation
5. Crisis intervention
6. Crisis stabilization
7. Adult residential treatment services
8. Crisis residential treatment services
9. Psychiatric health facility services
10. Intensive care coordination (for persons in care under the age of 21)
11. Intensive home-based services (for persons in care under the age of 21)
12. Therapeutic behavioral services (for persons in care under the age of 21)
13. Therapeutic foster care (for persons in care under the age of 21)
14. Psychiatric inpatient hospital services
15. Targeted case management
16. Peer Support Services
17. For persons in care under 21 years of age, the Contractor shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welf. & Inst. Code 14184.402 (d))

Claiming for Services

In an earlier section we explored the importance of identifying needs, assessing for conditions and/or diagnoses to recommend medically necessary services and initiate care planning and treatment. As mentioned previously**, in order to comply with claiming (billing), the health record must include an admission diagnosis prior to claiming any service**. The diagnosis (ICD 10 code set) is informed by assessment. Additionally, the health record must also include case coordinator, Onset of Services, and CSI information prior to claiming for services. Here, we will explore the intersection of progress notes with code sets for submitting claims for reimbursement.

Mental Health Service Codes

Mental health services are those individual, group, or family therapies and interventions that are designed to reduce mental disability. They also facilitate improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. Services are directed toward achieving the person's/family's goals and must be consistent with the current Treatment Plan and or Problem List. Definitions for all service codes as well as who shall claim for each service code are included below.

Location

When entering progress notes, the Location option refers to the location of the service being provided and/or the location of the beneficiary while receiving the service. For example, if a service is being provided to a person in care via telephone (only), the Location options to be select can be either: Telephone Client at Home, or Telephone Client not at Home. On the other hand, if services are being provided to a person in care via Telehealth (i.e. telephone or voice-only web calls such as zoom without video) and audio/video interactions (videoconferencing, i.e. zoom), these can be indicated selecting the Location option as either: Telehealth Client at Home or Telehealth Client not at Home. There are no longer distinct telehealth codes to use.

Note: If a person is unhoused, it is appropriate to choose the location of "Client not at Home". If a person is staying in a temporary shelter, or transitional housing, it is appropriate to use "Client at Home" as the location since that is the identified place where they are currently residing.

Assessment (331CA/332CA)

This code is used to document the clinical analysis of the history and current status of the individual's mental, emotional, or behavioral health. It includes appraisal of the individual's functioning in the community such as living situation, daily activities, social support systems, and health history and status. Assessment includes screening for substance use/abuse, establishing diagnoses and may include the use of testing procedures. Per BHIN 22-019 and BHIN 23-068:

Licensed, registered, waivered, and/or under the direction of a licensed mental health professional (as defined in the state plan) must complete certain aspects of the Assessment services including:

- The diagnosis,
- Mental Status Exam (MSE)

- Medication history, and
- Assessment of relevant conditions and psychosocial factors affecting the person's physical and mental health

Other qualified staff (i.e. MHRS staff) may contribute to the assessment consistent with their scope of practice. These include making contributions to the assessment such as: gathering the person in care's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals (BHIN 23-068)

Note: All mental health services provided to assess a child/youth for eligibility for mental health treatment through an IEP process should be coded as assessment.

Assessment Progress Notes describe:

- People involved in the services and their role.
- Clear description of why assessment is being completed and/or the reasons for referral for assessment.
- Provider's interventions, including observations of the person during the session.
- Person in care responses to interventions.
- Describes preliminary findings and clinical hunches.
- Information on the follow up plan or next steps.
- If eligibility for medically necessary services are met, clearly document how it is met.

Plan Development (391CA/392CA)

This code is used to document the development of the person's treatment plan and/or problem list, review the treatment plan and/or problem list with the person in care or treatment team, and/or monitor the person's progress related to the treatment plan and/or problem list. Plan Development may be claimed by any practitioner. Plan Development is expected to be provided during the development of the initial treatment plan and/or problem list and for subsequent updates. However, it may be used during other times, as clinically indicated to address the person's needs. For example, when the person's status changes (i.e., significant improvement or deterioration) and there may be a need to update the treatment plan and/or problem list.

Plan development includes:

- Completing Transition of Care tool for persons in care
- Monitoring progress to evaluate if the treatment plan and/or problem list needs modification.
- Consultation/collaboration with mental health practitioners or other professionals

to evaluate the treatment plan and/or problem list (e.g. probation officer, teachers, and social workers) involved in the person's care to develop, approve, or to modify the care plan.

Note: Time spent developing acute care discharge plans may be claimed as Case Management (301CA). The Utilization Review process should be coded using the Utilization Review/Quality Improvement (UR/QI) indirect service code (802). Any recommendations by the reviewer must be completed by the practitioner and may not be billed to the person nor should the non-billable service code or any other service code be used to document the time spent on these corrections.

Case Management (301CA/302CA) (same as Targeted Case Management)

Case Management are services that assist a person to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services that are impacted by person's mental health. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure persons in care access to service and the service delivery system; monitoring of the person's progress once they receive access to services; and development of the plan for accessing services. Interventions must clearly document the connection between the case management need and mental health needs.

When Case Management services will be provided to support a person to reach mental health treatment goals, they must be included as interventions on the person in care's problem list or treatment plan. Think about how the person in care's mental health is negatively impacting their ability to access these services or perform these activities without intervention by a mental health practitioner. Note: The person in does not have to be present to bill this service code.

All targeted case management (TCM) require specific documentation and the documentation shall be included in the assessment (Domain 7 and selected under Type of Service) **OR** imbedded in the narrative of the progress note. If imbedded in the progress note, the following elements are required:

- Specifies the goals and actions to address the medical, social, educational, and other services needed
- Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals
- Identifies a course of action to respond to the assessed needs
- Includes **A transition plan** when a person in care has achieved the goals.

As an added measure in supporting practitioners with meeting the CM documentation requirements if imbedded in the progress note, **a right-click template** has been included on the Clinical Progress Note MC form in Avatar. A sample note is provided at the end of this guide.

Case management includes, but is not limited to, the following:

- Inter and intra-agency communication, coordination, and referral.
- Monitoring service delivery to ensure an individual's access to service and the service delivery system.
- Linkage services focused on acquiring transportation, housing, or securing financial needs.
- Specific to MAs: Coordinating with PCP, Pharmacy, etc. (8-minute claiming threshold)

Case management services also include placement services such as:

- Locating and securing an appropriate living environment.
- Locating and securing funding.
- Pre-placement visit(s).
- Negotiation of housing or placement contracts.
- Placement and placement follow-up.
- Accessing services necessary to secure placement.

Case management services may be provided in different settings. For example:

- Case management services may be provided to persons in care who are also actively receiving services in adult crisis residential placements.
- Case management services may be provided to persons who are hospitalized, but only when the service provided is directly related to discharge planning for the purpose of coordinating placement of the person upon discharge.
- Case management services may be provided to persons in care who are incarcerated; these services should be documented using the correct lock out code.

**Refer to the Allowable Billing/Lock out Grid further in this guide for more information

Clinician Consultation (363CA)

Clinician Consultation is designed to support clinicians with complex cases and includes collaborative discussion of specific aspects of a person in care's case with other clinicians to support the provision of care.

- Clinician Consultation may use when the following types of clinicians are conferring: physicians, physician assistants, registered nurses, nurse practitioners, psychiatrists, licensed or licensed-eligible clinicians, or clinical pharmacists.
- Clinician Consultation may be used for time spent in supervision while the conversation supports the provision of care.
- Only the clinician seeking the consultation may bill for the time.
- The person in care does not have to be present to bill this service code
- Note: Clinician Consultation is distinguishable from case management in that this code would be used solely when needing consultation and NOT care coordination (which is typically a 301CA code)

Psychiatric Evaluation of Records from Outside System

Psychiatric Evaluation of Records from ***Outside System*** (90885) falls under "assessment". Assessment (in which 90885 is grouped) means a service activity designed to collect information and evaluate the current status of a person in care's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that person in care. Assessment shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards. This code is allowed as follows:

- To review psychiatric records from outside systems only (i.e. Social Services, Probation, Education)
- Should ***only be used*** during transitions of care
- The daily maximum allowance for this is 30 minutes
- The person in care does not have to be present to bill this code
- **Available to psychiatrists and licensed/licensed-eligible staff**

Intensive Care Coordination (ICC)

Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care and planning for, and coordination of services to persons in care under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria for this service. The difference between this service code and traditional Case Management is that ICC must be used to facilitate implementation of the cross- system/multi-agency collaborative services approach. ICC also differs from Case Management in that it typically requires more frequent and active participation by the ICC Coordinator to ensure that the needs of the child/youth are being met. The ICC Coordinator is the case coordinator assigned to the case. The

following service codes are available:

- 201CA: Intensive Care Coordination (All Other Persons In Care)
- 202CA: Intensive Care Coordination (IEP Persons In Care/26.5)
- 208CA: Intensive Care Coordination (Katie A.)

The narrative of the **progress notes** for Intensive Care Coordination services require specific documentation as follows:

- The goals, treatment, service activities, and assistance to address services needed by the person in care.
- Active participation of the person in care and others to develop those goals.
- A course of action to respond to the assessed needs.
- **A transition plan** when a person in care has achieved the goals.

All Intensive Care Coordination (ICC) require specific documentation and the documentation shall be included in the assessment (Domain 7 and selected under Type of Service) **OR** imbedded in the narrative of every progress note. If imbedded in the progress note, the following elements are required:

- Specifies the goals and actions to address the medical, social, educational, and other services needed
- Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals
- Identifies a course of action to respond to the assessed needs
- **A transition plan** when a person in care has achieved the goals.

As an added measure in supporting practitioners with meeting these ICC documentation requirements if imbedded in the progress note, **a right-click template** has been included on the Clinical Progress Note MC form in Avatar. A sample note is provided at the end of this guide.

Intensive Home-Based Services (IHBS)

Intensive Home-Based Services (IHBS) are individualized and strength- based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS is provided to persons in care under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria for this service. These services are predominantly delivered outside of the office setting such

as at the person's home, school, or another community location. IHBS services may include (but is not limited to): Assessment, Treatment Planning, Rehabilitation, Therapy, and Collateral. The IHBS services have been expanded to include the following:

IHBS Codes	Description
IHBS311CA	IHBS Collateral Rehabilitation
IHBS312CA	IHBS Collateral Rehabilitation 26.5
IHBS311-8CA	IHBS Collateral Rehabilitation (Katie A)
IHBS331CA	IHBS Assessment and Evaluation
IHBS332CA	IHBS Assessment 26.5
IHBS331-8CA	IHBS Assessment and Evaluation (Katie A)
IHBS341CA	IHBS Individual Psychotherapy
IHBS342CA	IHBS Individual Psychotherapy 26.5
IHBS341-8CA	IHBS Individual Psychotherapy (Katie A)
IHBS351CA	IHBS Group Rehabilitation
IHBS352CA	IHBS Group Rehabilitation 26.5
IHBS351-8CA	IHBS Group Rehabilitation (Katie A)
IHBS353CA	IHBS Group Psychotherapy
IHBS354CA	IHBS Group Psychotherapy 26.5
IHBS353-8CA	IHBS Group Psychotherapy (Katie A)
IHBS356CA	IHBS Family Group Rehabilitation
IHBS356-2CA	IHBS Family Group Rehabilitation 26.5
IHBS356-8CA	IHBS Family Group Rehabilitation (Katie A)
IHBS357CA	IHBS Family Group Psychotherapy
IHBS357-2CA	IHBS Family Group Psychotherapy 26.5
IHBS357-8CA	IHBS Family Group Psychotherapy (Katie A)
IHBS358CA	IHBS Collateral Group Rehabilitation
IHBS358-2CA	IHBS Collateral Group Rehabilitation 26.5
IHBS358-8CA	IHBS Collateral Group Rehabilitation (Katie A)
IHBS359CA	IHBS Multiple Family Group Psychotherapy
IHBS359-2CA	IHBS Multiple Family Group Psychotherapy 26.5
IHBS359-8CA	IHBS Multiple Family Group Psychotherapy (Katie A)
IHBS381CA	IHBS Mental Health Rehabilitation
IHBS382CA	IHBS Mental Health Rehabilitation 26.5
IHBS381-8CA	IHBS Mental Health Rehabilitation (Katie A)
IHBS391CA	IHBS Plan Development
IHBS392CA	IHBS Plan Development 26.5
IHBS391-8CA	IHBS Plan Development (Katie A)

Child & Family Team (CFT)

The Child and Family Team (CFT) is a group of individuals who are engaged in a variety of processes to identify the strengths and needs of the child or youth and his or her family, to help achieve positive outcomes for safety, permanency, and well-being. Typical CFT participants include individuals involved in the child's care and wellbeing and who are invested in the child's/youth's and family's success. CFT meetings provide meaningful opportunities for children/youth and their families to participate in the development and implementation of individual case or treatment plans, or other related services that are designed to meet their needs.

For children and youth in the child welfare or juvenile probation systems, the placing agency is responsible for convening and engaging members of the CFT. County mental health representatives are important CFT resources to support care coordination and collaborative decision-making. A CFT must occur at least every 90-days. The following service codes are available:

- 241CA: Child and Family Team (All Other Persons in Care)
- 242CA: Child and Family Team (IEP Persons In Care/26.5)
- 248CA: Child and Family Team (Katie A.)

Family First Preservation Services Act (FFPSA)

The FFPSA was signed into law on February 9th, 2018 and was designed to enhance supportive services for families to help children remain at home and reduce unnecessary congregate care placements by increasing options for prevention services, increased oversight and requirements for placement, and enchasing the requirements for congregate care placement settings. The following FFPSA service codes are available below (Note: *Only certain Children's programs should be using these codes*):

Service Code	Description
FFPSA201CA	FFPSA INTENSIVE CARE COORDINATION
FFPSA202CA	FFPSA INTENSIVE CARE COORDINATION 26.5
FFPSA208CA	FFPSA INTENSIVE CARE COORDINATION (Katie A)
FFPSA241CA	FFPSA CFT
FFPSA242CA	FFPSA CFT 26.5
FFPSA248CA	FFPSA CFT (Katie A)
FFPSA312CA	FFPSA COLLATERAL REHABILITATION 26.5
FFPSA3318CA	FFPSA QI ASSESSMENT AND EVALUATION (Katie A)
FFPSA331CA	FFPSA QI ASSESSMENT AND EVALUATION
FFPSA332CA	FFPSA QI ASSESSMENT AND EVALUATION 26.5
FFPSA3418CA	FFPSA INDIVIDUAL PSYCHOTHERAPY (Katie A)

FFPSA341CA	FFPSA INDIVIDUAL PSYCHOTHERAPY
FFPSA342CA	FFPSA INDIVIDUAL PSYCHOTHERAPY 26.5
FFPSA351-8CA	FFPSA GROUP REHABILITATION (Katie A)
FFPSA351CA	FFPSA GROUP REHABILITATION
FFPSA352CA	FFPSA GROUP REHABILITATION 26.5
FFPSA353-8CA	FFPSA GROUP PSYCHOTHERAPY (Katie A)
FFPSA353CA	FFPSA GROUP PSYCHOTHERAPY
FFPSA354CA	FFPSA GROUP PSYCHOTHERAPY 26.5
FFPSA356-2CA	FFPSA FAMILY GROUP REHABILITATION 26.5
FFPSA356-8CA	FFPSA FAMILY GROUP REHABILITATION (Katie A)
FFPSA356CA	FFPSA FAMILY GROUP REHABILITATION
FFPSA357-2CA	FFPSA FAMILY GROUP PSYCHOTHERAPY 26.5
FFPSA357-8CA	FFPSA FAMILY GROUP PSYCHOTHERAPY (Katie A)
FFPSA357CA	FFPSA FAMILY GROUP PSYCHOTHERAPY
FFPSA358-2CA	FFPSA COLLATERAL GROUP REHABILITATION 26.5
FFPSA358-8CA	FFPSA COLLATERAL GROUP REHABILITATION (Katie A)
FFPSA358CA	FFPSA COLLATERAL GROUP REHABILITATION
FFPSA359-2CA	FFPSA MULTIPLE FAMILY GROUP PSYCHOTHERAPY 26.5
FFPSA359-8CA	FFPSA MULTIPLE FAMILY GROUP PSYCHOTHERAPY (Katie A)
FFPSA359CA	FFPSA MULTIPLE FAMILY GROUP PSYCHOTHERAPY
FFPSA381-8CA	FFPSA MENTAL HEALTH REHABILITATION (Katie A)
FFPSA381CA	FFPSA MENTAL HEALTH REHABILITATION
FFPSA382CA	FFPSA MENTAL HEALTH REHABILITATION 26.5
FFPSA391-8CA	FFPSA PLAN DEVELOPMENT (Katie A)
FFPSA391CA	FFPSA PLAN DEVELOPMENT
FFPSA392CA	FFPSA PLAN DEVELOPMENT 26.5

Continuum of Care (CCR)

The State implemented Continuum of Care Reform in January of 2017. Continuum of Care Reform required mental health plans to assess children and youth before being placed in an STRTP and to participate in a child and family team when the child or youth needs mental health treatment.

Service Code	Description
CCR241CA	CCR CFT
CCR242CA	CCR CFT 26.5
CCR248CA	CCR CFT (KATIE A)

Psychology

There have been additional codes specific to psychologists that may be used based on the service being provided. The following codes may only be used by **licensed/waivered psychologist ONLY**. These codes include:

- **Developmental Screening** (15 minutes) (96110-1CA/96110-2CA/96110-8CA): is often performed in the context of preventative medicine services but may also be reported when screening is performed with other evaluation and management (E&M) services such as acute illness or follow-up visits.
- **Developmental Testing** (first hour) (96112-1CA/96112-2CA/96112-8CA): includes assessment of fine and/or gross motor language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report.
- **Neurobehavioral Status Exam** (first hour) (96116-1CA/96116-2CA/96116-8CA)
- **Standardized Cognitive Performance Testing** (per hour)(96125-1CA/96125-2CA/96125-8CA): is the clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities.
- **Brief Emotional/Behavioral Assessment** (15 minutes) (96127-1CA/96127-2CA/96127-8CA): may be used to report behavioral assessments for persons in care
- **Psychological Testing Evaluation** (first hour) (96130-1CA/96130-2CA/96130-8CA): may be used when administering standardized psychological tests to a client, interpreting the results, establishing a treatment plan, and preparing a report as such.
- **Neuropsychological Testing Evaluation** (first hour)(96132-1CA/96132-2CA/96132-8CA): may be used to describe testing which is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain.
- **Psychological or Neuropsychological Test Administration** (first 30 minutes)(96136-1CA/96136-2CA/96136-8CA): may be used for test administration and scoring for psychological/neuropsychological testing
- **Psychological or Neuropsychological Test Administration** (15 minutes) (96146-1CA/96146-2CA/96146-8CA): may be used for automated testing and results for psychological/neuropsychological testing.

Note: For each service that has as maximum duration and the service time exceeds that, then an Add-On will be available for the extended service time (see Add-On section

for more). Further, *only certain services* will have psychology extended Add-Ons and *only certain services* will allow the extended service time Add-On.

Peer Support Specialists Codes

Certified Peer Support Specialists can provide a distinct number of services to support persons care with their mental health and/or SUD needs. The following service codes are available:

- **Peer Engagement (323CA):** Activities and coaching to encourage and support persons in care to participate in behavioral health treatment. Engagement may include supporting persons in care in their transitions between levels of care and supporting persons in care in developing their own recovery goals and processes.
- **Peer Therapeutic Activity (324CA):** A structured non-clinical activity to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the person's treatment to attain and maintain recovery within their communities. Such activities may include, but are not limited to, advocacy on behalf of the person in care; promotion of self-advocacy; resource navigation; and collaboration with the person in care and others providing care or support to the person in care, family members, or significant support persons.
- **Peer Group Education and Skill Building (325CA):** Providing a supportive environment in which persons in care and their families learn coping mechanisms and problem-solving skills in order to help the persons in care achieve desired outcomes. These groups promote skill building in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Individual Psychotherapy (341CA/342CA)

Therapy means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction of functional impairments and restoration of functioning as a means to improve coping and adaptation. Therapeutic intervention includes the application of strategies incorporating the principles of development, wellness, adjustment to impairment, and recovery and resiliency. Therapy should assist a person in acquiring greater personal, interpersonal and community functioning, or to modify feelings, thought processes, conditions, attitudes or behaviors. These interventions and techniques are specifically implemented in the context of a professional clinical relationship.

Group Rehabilitation (351CA/352CA)

This code is based on the specific service being provided and is used for rehabilitation interventions offered to more than one person in a group setting. Mental Health Rehabilitation Services may be provided to more than one individual at the same time. One or more practitioners may provide these services and the total time for intervention and documentation may be claim by each practitioner.

This code is used to document assisting persons, in a group setting in improving skills or the development of a new skills. Rehabilitation means a recovery or resiliency-focused service activity identified to address a mental health need in the plan. This service activity provides assistance in restoring, improving, and/or preserving a person's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the persons in care while in a group setting.

Group Rehabilitation also includes providing/linking to resources and/or medication education so long as it is within the practitioner's scope of practice.

Group Rehabilitation services are provided as part of a comprehensive specialty mental health services program available to Medi-Cal beneficiaries who meet medical necessity for mental health services established by the State. These services are based on the person's need for Rehabilitative Mental Health Services which is established by an assessment and documented in the treatment plan.

Rehabilitative services may include:

- Teaching daily living, social, and leisure skills, grooming and personal hygiene, meal preparation, and/or supporting skills around medication management.
- Counseling of the person in care including psychosocial education aimed at helping achieve the individual's goals.
- Education around medication (i.e., such as helping improve the person in care's understanding the benefits of medication, so long as it is within the practitioner's scope of practice).

At this time each group practitioner must individually document the group service delivered in accordance with medical necessity standards and meet the progress note requirements mentioned earlier. **This would require the use of a group progress note.**

Group Psychotherapy (353CA/354CA)

Psychotherapy means the use of psychological methods within a professional relationship to assist the persons in care to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and interpersonal processes.

This code is based on the specific service being provided and is used for psychotherapy interventions offered to more than one person in a group setting. Psychotherapy services may be provided to more than one individual at the same time. One or more practitioners may provide these services and the total time for intervention and documentation may be claim by each practitioner. This code may be claimed by practitioners who are licensed, registered, or waivered practicing within their scope of practice.

At this time, *each* group practitioner must *individually* document the group service delivered in accordance with medical necessity standards and meet the progress note requirements mentioned earlier. **This would require the use of a group progress note.**

Family Group Rehabilitation (356CA/356-2CA)

We recognize that there may be times when we may provide services to multiple family members opened to mental health services. This code is used to document the services provided to family members where **more than one family member is opened to services** and were present during a particular service. The aim is that this code will help to ensure that all persons, who were present during the service, receive appropriate documentation in their medical record. **This would require the use of a group progress note.**

Family Psychotherapy (357CA/357-2CA)

There are many times when family therapy is warranted in treatment in order to assist the person in their recovery. This code is used to document services provided to a person and one or more family members which focus on symptom reduction as a means to improve functional impairments. This is different than the 356 service code because the family members are **NOT** opened to mental health services within our system. **The *individual* progress note form would be used.**

Collateral Group Rehabilitation (358CA/358-2CA)

This code is for group services that are provided to a person's family for the purpose of

psychoeducation, support, etc., as it relates to the person in care's mental health needs. This code is specifically helpful to accurately document the services provided to the person's family that may be helpful in gaining a better understanding of the person in care's mental health needs or of mental health in general. **This would require the use of a group progress note.** Note: The person in care does not have to be present to bill this service code.

Multiple Family Group Psychotherapy (359CA/359-2CA)

This code is for group services that are provided to **more than 1** person in care **and** their family members as it relates to the mental health needs of the persons in care. It is meant to focus on symptom reduction as a means to improve functional impairments. **This would require the use of a group progress note.**

Mental Health Rehabilitation (381CA/382CA)

This code is used to document assisting the person in improving a skill or the development of a new skill set. Rehabilitation means a recovery or resiliency-focused service activity identified to address a mental health need in the treatment plan and/or problem list. This service activity provides assistance in restoring, improving, and/or preserving a person's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the person. Rehabilitation also includes support resources, and/or medication education (within the practitioner's scope of practice). **This code may be claimed by any practitioner**.

Rehabilitative Mental Health Services are provided as part of a comprehensive specialty mental health services program available to Medicaid (Medi-Cal) persons in care that meet medical necessity criteria established by the State. They are based on the person's need for Rehabilitative Mental Health Services established by an assessment and documented in the treatment plan and/or problem list.

Rehabilitative services may include:

- Teaching daily living, social, and leisure skills, grooming and personal hygiene, meal preparation, and/or supporting skills around medication management.
- Counseling of the person in care including psychosocial education aimed at helping achieve the individual's goals.
- Education around medication (i.e., such as helping improve the person in care's understanding the benefits of medication, so long as it is within the practitioner's scope of practice).

At times, it can be difficult to distinguish between case management services and mental health services. A common misconception is that if the service is on a treatment plan then it is a mental health service. This is not accurate. Services that support the person in care to **improve** skills are considered Mental Health services, where Case Management services involve the staff completing activities to support the person.

Medication Support Services (361CA/362CA)

This code is used exclusively by medical staff when it is within their scope of practice to provide these services. Medication Support Services supports the person in care in taking an active role in making choices about their mental health care and helps them make specific, deliberate, and informed decisions about their treatment options and mental health care. This service code may include:

- Providing detailed information about how medication works.
- Different types of medications available and why they are used.
- Anticipated outcomes of taking a medication.
- The importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate).
- How the use of the medication may improve the effectiveness of other services a person is receiving (e.g., group or individual therapy).
- Possible side effects of medications and how to manage them.
- Information about medication interactions or possible complications related to using medications with alcohol or other medications or substances.
- Impact of choosing to not take medications.
- Specific to MAs: Brief assessment and medication reconciliation (8-minute claiming threshold)

Note: Medication support services may only be provided within their scope of practice by a Physician, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Physician Assistant, a Nurse Practitioner, and a Pharmacist.

Limitations**:** The *maximum number of hours* claimable for medication support services *in a 24-hour period* is **4 hours**. This service is not duplicative of the drug counseling requirements described in 42 CFR 456.705.

Medication Support Services for Urgent Appointment (361UCA)

This code is used exclusively by medical staff within their scope of practice. This code may be used to provide urgent medication support services to person in care. “Urgent” is defined by the person at the time of requesting the appointment or by the practitioner requesting the urgent appointment in an effort to avoid further decompensation by the person. The individual may or may be new to services within MCBH.

Medication Support Services – Lock Out Setting (364CA)

This code is used exclusively by medical staff when it is within their scope of practice to provide these services. This code is used to accurately reflect services provided to those individuals who are in setting that are considered “Lock out” settings. Lock out settings may include: incarcerated, inpatient unit, medical hospital, IMD, etc.

Medication Support Conference (365CA)

This code is used when there is a medical support conference with an interdisciplinary team of health care professionals, spending 30 minutes or more, not face-to-face with the client and/or family.

Crisis Intervention (271CA/272CA)

Crisis Intervention is provided when the person in care requires an unplanned, immediate response or intervention that is intended to help a person exhibiting acute psychiatric symptoms which, if untreated, present an imminent threat to the person or others and help him/her stabilize and maintain in a community setting. The crisis must be a crisis related to the person. If a significant support person, such as a parent, is experiencing a crisis, the crisis code cannot be used; the person specifically must be in crisis.

Crisis Interventions include services to person experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves (including provision/utilization of food, clothing, and shelter despite having access to it) due to a mental disorder. Service activities may include, but are not limited to assessment, collateral, and therapy to address the immediate crisis. Crisis Intervention activities are usually face-to-face or by telephone with the person or significant support persons and may be provided in the office or in the community. The maximum amount of time that can be spent on Crisis Intervention for a person in one day is 8 hours or 480 minutes. If a person is hospitalized, this code can only be used on the date of admission of an inpatient hospitalization (i.e., services or interventions being provided to the person in care leading up to the hospitalization). Note: Crisis Intervention progress notes may not always link to the person’s treatment plan.

- 271CA: Crisis Intervention (Open Outpatient Episodes)
- 272CA: Crisis Intervention (IEP Persons Only/26.5)

Note: The maximum billing per day by Licensed/Licensed eligible staff is 74 minutes. The Add-On of Extended Service will need to be used beyond this. See Add-On Matrix for more.

Examples of Crisis Intervention Activities:

- Person in crisis – assessed mental status and current needs related to immediate crisis.
- Danger to self and others – assessed/provided immediate therapeutic responses to stabilize crisis.
- Gravely disabled person/current danger to self – provided therapeutic responses to stabilize crisis.
- Person was an imminent danger to self/others – supported person who was having a severe reaction to current stressors.

Crisis Intervention (Crisis Team ONLY) (371CA/372CA)

- This service code ***is used exclusively*** by the Crisis Team members to document any services provided to person opened to services within our system. The use of this service code is important because it allows for communication and good clinical care to accurately reflect services provided to persons in cares.
- A crisis intervention may include providing counseling to the persons in care's significant support person(s) involved in crisis stabilization – i.e. how to follow the safety plan.
- A crisis intervention progress note should document service which address the immediate mental health emergency and describe the nature of the crisis, the crisis stabilization interventions utilized, the person's response and the overall outcome.

Note: The maximum billing per day by Licensed/Licensed eligible staff is 74 minutes. The Add-On of Extended Service will need to be used beyond this. See Add-On Matrix for more.

Collateral Rehabilitation (311CA/312CA)

This code is used to document contact with any "Significant Support Person" in the life of the person (e.g., family members, roommates) with the intent of improving or maintaining the mental health of the person. This excludes other professionals involved in the person's care. Collateral may include helping significant support persons understand and accept the person's challenges/barriers and involving them in planning and provision of care. Remember, there must be a current Authorization to Use, Exchange, or Disclose Confidential Information in the chart to include these supports in treatment. These services must be included in the person's treatment plan (for programs that require a treatment plan) to support the person's recovery. **Note**: when consulting with other professionals involved with the person's care, use the case management service code (301CA)

When using Collateral Rehabilitation as a primary service, remember that:

- **The Collateral Rehabilitation (311CA/312CA) service code should be used**
- **Collateral is the primary service being provided (i.e. meeting with the significant support person only)**
- **The person in care does not have to be present to bill this service code**

When using Collateral as an *Add-On* (See Add-On chapter):

Collateral may include, but is not limited to:

- Consultation and training of the significant support person to assist in better utilization of mental health services by the person.
- Consultation and training of the significant support person to assist in better understanding of the person's serious emotional disturbance (e.g., psychoeducation).
- Specific to MAs: Receiving/giving information to the parent/caregiver related to person in care's treatment, care, etc. (8-minute claiming threshold)

Non-Billable Services (330CA)

This code is used to document services that were delivered, but do not meet medical criteria for service delivery. This code along with the "No Medical Necessity" codes are used to document services that are relevant to the person's care but are not Medi-Cal reimbursable. This 330CA service code must be used in the event the record is "out-of-compliance" in accordance of documentation standards. This 330CA code and no medical necessity codes may be used by any practitioner.

The following services are not Medi-Cal reimbursable:

1. Any documentation after the person is deceased.
2. Preparing documents for court testimony for the purpose of fulfilling a requirement. Whereas when the preparation of documents is directly related and reflects how the intervention impacts the person's mental health treatment and/or progress in treatment, then the service may be billable.
3. Completing the reports for mandated reporting such as a CPS or APS.
4. No service provided: Missed visit. Waiting for a "no show" or documenting that a person missed an appointment.
5. Services under 8 minutes for most staff/service codes. For MD/NP/PA billing Medication Support services duration under 10 minutes. For LVN/RN/MA billing Medication Support services duration under 8 minutes.
6. Traveling to a site when no service is provided due to a "no show". Leaving a note on the door of a person in care or leaving a message on an answering machine or with another individual about the missed visit.
7. Personal care services provided to individuals including grooming, personal

hygiene, assisting with self- administration of medication, and the preparation of meals.

8. Purely clerical activities (faxing, copying, calling to reschedule, appointment, etc.)
9. Recreation or general play.
10. Socialization-generalized social activities which do not provide individualized feedback.
11. Childcare/babysitting.
12. Academic/Educational services- actually teaching math or reading, etc.
13. Vocational services which have, as a purpose, actual work or work training.
14. Multiple Practitioners in a Case Conference or meeting: Only practitioners directly contributing (involved) in the person 's care may claim for their services. Each practitioner's unique contribution in the meeting must be clearly noted.
15. Supervision of clinical staff or trainees is not reimbursable because it does not center around the person care (i.e., development of personal insight that may be impacting clinician's work with the person in care). Whereas, reviewing and amending/updating the treatment plan with a supervisor is reimbursable (i.e., the topic of discussion is centered on exploring alternative interventions that may be helpful in helping person in care reach their goals).
16. Utilization management, peer review, or other quality improvement activities that have already been billed to the person in care. (In order to avoid double billing, if the utilization management has been billed to the person in care, then do not document this time as "QI" time).
17. Interpretation/Translation ONLY: an intervention must be provided to person in care in order to make service billable.
18. "Lock Out" setting for things not covered in "Lock Out" codes (Refer to "chart of allowable billing").
19. Providing some forms of transportation (MHSUDS Info Notice 17-040)

Clarification on above items:
As long as the focus of the service meets medical necessity criteria, the following are examples of reimbursable services.

- Academic/Educational Situations:
    - Reimbursable: Sitting with the person in care in a community college class to help reduce their anxiety and then debriefing the experience afterward.
    - Not Reimbursable: Assisting the person in care with their homework.
    - Not Reimbursable: Teaching a typing class at an adult residential treatment program.
- Recreational Situations:
    - Reimbursable: Introducing a person in care to a Wellness Center and debriefing their visit.

    - Not Reimbursable: Teaching the individual how to lift weights.
- Vocational Situations:
    - Reimbursable: Responding to the employer's call for assistance when the person in care is in tears at work because they are having trouble learning to use a new cash register-- if the focus of the intervention is assisting the individual to decrease their anxiety enough to concentrate on the task of learning the new skill.
    - Not Reimbursable: Visiting the person in care's job site to teach them how to use a cash register.

"No Medical Necessity" Codes (No-MN)

These "No Medical Necessity" codes (see below) can be used when services must be provided but the service are not medically necessary as defined by Medi-Cal. These codes may be used by any practitioner. These codes function the same as the 330CA service code, however, they more accurately document the type of service delivered.

Oftentimes, these codes are used by those MCBH programs that work in partnership with other providers and agencies that fund services and decide the frequency of services, etc. It may occur that services may not be medically necessary, but the partner program wishes for us to continue to provide services to the person. For example, persons with an IEP whose services are the responsibility of the school district, not Medi-Cal, may use these codes. Other times, programs use these codes to clearly delineate the no medical necessity services provided by their program. For example, this code may be used when documenting transportation without a mental health intervention or rescheduling an appointment for the person in care.

These "No Medical Necessity" codes use the exact criteria as the MCBH outpatient service code (i.e. collateral, case management, timeliness, etc.) The same rules apply with regards to scope of practice and practitioners may bill accordingly. These codes simply note that there are no *medically necessary* services being provided, even if services are still being provided.

IEP Persons In Care		**All Other Persons in Care**	
305CA	No MN Case Management	401CA	No MN Case Management
315CA	No MN Collateral Rehabilitation	411CA	No MN Collateral Rehabilitation
335CA	No MN Assessment	431CA	No MN Assessment
345CA	No MN Individual Therapy	441CA	No MN Individual Therapy
355CA	No MN Group	451CA	No MN Group
385CA	No MN Mental Health Rehabilitation	481CA	No MN Mental Health Rehabilitation
395CA	No MN Plan Development	491CA	No MN Plan Development

Lock Out Codes

These codes are used to accurately reflect the services provided to those individuals who are in settings that are considered “lock out” settings. You may use these codes when providing case management services, group therapy, or mental health services. Lock out settings may include incarceration, inpatient unit, medical hospital, IMD, etc. These codes may be used when services that may benefit the person’s recovery are provided while the individual is in what is considered a “lock out” setting. Please refer to the chart of “Allowable Billing/Lock out Grid” in this guide for more billing code information.

The following lock out codes that are available for IEP, Katie A, and All other persons in care respectively:

IEP Persons in Care	
406CA	Intensive Case Coordination
407CA	Intensive Homebased Services
Katie A Persons in Care	
409CA	Intensive Care Coordination
428CA	Intensive Homebased Services
All Other Persons in Care	
405CA	Case Management
435CA	Assessment
445CA	Individual Counseling
455CA	Group Counseling
471CA	Crisis Intervention
475CA	Collateral Rehabilitation
485CA	Mental Health Rehabilitation
495CA	Plan Development

Note: Lock out Codes will not have Add-Ons since they are non-billable service codes

Add-Ons

A big change as a result of Payment Reform, effective 7/1/2023, is the use of Add-on Codes. An Add-On Code is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. Basically, the provider would select a service and an "Add-On" code for applicable additional situations/services. By "adding on" a code, the service reimbursement rates change and is more reflective of the specific service conducted by the provider. The progress notes in Avatar have been updated with Add-On fields. Any Add-On selected must be justified in the in the progress note narrative and the description should be brief (See Add-on Matrix in the Appendix). The following are the Add-Ons available:

Interactive Complexity

Should be used when services have been complicated by communication difficulties during the visit. **It is meant to reflect increased intensity, not increased time**, and must be used in conjunction with primary service codes.

Interactive complexity is often present with persons in care who:

- Have other individuals legally responsible for their care.
- Request others to be involved in their care during the visit, like a caregiver or family member.
- Require the involvement of other third parties, such as child welfare agencies or parole officers.
- Although interactive complexity is common during visits with children and adolescents, it can also apply to adults.

Interactive complexity Add-On may be used when at least one of the following factors are present during the visit:

- The need to manage maladaptive communication.
- Caregiver emotions or behaviors that interfere with treatment.
- Mandated reporting of a sentinel event to a third party (like abuse or neglect to state agency) with initiated discussion of the event and/or a report with the client and other visit participants.
- Use of play equipment, physical devices to communicate with a patient who has a language barrier.

Interactive complexity:

- **This Add-On may be used for all service codes with the following exception:**
  - ***Cannot be used in conjunction with* Psychotherapy for Crisis (service code) or the Interpretation (Add-On)**
- **This Add-On is only available for licensed/licensed eligible & MA staff only.**

Examples of Interactive Complexity:

- Example 1: Person in care is having difficulties with responding to question and the clinician reframes the question differently several times so that the person understands and is able to respond.
- Example 2: A clinician uses play equipment to communicate with the person in care (using a dry erase board with a selectively mute person in care).
- Example 3: A person in care presents with severe auditory hallucinations and the clinician is utilizing the support person to engage the person in care in the session.
- Example 4: The clinician is having a discussion with a support person regarding the CPS/APS event, safety concerns, and repairing trust. *The actual completion of the form should be documented separately as a non-billable.

Interpretation

Should be used when the use of sign language/oral interpretation is used during the service. Interpretation is specific to interpretation NOT translation (i.e. interpretation is oral translation is written). Interpretation is provided by a third party.

Interpretation:

- **Cannot be used in conjunction with the Interactive Complexity Add-On (staff are advised to use Interpretation).**
- **Interpretation time should be equal to the direct service duration.**
- **This Add-On is available for all service codes.**
- **This Add-On may be used by any staff member.**

Examples of Interpretation:

- Example 1: A therapist is providing family therapy and a MCBH Behavioral Health Aid (BHA) is used to provide interpretation. The therapist will bill the family therapy service code and use the interpretation Add-On. If the MCBH BHA is providing interpretation solely, that staff would not be using the interpretation Add-On and will instead reflect their activity in the scheduling calendar (See CalAIM Memo 010 related).

- Example 2: A psychiatrist is conducting a follow-up medication support appointment with the therapist present and a MCBH BHA providing interpretation. The psychiatrist or the therapist will use the interpretation Add-On but not the MCBH BHA. If the MCBH BHA is providing interpretation solely, that staff would enter the time used to help with interpretation into the Scheduling Calendar (see CalAIM Memo 010 related)

Collateral

Collateral services include sessions with the person in care's significant support persons and focused on the treatment needs in terms of supporting the achievement of the person in care's treatment goals. Significant support persons are individuals that have a personal, not official or professional relationship with the person in care.

Collateral:

- **Collateral is not the primary service but instead an Add-On to another primary service.**
- **The person in care must be present during the service**
- **This Add-On is used with certain service codes (see Add-On Matrix) with the following exception:**
  - **The Collateral Add-On cannot be used with Assessment and Crisis Intervention.**
- **This Add-On is available to Psychiatrists and Licensed/licensed-eligible staff with the exception of Plan Development, which may be used by any staff member.**
- **This Add-On cannot be used by Certified Peer Specialists.**

Examples of Collateral:

- Example 1: Mother and child are participating in a medication support session together for 30 minutes. In this case the Psychiatrist will bill 20 minutes 361CA Medication Support for symptoms evaluation with the person in care and will use the Collateral Add-On for 10 minutes for obtaining collateral from the parent.
- Example 2: There is an individual therapy session with the person in care for 45 minutes and the significant support person attends the last 15 minutes of the session to discuss interventions to be used in the home (basically a 60 minute session). The therapist will bill 341 CA Individual Psychotherapy for 45 minutes with the Collateral Add-On of 15 minutes.

Psychotherapy for Medication Support

Should be used when a person in care is being seen for a primary medication support service and the psychiatrist provides psychotherapy services as adjunct to the primary reason for the visit.

Psychotherapy for mediation support:

- **This Add-On can only be used with the Medication Support Service codes.**
- **Cannot be used in conjunction with Psychotherapy for Crisis, Family Psychotherapy, or Group Therapy codes.**
- **Can only be used by psychiatrists or extenders (NP, PA, and CNS).**

Example of Psychotherapy for Medication Support:

- The psychiatrist is meeting with the person in care for a follow-up medication support (361CA) session. During the session, the person in care becomes emotionally dysregulated, paranoid, and anxious. The psychiatrists utilizes DBT therapy interventions to help the person in care regulate and manage their symptoms.

Case Management (Any Staff Billing 361CA Service)

This Add-On should be used when case management services are being rendered *in addition to* the Medication Support service as the primary service.

Psychology Extended Service

The psychology Add-On should be used in conjunction with the other (newly created) primary psychology codes when applicable. For each primary service that has a maximum duration and the service time exceeds that, then an Add-On will be available for the extended time.

Example of psychology extended service:

- The psychologist meets with the person in care (child) at the clinic and spends 90 minutes in this session. The psychologist would use 96112-1CA: Developmental Testing as the primary service code. The maximum code duration is 60 minutes. The psychologist will also need to use the 96113-1CA: Developmental Testing for each additional 30 minutes. For this scenario:
- Direct service duration is 90 minutes; documentation duration is 10 minutes; travel duration is 0. The psychologist will use the 96112-1CA service code: 60 minutes and will also use the 96113-1CA indicating 30 minutes.

These corresponding psychology Add-Ons may be used:

Service Code	Add-On Description	Rule
All Other Persons in Care		
96113-1CA	Developmental Testing, Each Additional 30 Minutes	Each Additional 30 minutes
96121-1CA	Neurobehavioral Status Exam, Each Additional Hour	Each Additional hour
96131-1CA	Psychological Testing Evaluation, Each Additional Hour	Each Additional hour
96133-1CA	Neuropsychological Testing Evaluation, Each Additional Hour	Each Additional hour
96137-1CA	Psychological or Neurological Test Administration	Each Additional 30 Minutes
IEP		
96113-2CA	Developmental Testing, Each Additional 30 Minutes-26.5	Each Additional 30 minutes
96121-2CA	Neurobehavioral Status Exam, Each Additional Hour-26.5	Each Additional hour-26.5
96131-2CA	Psychological Testing Evaluation, Each Additional Hour-26.5	Each Additional hour-26.5
96133-2CA	Neuropsychological Testing Evaluation, Each Additional Hour-26.5	Each Additional hour-26.5
96137-2CA	Psychological or Neuropsychological Test Administration	Each Additional 30 Minutes
Katie A		
96113-8CA	Developmental Testing, Each Additional 30 Minutes (Katie A)	Each Additional 30 minutes
96121-8CA	Neurobehavioral Status Exam, Each Additional Hour (Katie A)	Each additional hour
96131-8CA	Psychological Testing Evaluation, Each Additional Hour (Katie A)	Each additional hour
96133-2CA	Neuropsychological Testing Evaluation, Each Additional Hour (Katie A)	Each additional hour
96137-8CA	Psychological or Neuropsychological Test Administration (Katie A)	Each Additional 30 Minutes

Clinical Supervision and Billing

It is important to remember that the Board of Behavioral Sciences and Board of Psychiatry do not govern Department of Health Care Services (DHCS) billing. Clinical supervision is billable as consultation using the Case Management (301CA) service code or the Plan Development (391CA) service code when:

- Discussing a person in care's case for the purposes of consultation toward meeting treatment plan goals (301CA).
- Consultation/collaboration with mental health practitioners or other professionals

(e.g. probation officer, teachers, and social workers) is to evaluate the treatment plan, approve, or to modify the care plan (391CA).

- The supervision is centered around identification of treatment strategies that may benefit the person, thus documentation of this in the “plan” section of the progress note (301CA).
- Consultation that is geared at determining appropriate diagnosis given person’s presentation (301CA).

Clinical supervision is NOT billable when:

- Discussing a new technique or approach to use with a person and the discussion focuses on “learning” for the practitioner.
- Exploring transference or counter-transference issues.
- Reviewing personal items that are impacting the clinical treatment.
- Discussing organizational/staffing issues that are impacting the clinical treatment.

Some discussions that occur within supervision may be billable as Quality Improvement time, specifically as it relates to the education or technical aspects of these procedures:

- Treatment Plans and/or Problem Lists
- Progress note format and documentation
- Medical Necessity procedures
- Mental Status procedures
- Psychosocial Assessment content and procedures

Finalizing a Note

- When a practitioner finalizes the progress note they are providing a legal electronic signature that the information they are submitting is accurate.
- Finalizing a progress note generates a billing for the services provided to the person in care.
- In the event of a progress note was completed in error, complete the “Error Reporting” form as soon as possible to identify the service needing correction.

Allowable Billing/Lock out Grid

	Mental Health Services 2231CA, 232CA, 233CA, 234CA, 235CA, 236CA, 311CA, 331CA/332CA, 341CA/342CA, 350CA, 351CA, 353CA, 356CA, 357CA, 358CA, 359CA, 381CA/382CA, 391CA/392CA, 331CA, 341CA	Med Support 361CA, 361UCA	Case Management 201CA, 202CA, 208CA, 241CA, 242CA, 248CA, 301CA/302CA	Crisis Intervention 271CA, 272CA, 371CA*	Hospital Inpatient	Hospital Inpatient Admin Day	Day Treatment	Adult Crisis Residential
MH/TBS	M	M	M	M	A	L	L	A
Med Support	M	M	M	M	A	L	M	M
Case Management	M	M	M	M	I	I	M	M
Day Treatment [34]	T	M	M	M	A	L	L	A
Crisis Intervention [35]	M	M	M	M	A	L	M	A
Hospital Inpatient	A	A	I	A	L	L	A	A
Hospital Inpatient Admin Day	L	L	I	L	L	L	L	L
Adult Crisis Residential	A	M	M	A	A	L	A	L
Jail	L	L	L	L	L	L	L	L

Code	Color	What it means
I = Institution Limitations	•	• This code indicates that only services geared towards discharge planning are permitted.
L= Lock out*	•	• Do not bill.
A= Lock out except for day of admission	•	• Only bill this code on the admission date.
T= Lock out during actual time service is provided	•	• Do not provide this service at the same time as a specified service. For example, we cannot bill for both a mental health service and day treatment at the same time.
M=Multiple Services on same day	•	• You can enter services, but be mindful of daily maximum.

Chart of Billing Daily Maximum Per Person

Title	Service Codes	Max billing PER Person
Mental Health or Therapeutic Behavioral Services	IHBS311CA/IHBS312CA (Expanded Codes) – Intensive Home Based Services 231CA, 232CA, 233CA, 234CA, 235CA, 236CA – Therapeutic Foster Care 311CA/312CA – Collateral Rehabilitation 331CA/332CA – Assessment 341CA/342CA – Individual Psychotherapy 351CA/352CA – Group Rehabilitation 353CA/354CA – Group Psychotherapy 356CA/356-2CA – Family Group Rehabilitation 357CA/357-2CA – Family Group Psychotherapy 358CA/358-2CA – Collateral Group Rehabilitation 381CA/382CA – Mental Health Rehabilitation 391CA/392CA – Plan Development 323CA, 324CA, 325CA – Peer Support Services	TBD
Medication Support	361CA – Medication Support 361UCA – Medication Support Urgent	Max 4 hours or 240 minutes per day per
Clinician Consultation	363CA – Clinician Consultation	Must be >30 minutes
Medication Support Conference	365CA – Medication Support Conference	Must be 30 Min or >
Case Management	201CA, 202CA, 208CA – Intensive Care Coordination 301CA//302CA – Case Management 241CA, 242CA, 248CA – Child Family Team (CFT)	Maximum of 24 hours (1440) minutes per day
Crisis Intervention	271CA, 272CA, 371CA (Crisis Team Only) – Crisis Intervention	8 hours (480 minutes) per day

Scope of Practice

Staff must only provide services that are within their scope of practice and scope of competency. Scope of practice refers to how the law defines what members of a licensed profession may do in their licensed practice. It applies to the profession as a whole. Scope of competence refers to those practices for which an individual member of the profession has been adequately trained. Access to forms in the electronic health record adhere to scope of practice and credentials/title to ensure staff have access to forms based on their roles within the organization and/or within the treatment team.

Some services are provided under the direction of another licensed practitioner. "Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval and signing plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the mental health services provided. Services are provided under the direction of a physician, a psychologist, a waivered psychologist, a licensed clinical social worker, a registered licensed clinical social worker, a marriage and family therapist, a registered marriage and family therapist, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).

"Waivered/Registered Professional" means:

- For a psychologist candidate, an individual employed or under contract to provide services as a psychologist who is gaining the experience required for licensure and who has been granted a professional licensing waiver to the extent authorized under State law; or
- For a marriage and family therapist candidate, professional clinical counselor candidate, or a licensed clinical social worker candidate, an individual who has registered with the corresponding state licensing authority for marriage and family therapists, professional clinical counselor, or clinical social workers to obtain supervised clinical hours for marriage and family therapist, professional clinical counselor, or clinical social worker licensure, to the extent authorized under state law.

Below are tables containing the most common licenses or professional classifications in the Behavioral Health field, with brief definitions and characteristics. In conjunction with information and tables from the preceding sections, these following tables can be used to help further clarify what clinical activities are within the scope of practice of particular professionals.

Note: The following Behavioral Health staff titles may not completely align with those of contracted providers.

AA, Bachelor's, and/or Accrued Experience	
Title	Definitions/Characteristics
MHRS (Mental Health Rehabilitation Specialist) (Cal. Code Regs. tit. 9 § 630)	• Possesses a bachelor's degree (BS or BA) in a mental health related field and a minimum of four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. • Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis. • Up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting.
Medical Assistant	• Possess a certificate from an approved Medical Assistant training curriculum.
Social Worker III	• Possesses a bachelor's degree (BS or BA) in a mental health related field and minimum of two years of experience providing direct services in the mental health field.
Other, Unlicensed	• Any other direct service staff providing support services that does not meet any of the other specified licensure or classification definitions/characteristics.

Graduate School (pre-Master's or pre-Doctoral)	
Title	Definitions/Characteristics
Psychologist Intern (pre-Doctoral)	• Completed academic courses but have not been awarded their doctoral degree. • Completing one of the final steps of clinical training, which is one year of full-time work in a clinical setting supervised by a licensed psychologist. • Intern status requires a formal agreement between the student's school and the licensed psychologist that is providing supervision.
Psychologist Trainee (pre-Doctoral)	• In the process of completing a qualifying doctoral degree. • Often called "Practicum Students." • Receiving academic credit while acquiring "hands-on" experience in psychology by working within a variety of community agencies, institutions, businesses, and industrial settings. • Supervised by a licensed psychologist.
MSW/MFTi/PCC Intern	• In the process of completing a qualifying doctorate or master's program. • Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. • Completing clinical hours as part of their graduate school internship field placement.

Post-Master's, Pre-License	
Title	Definitions/Characteristics
MSW/MFTi/PCC Applicant	• Completed a qualifying Doctorate or Master's degree • Application has been submitted to CA Board of Behavioral Sciences (BBS) • Awaiting BBS registration number • Applicants may count supervised experience gained between the degree award date and the issue date of the Associate registration number, IF the Associate application is received within 90 days of the qualifying degree award date.
Associate SW/MFT/PCC	• Completed a qualifying Doctorate or Master's degree. • In the process of obtaining clinical hours towards an LCSW/LMFT/LPCC license • Registered with the CA Board of Behavioral Sciences (BBS) • Possesses a current BBS registration certificate (which contains a valid BBS registration number)

Licensed	
Title	Definitions/Characteristics
Psychologist (Licensed)	• Licensed by the CA Board of Psychology • Possesses a current CA Board of Psychology license certificate (which contains a valid license number)
Psychologist (Waivered)	• Issued a waiver by the State of CA Department of Mental Health to practice psychology in CA. Possess valid waiver. • Waiver is limited to 5 years.
LCSW (Licensed Clinical Social Worker) LMFT (Licensed Marriage Family Therapist) LPCC (Licensed Professional Clinical Counselor)	• Licensed by the CA Board of Behavioral Sciences (BBS) • Possesses a current BBS license certificate (which contains a valid BBS license number)

DHCS Practitioner Categories (effective 7/1/2023)	
Title	**Provider Type**
Physician	Psychiatrist
Licensed Psychiatric Technician	Licensed Psychiatric Technician
Registered Nurse	Registered Nurse
Psychiatric Nurse Practitioner	Psychiatric Nurse Practitioner
Physician Assistant	Physician Assistant
Occupational Therapist	Occupational Therapist
Medical Assistant	Medical Assistant
Psychologist (Post Doctorate)	• Licensed • Waivered (Post Doctorate)
Licensed Practitioner of the Healing Arts (LPHA)	• LCSW • MFT • LPCC
Licensed Practitioner of the Healing Arts – Intern (LPHA-Intern)	• ASW • AMFT • APCC
Mental Health Rehabilitation Specialist (MHRS)	• Social Worker III (MCBH Only) • Staff who meet the Title 9 MHRS requirements • Master's Level Intern (A student in the process of completing a qualifying doctorate or Master's program; Not officially registered with the California Board of Behavioral Sciences (BBS); Does not have a BBS registration certificate or number and is completing clinical hours as part of their graduate or internship field placement and is supervised by a licensed practitioner)
Peer Support Specialist	• Certified Peer Support Specialist (through CalMHSA)
Other Qualified Providers	• Any other direct service staff providing support services that does not meet any of the other specified licensure or classification definitions/characteristics. • i.e. Bachelor's level interns, MCBH Behavioral Health Aides

Master's Level Intern – Added by MCBH; not previously part of DHCS category	• Student in graduate school completing their Master's Degree and Internship • Services provided by this staff are the same as Licensed/licensed eligible staff but under the supervision of a Licensed staff reviewing their work
Psychologist Intern – Added by MCBH; not previously part of DHCS category	• Student in the process of completing a qualifying doctoral degree • Often called "Practicum Students" • Receiving academic credit while acquiring "hands-on" experience in psychology by working within a variety of community agencies, institutions, businesses, and industrial settings. • Supervised by a Licensed Psychologist

Provider Eligible Codes

Code	Eligible Provider
201CA, 202CA, 208CA Intensive Care Coordination	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
231CA, 232CA, 233CA,234CA, 235/235CA, 236CA Therapeutic Foster Care	Authorized “TFC Parent” Only * (prior authorization required)
241CA, 242CA, 248CA Child Family Team (CFT)	All direct service staff (not including admin support)
271CA, 272CA Outpatient Crisis Intervention	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
301CA Case Management	All direct service staff (including MAs), excluding Certified Peer Support Specialists (not including admin support)
302CA Case Management (school-based team only)	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
311CA/312CA Collateral Rehabilitation	All direct service staff (including MAs), excluding Certified Peer Support Specialists (not including admin support)
330CA Non-Billable	All direct service staff (not including admin support)
331CA Assessment	*Licensed/Registered/Waivered Staff and Associates, MHRS, and Other Qualified Providers
336 Triage (Assessment Teams only)	*Licensed/Registered/Waivered Staff and Associates ONLY
332CA Assessment (school-based team only)	*Licensed/Registered/Waivered Staff and Associates ONLY
341CA Individual Psychotherapy	*Licensed/Registered/Waivered Staff and Associates ONLY
342CA Individual Psychotherapy (school-based team only)	*Licensed/Registered/Waivered Staff and Associates ONLY
351CA Group Rehabilitation	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
353CA Group Psychotherapy	*Licensed/Registered/Waivered Staff and Associates ONLY
356CA Family Group Rehabilitation	All direct service staff, excluding Certified Peer Support Specialists

	(not including admin support)
357CA Family Psychotherapy	*Licensed/Registered/Waivered Staff and Associates ONLY
358CA Collateral Group Rehabilitation	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
361CA Medication Support 361UCA Medication Support Urgent appointment 364CA Medication Support "Lock Out"	*Licensed medical staff only (Including MAs, excluding Urgent)
363 Clinician Consultation	Licensed/Registered/Waivered staff and Associates ONLY
365 Medication Support Conference	*Licensed medical staff only
371CA Crisis Intervention (Crisis Team ONLY)	All direct service staff (not including admin support)
381CA Mental Health Rehabilitation	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
391CA Plan Development	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
392CA Plan Development (school based team only)	All direct service staff, excluding Certified Peer Support Specialists (not including admin support)
"No Medical Necessity" for school-based team persons only: 305CA Case Management 315CA Collateral (Non-billable) 335CA Assessment 345CA Individual Therapy 355CA Group Rehab 385CA Mental Health 395CA Plan Development	All direct service staff (not including admin support) & Licensed/Registered/Waivered Staff and Associates ONLY
"No Medical Necessity" For All Other Persons: 401CA Case Management 411CA Collateral 431CA Assessment 441CA Individual Therapy 451CA Group 475CA Collateral 481CA Mental Health 491CA Plan Development	All direct service staff (not including admin support) & Licensed/Registered/Waivered Staff and Associates ONLY

Lock-Out Codes 405CA Case Management 406CA Intensive Case Coordination 407CA Intensive Homebased Services 435CA Assessment 441CA Individual Counseling 455CA Group Counseling 475CA Collateral 485CA Mental Health Rehabilitation 491CA Plan Development	All direct services staff (not including admin support) & Licensed/Registered/Waivered Staff and Associates ONLY
Peer Support Services 323CA, 324CA, 325CA	Certified Peer Specialists

Scope of Practice Matrix

	Physician	Licensed or Waivered Psychologist (post doctorate)	Licensed, Registered or Waivered staff: ACSW/ LCSW, AMFT/ LMFT, APCC/ LPCC (post MA/MS)	RN with Master's degree in MH Nursing or related field	Psychiatric Nurse Practitioner	Registered Nurse	Licensed Vocation Nurse/ Licensed Psychiatric Technician	Trainee/ Student/ Intern: Post BA/BS degree. Enrolled in MA/ MS/ doctorate program	Mental Health Rehabilitation Specialist: BA/ BS in MH related field and 4 yrs MH experience	Certified Peer Specialist	Other Qualified Staff approved by BH Director: typically 18+, High School Equivalency, Driver's License
Assessment: MH + medical history (hx), Substance use + exposure, strengths, risks, barriers to achieving goals	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Assessment: Diagnosis, MSE, medication hx, assessment of relevant conditions and psychosocial factors affecting the person's physical and MH	Yes	Yes	Yes	Yes	Yes	No	No	Yes*	No	No	No
Behavioral Health Prevention Education Service	No	No	No	No	No	No	No	No	No	Yes*	No
Collateral	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Care/Client/Treatment Plan	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes++	Yes++	Yes*,++	Yes++	No	Yes*,++
Intensive Care Coordination (ICC)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Intensive Home-Based Services (IHBS)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Medication Support	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Medication Prescribing	Yes	No	No	No	Yes	No	No	No	No	No	No
Medication Administering	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Medication Dispensing	Yes	No	No	Yes+	Yes	Yes+	No	No	No	No	No
Plan Development	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Problem List	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*
Psychological Testing	No	Yes	No	No	No	No	No	Yes+++	No	No	No
Psychotherapy	Yes	Yes	Yes	No	Yes	No	No	Yes*	No	No	No
Rehabilitation Counseling	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Self Help/Peer Services	No	No	No	No	No	No	No	No	No	Yes*	No
Targeted Case Management	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Therapeutic Behavioral Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*

* 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

Special Populations

Katie A. Subclass

As set forth in the “Katie A. Settlement Agreement”, there are children and youth who have more intensive needs to receive medically necessary mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs, in order to facilitate reunification and to meet their needs for safety, permanence, and well-being.

Children/youth (up to age 21) are considered to be a member of the Katie A. Subclass if they meet the following criteria:

- Are full scope Medi-Cal (Title XIX) eligible;
- Have an open child welfare services case {means any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court-ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made}; and
- Meet the medical necessity criteria for Specialty Mental Health Services (SMHS) as set forth in CCR, Title9, Section 1830.205 or Section 1830.210.

In addition to:

- Currently being considered for: Wraparound, therapeutic foster care, specialized care rates due to behavioral health needs, or other intensive EPSDT services, including but not limited to Therapeutic Behavioral Services or crisis stabilization/intervention (see definitions listed in glossary); OR
- Currently in or being considered for group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs.
- All codes for Katie A. are mentioned in the previous section of Mental Health Services

Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Service (TBS) is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health service as defined in CCR, Title 9, §1810.215. TBS is an intensive one-to-one, short-term outpatient treatment intervention for persons in care under age 21 with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs, or to enable a transition from any of those levels to a

lower level of residential care.

Therapeutic behavioral services are intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or planned transition to a to a lower level of placement. The purpose of providing TBS is to further the child/youth's overall treatment goals by providing additional TBS during a short-term period.

Staff who provide and/or authorize TBS services shall provide the EPSDT/TBS brochure at the time of admission. These efforts shall be documented in the person in care's health records. The EPSDT/TBS brochure can be found on the Department of Health Care Services (DHCS) website.

At this time only contracted provider offer TBS services to persons in care in Monterey County and exclusively use the Therapeutic Behavioral Services 581CA service code.

Therapeutic Foster Care

Is a short-term, intensive, highly coordinated, trauma-informed, and individualized service, provided by a "TFC Parent" to a child or youth with complex emotional and behavioral needs. TFC is available as an EPSDT benefit to children and youth, under the age of 21, who are Medi-Cal eligible and meet medical necessity criteria. TFC cannot be a stand-alone service; it shall be accompanied by other specialty mental health services (SMHS). Children and youth receiving TFC services also must receive Intensive Care Coordination (ICC) and other medically necessary SMHS. There must be a Child Family Team (CFT) in place to guide and plan TFC service provision.

The "TFC Agency" is responsible for ensuring "TFC Parent" meets all requirements under the Resource Family Approval program standards. The "TFC Parent" will work under the supervision of the "TFC Agency" and under the direction of a Licensed Health Professional (LPHP) or a Waivered or Registered Mental Health Professional (WRMP), employed by the "TFC Agency." The "TFC Agency" assumes ultimate responsibility for directing the interventions provided by the "TFC Parent." The "TFC Agency" has a valid contract with MCBH to delivery TFC services, per regulations.

Service Code	Service Description
298CA	THERAPEUTIC FOSTER CARE (Katie A)
299CA	THERAPEUTIC FOSTER CARE (All Other Persons In Care)

Day Treatment Intensive and Day Rehabilitation Services

There are two types of Day Treatment services available under Cal. Code Regs., tit. 9, ch. 11: Day Treatment Intensive (DTI) and Day Rehabilitation (DR).

Day Treatment Intensive	Day Rehabilitation
A structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals.	A structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals.
Services are available at least three hours and less than 24 hours each day the program is open.	
Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and collateral.	

Prior Authorization

Prior authorization or MCBH referral is required for DTI and DR services. For the purposes of prior authorization, referral by MCBH to a Contracted Provider is considered to serve the same function as approving a request for authorization by a Contracted Provider or person in care. Both day program services require a referral from Monterey County Behavioral Health (MCBH) or prior authorization from MCBH prior to the delivery of service.

Day Treatment Intensive	Day Rehabilitation
Initial authorization is up to 90 days for DTI services.	Initial authorization is up to 180 days for DR services.
Providers must request advanced payment at least every three months for continuation of DTI.	Providers must request advance payment at least every six months for continuation of DR.

Day Treatment Documentation Requirements

Providers shall complete a daily progress note for day treatment services (including DTI and DR). Daily progress notes should include total number of minutes/hours the person actually attended the program. All other progress note requirements shall also be met in

BHIN 22-019 and BHIN 23-068.

Contact and Site Requirements

DTI and DR services shall have a clearly established site for services, although all services need not be delivered at that site.

Service Components

At a minimum, the following DTI and DR service components shall be provided (MHSUDS 17-040):

- Therapeutic Milieu: This component must include Process Groups and Skill-Building Groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the Therapeutic Milieu is to teach, model, and reinforce constructive interactions by involving persons in care in the overall program. The program includes behavior management interventions that focus on teaching self-management skills that persons in care may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to individuals on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.
- Process Groups: These groups, facilitated by staff, shall assist each person in care to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. DR may include psychotherapy instead of Process Groups, or in addition to Process Groups.
- Skill-Building Groups: In these groups, staff shall help persons in care identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, individuals identify skills that address symptoms and increase adaptive behaviors.
- Adjunctive Therapies: These are therapies in which both staff and persons in care participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the modality to develop or enhance skills directed toward achieving the person's treatment goals. Adjunctive Therapies assist the person in care in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive Therapies provided as a component of DR or DTI are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the individual's needs.

DTI shall additionally include:

- Psychotherapy: Psychotherapy means the use of psychological methods within a professional relationship to assist the person(s) in care to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

Attendance

Providers should ensure Medi-Cal reimbursement is received only if the person in care is present for at least 50 percent of scheduled hours of operation for that day. In cases where absences are frequent, it is the responsibility of the provider to re-evaluate the individual's need for the DR or DTI program and take appropriate action.

Contact with Significant Support Persons

Providers shall have at least one contact per month with a family member, caregiver or other significant support person identified by an adult person in care, or one contact per month with the legally responsible adult for a person in care who is a minor. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). Adult persons in care may decline this service component. The contacts should focus on the role of the support person in supporting the person in care's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for DTI and DR.

Written Program Description

Providers shall ensure there is a Written Program Description for DTI and DR. The Written Program Description must describe the specific activities of each service and reflect each of the required components of the services as described in this section. The DTI and DR provider shall review the Written Program Description for compliance with this section prior to the date the provider begins delivering DTI or DR.

Mental Health Crisis Protocol

Providers shall ensure that there is an established protocol for responding to persons in care experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other SMHS necessary to address the individual's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the DTI or DR Program staff shall have the capacity to handle the crisis until the person in care is linked to an outside crisis service.

Written Weekly Schedule

Providers shall ensure that a weekly detailed schedule is available to persons in care and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The Written Weekly Schedule will specify the program staff, their qualifications, and the scope of their services.

Staffing Requirements

Staffing ratios shall be consistent with the requirements in Cal. Code Regs., tit. 9, section 1840.350, for DTI, and Cal. Code Regs., tit. 9 section 1840.352 for DR. For DTI, staff shall include at least one staff person whose scope of practice includes psychotherapy.

Day Treatment Intensive	Day Rehabilitation
At a minimum there must be an average ratio of at least one staff from the following list providing DTI services to eight persons in attendance during the period the program is open.	At a minimum there must be an average ratio of at least one staff from the following list providing DR services to ten persons in attendance during the period the program is open.
Staff providing services in DTI programs serving more than 12 persons in attendance shall include at least one staff from two of the following groups.	Staff providing services in DR programs serving more than 12 persons in attendance shall include at least two of the following.
• Licensed Mental Health Professionals: Includes any of the following providers who are licensed in accordance with applicable State of California licensure requirements: licensed physicians; licensed psychologists (includes waivered psychologists); licensed clinical social workers (includes waivered or registered clinical social workers); licensed professional clinical counselors (includes waivered or registered professional clinical counselors); licensed marriage and family therapists (includes waivered or registered marriage and family therapists); registered nurses (includes certified nurse specialists and nurse practitioners); licensed vocational nurses; licensed psychiatric technicians; and licensed occupational therapists. • Mental Health Rehabilitation Specialists as defined in Section 630. • Clinical Trainees: An unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Mental Health Professional; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant	

requirements of the program and/or applicable licensing board to participate in the practicum, clerkship or internship and provide rehabilitative mental health services, including, but not limited to, all coursework and supervised practice requirements. • Medical Assistants	
Staff providing DTI services who do not participate in the entire DTI session, whether Full Day or Half-Day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. MCBH shall ensure that there is a clear audit trail of the number and identity of the persons who provide DTI services and function in other capacities.	Staff providing DR services who do not participate in the entire DR session, whether Full Day or Half-Day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. MCBH shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitative services and function in other capacities.

- Program staff may be required to spend time on DTI and DR activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, and caregiver contacts).
- The provider shall require that at least one staff person be present and available to the group in the therapeutic milieu for all scheduled hours of operation.
- The provider shall require DTI and DR programs to maintain documentation that enables MCBH and the Department of Health Care Services to audit the program if it uses DTI or DR staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The day program provider shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which DTI or DR activities are being performed exclusive of other activities.

Continuous Hours of Operation

DTI and DR shall be billed as half days or full days of service. The following requirements apply when claiming for DTI and DR services:

- A Half-Day shall be billed for each day in which the person in care receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open. Not offered with MCBH.
- A Full Day shall be billed for each day in which the person in care receives face-to-face services in a program with services available more than four hours per day.

- Although the person in care must receive face-to-face services on any Full Day or Half-Day claimed, all service activities during that day are not required to be face-to-face with the person in care.
- The requirement for continuous hours of operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The DTI and DR program shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

Lock Outs

Mental health services are not reimbursable when provided by DTI or DR staff during the same time period that DTI or DR is being provided.

Two Full Day or one Full Day and one Half-Day or two Half-Day programs may not be provided to the same person in care on the same day.

Peer Support Services

Peer Support Services are a new service implemented as a County Option effective July 1, 2022. Services are provided by Certified Peer Support Specialists, who are individuals in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification. Peer Support Specialists must meet all other applicable California state requirements, including ongoing education requirements.

Peer Support Services must be provided under the direction of a Behavioral Health Professional. An individual directing a service is not required to be physically present at the service site to provide direction. The licensed professional directing a service assumes ultimate responsibility for the service provided. Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements.

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower persons in care through strength-based coaching, support linkages to community resources, and to educate persons in care and their families about their conditions and the process of recovery.

People in care may concurrently receive Peer Support Services and services from other levels of care. Services may include contact with family members or other people supporting the person in care (defined as “collaterals”) if the purpose of the collateral’s participation is to focus on the treatment needs of the person in care by supporting the achievement of the person in care’s treatment goals. **Peer support services are based on an approved plan of care** and are delivered and claimed as a standalone service and may be provided in a clinical or non-clinical setting. **The care plan must reflect the needs and preferences of the beneficiary in achieving the *specific*, individualized goals that have *measurable* results and are specified in the care plan. The care plan may be documented in the current Avatar Treatment Plan forms.**

Peer Support Service components include:

- Educational Skill Building Groups: activities that provide a supportive environment in which persons in care and their families learn coping mechanisms and problem-solving skills in order to help the person in care achieve desired outcomes. These groups promote skill building for the persons in care in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

- Engagement services: activities and coaching led by Peer Support Specialists to encourage and support persons in care to participate in behavioral health treatment. Engagement may include supporting persons in care in their transitions between levels of care and supporting persons in care in developing their own recovery goals and processes.
- Therapeutic Activity: a structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the person in care's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the person in care; promotion of self-advocacy; resource navigation; and collaboration with the persons in care and others providing care or support to the person in care, family members, or significant support persons. Peer Support Services are billable services that must be based on a treatment care plan approved by a Behavioral Health Professional (see definition of Behavioral Health Professional above; this term is specific to the administration of Peer Support Services).

Certified Peer Support Specialist Role

The peer recovery support movement emphasizes services that are delivered and designed by people who have experienced both substance use and recovery. Peers elevate the voice of recovery through serving as living testaments to recovery and helping others along their recovery journey. Peer workers provide a range of activities including advocacy, coaching, modeling, mentoring, self-assessment and supporting individuals in building healthy relationships and natural supports to remain active participants in their communities. While there are many roles for peers, the focus in this manual is on the role certified Medi-Cal Peer Support Specialists. Before moving on to the specific role of certified Medi-Cal Peer Support Specialist, we want to acknowledge the years of ongoing contribution by Peer workers in behavioral health programs. Peer workers continue to have an important role in the delivery of behavioral health services, whether they seek certification as Medi-Cal Peer Support Specialists or continue the delivery of Peer support in other ways. Certification of Medi-Cal Peer Support Specialists permits an additional pathway for Peer support within a standardized scope of work and code of ethics.

Certified Medi-Cal Peer Support Specialist Role

Peer Support services are provided by certified Medi-Cal Peer Support Specialists. Certified Medi-Cal Peer Support Specialists are individuals who are 18 years of age or older, who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of behavioral health treatment services or as a parent or family member of a consumer, and who have a current Peer Support Specialist certification in California. The Peer Support Specialist serves as part of an integrated and/or multidisciplinary treatment team and offers an invaluable perspective on the

most effective services to best support the recovery of the person in care. The role of the Peer Support Specialist is to offer support and therapeutic services based on shared understanding, respect, and mutual empowerment between people in similar situations. Their lived experience allows Peers to understand, support, and partner alongside persons in care and/or the person's significant support persons to support their recovery journey. Certified Medi-Cal Peer Support Specialists can provide unique prevention, early intervention, treatment, and recovery services (BHIN 21-041).

Note: Available service codes for Peer Support Specialists can be found in the Mental Health Services Section

Full-Service Partnership (FSP)

Full-Service Partnership (FSP) services provide services to support the most severely mentally ill persons in care and their families, twenty-four hours a day, seven days a week. When a person in care enters an FSP program to receive services, they are required to sign a Treatment Plan Participation Consent form. This can be found in AVATAR and or under the Printable Documents tab on the QI Website.

These wraparound services include treatment, case management, peer support, transportation, housing, crisis intervention, family education, vocational training and employment services, as well as socialization and recreational activities, based upon the individual's needs and goals to obtain successful treatment outcomes. FSP programs will focus on doing "whatever it takes" with the resources available to help people meet their individual recovery goals. The program provides the services necessary to help a person with serious mental illness live successfully in the community rather than in jails, hospitals, institutions, or on the streets.

FSP practitioners work in partnership with persons in care, their family, caregivers, other providers, and community to provide a full range of services. Each site is responsible for maintaining outcome measurements and data collection based on the four age groupings as specified in the Community Services and Supports (CSS) Plans:

- Youth (ages 0-15)
- Transitional Age Youth (ages 16-25)
- Adults (ages 26-59)
- Older Adults (ages 60+)

The following forms are required for this program:

- Outcome Measurements Application Baseline (Partnership Assessment Form - PAF)
- KET (Key Event Tracking)
- 3M forms (Quarterly Assessment)

Please note: the MHSA FSP Outcome Reporting Documentation Guide can be found on the QI website.

Partnership Assessment Form (PAF):

A baseline assessment should be completed within the first 30 days after starting the FSP. The PAF is done at time of entry into an FSP program to establish baseline. A PAF is valid until the person in care has been dis-enrolled from a program AND a lapse of 365 days has occurred since the PAF was discharged. If your program receives a person in care with an existing PAF, meaning that no lapse of 365 or greater days has occurred between events, then your program must enter a KET for admission into your program.

Key Event Tracking (KET):

This form is often referred to as “Key” form and is used for tracking key events. A program only needs to complete the section of the KET for which you are reporting a change with three exceptions: dis-enrolling the person, transferring the person, or receiving a transferred person in care. When a person in care changes from one program to another, the referring program must complete a KET document indicating the transfer. The receiving program must immediately complete a KET document to complete the transfer process.

If a program opens a person in care for FSP services after the person in care has been closed to another FSP program, but less than 365 days have lapsed since the discharge from the previous FSP program, the new program must complete a KET document—a PAF should not be completed, unless more than 365 days have lapsed.

Note: The changing of an apartment but staying within the same complex does not constitute a need to complete a new form.

3M Forms:

The three-month assessment (3M) is due on every 3-month anniversary of your start date [Baseline Partnership Date – the date you first provided FSP services, not outreach and engagement. You must have an episode opening in the Integrated System (IS)]. There is a 15-day window prior to the 3-month anniversary and 30 days after to complete it.

Care Transitions

Given the multiple healthcare delivery systems and resources that a person in care can be served in, there is a need for care coordination to successfully transition between providers and care settings. We should think about care as occurring across a continuum with an understanding that people's needs change over time. Given that individual needs can also be addressed concurrently by providers in different agencies or systems, coordination of care is a necessary element of your service provision. The goal of care coordination is to meet the person's needs through proactive and deliberate activities that include the person in care and to organize or coordinate with other service providers to facilitate the appropriate delivery of services across providers, treatment settings, and healthcare systems. It is likely that the coordination of services may include other treatment team members to help carry out activities, with each provider identifying what roles and activities they are taking on that support the person in care's overarching wellness (MCBH Policy 152).

As noted earlier in this guide, there are multiple service delivery systems that cover distinct Medi-Cal services, with some not covered by MCBH or best provided by another delivery system. Although a person may receive care from more than one delivery system or provider, the practitioner or Case Coordinator must ensure this is done without duplication. To avoid duplication of care and to facilitate the transitions between healthcare systems, DHCS has developed the Transition of Care Tool for transitioning care between the Managed Care Plan, who contracts with Carelon for non-specialty mental health services (NSMHS), and the Mental Health Plan, or Monterey County Behavioral Health.

Transition of Care Tool

The Transition of Care tool is intended to ensure that persons requiring transition or addition of services between delivery systems receive timely and coordinated care and improve health outcomes. The goal is to ensure persons in care have access to the right care, in the right place, at the right time.

The Transition of Care Tool is to be completed by MCBH staff and by contracted providers for persons receiving services from MCBH when either:

- Their existing mental health services (moderate to severe intensity) with MCBH needs to be transitioned to a lower level of care with Carelon (mild to moderate intensity); or
- Services need to be added to their existing mental health treatment with MCBH from Carelon (e.g., when person will continue medication support with MCBH and add individual therapy with Carelon) consistent with No Wrong Door Policy

regarding concurrent treatment and continuity of care requirements.

The Transition of Care Tool documents a person's needs for a transition of care referral or a service referral to Carelon or MCBH.

The Transition of Care Tool Does Not Replace

- MCBH's protocols for emergencies or urgent and emergent crisis referrals.
- MCBH's protocols that address clinically appropriate timely, and equitable access to care.
- MCBH clinical assessments, level of care determinations, and service recommendations.
- MCBH requirements to provide EPSDT services.

Description of Transition of Care Tool

The Transition of Care Tool is designed to leverage existing clinical information to document a person's behavioral health needs and facilitate a referral for a transition of care to, or addition of services from Carelon or MCBH, as needed. The Transition of Care Tool provides information from MCBH making the referral to Carelon to begin the transition of the person's care and includes specific fields to document the following elements:

The Transition of Care Tool provides information from MCBH making the referral to Carelon to begin the transition of the person's care. The Transition of Care Tool includes specific fields to document the following elements:

- Referring plan and care team.
- Person in care's demographics and contact information.
- Person's behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications.
- Services requested and receiving plan contact information.

Referring entities may provide additional documentation, such as medical history reviews, treatment plans, and medication lists, as attachments to the Transition of Care Tool.

Administering the Transition of Care Tool

The Transition of Care Tool must be used for both adults and youth alike to facilitate transitions of care to Carelon when their service needs change.

The determination to transition services and/or add services to Carelon must be made by the case coordinator via a patient-centered shared decision-making process. Once the case coordinator has made the determination to transition care or refer for additional services, the Transition of Care Tool may be completed by a clinician or a non-clinician. Persons shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference.

The Transition of Care Tool is built into the existing Avatar EHR system. Additional information shall not be added to the forms but may be included as attachments, to include medical history reviews, treatment plans, and medication lists. Please refer to QI Memo CalAIM Implementation 007 for further instructions on how to complete the Transition of Care Tool.

Following Administration of the Transition of Care Tool

After the Transition of Care Tool is completed, the person shall be referred to Carelon for NSMHS or additional mental health services. If the case coordinator has determined that a person in care will be transitioned to Carelon for NSMHS, MCBH staff shall complete the Notice of Adverse Benefit Determination (NOABD). A NOABD is not required if Carelon services are being added to existing MCBH services. MCBH shall coordinate the person’s referral, including ensuring the referral process has been completed, the person has been connected with a Carelon provider, Carelon has accepted the care of the person, and medically necessary services have been made available to the person.

Discharge Planning

Mental health treatment should always commence with the understanding that recovery is possible. Appropriate treatment and supports benefit people with a wide variety of conditions; lessening disability and improving the ability to live full and fulfilling lives. For this reason, the discussion about discharge planning begins at the time of initial assessment (as clinically appropriate) and continues throughout the course of treatment. Routinely asking yourself and the person in care how you will know when they are ready to discontinue treatment and what they imagine their life will look like after treatment is a valuable discussion that enhances engagement and instills hope for the future. Discharge from services can occur as a result of a number of issues, including:

- Goal attainment
- Person in care determines they are no longer interested in receiving services
- Person in care's needs may be better treated in a different setting
- Person in care moved out of County
- Person in care is in a long-term setting, such as incarceration or skilled nursing
- Death *

Whenever possible, discharge from mental health services should be done in conjunction with the person in care, must include the person in care and their social supports as full partners in the planning process, and should be done as far in advance as practical. Additionally, including other treatment providers, when applicable, paves the ways to successful transitions from one care setting to another. Detailed information on discharge planning should be clear, concise, and accurately communicated and documented.

However, we understand that there may be times when a person in care/family decides to "drop-out" of treatment with little notice or without notice at all. When this occurs, the practitioner should work with the treatment team on appropriate next steps such as a discussion about a reasonable outreach plan, which may include writing a letter, telephone calls, and/or home visits, if warranted. The case coordinator is responsible for reasonable outreach efforts and these efforts must clearly be documented in the person in care's medical record to maintain accuracy of the person's medical record.

Once determined that reasonable outreach efforts have been made, the person is no longer interested in continuing services, and/or in the event the person cannot be located, it is the case coordinator's responsibility to complete the discharge process. We strongly encourage the case coordinator to consult with the treatment team and/or their supervisor prior to discharging a person from services.

A successful discharge discussion includes a review of how the person can continue to receive any necessary support and how those needs may be addressed post-discharge from the program. Information contained in discharge plans and shared with the person in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the person is expected to receive and by whom, information on crisis supports, and available community services, to name a few. Additionally, providers who work with individuals ages 6 through 20 are required to complete the CANS at discharge as well as the PSC-35 for individuals who are ages 3 through 18.

To complete the discharge process, the case coordinator must complete the following:

- Ensure all progress notes are "finalized" (304 Draft Progress Notes by Clinician)
- Close out treatment goals on Person in Care's Treatment Plan
- Complete a progress note, which includes a treatment summary
- Add an end date to the "Client Case Coordinator" form
- Complete the "Discharge" form for your program
- Inform other service providers involved with treatment (psychiatrist/community programs/nurses, etc.)
- Practitioners who work with individuals ages 5 through 20 are required to complete the CANS
- Practitioners who work with individual ages 3 through 18 are required to complete the PSC
- Full-Service Partnership Programs:
    - When a 3M assessment coincides with the time of discharge, it must be completed at discharge before the KET form can be done for discontinuation of services
    - If a Partnership status is to be discontinued all other events and information about the Partnership must be entered on a separate KET prior to submitting the KET for the discontinuation; be sure to include the reason for discontinuation

Note: The episode may not be discharged until all progress notes have been finalized. Notes in "draft" will not permit the closure of the episode. Please contact the treatment team member directly requesting finalization of progress note(s).

Reminder: Time spent developing care discharge plans should be claimed as Case Management (301CA). Once the discharge from services is complete, no progress notes may be submitted to the closed episode. There is no "minimum" amount of time a person must remain opened for services prior to discharge.

*In the event of a death of a person in care. Please work closely with your Behavioral Health Unit Supervisor for added support during this often-difficult situation. As soon as feasibly possible, please complete an Unusual Incident Report and follow all procedures outlined in MCBH Policy 123 immediately upon knowledge of the person in care's death. Any outstanding progress notes may be written using a non-billable service code. Please remember to continue to uphold confidentiality of person in care's records (MCBH Policy 123).

Notice of Adverse Benefit Determination

A Notice of Adverse Benefit Determination (NOABD) must be given to a person in care whenever services are denied, changed, or terminated. A NOABD is entered when it is determined that a person is not eligible for services or there has been alteration in the services provided. Before completing a NOABD, practitioner should consult with supervisor (MCBH Policy 120).

What is a Notice of Adverse Benefit Determination (NOABD) and what is its purpose?

A Medi-Cal NOAB is a written notice that gives Medi-Cal applicants and persons in care an explanation of their eligibility for Medi-Cal coverage or benefits. NOABs include the eligibility decision and effective date of coverage, as well as any changes made in the person in care's eligibility status or level of benefits. The NOAB also includes information about hearing rights and how to appeal the decision if the person in care disagree with the eligibility determination.

All NOABDs are available and completed in the Electronic Health Record. Below are the types of NOABDs available:

A. Services Denied – When the MHP or its providers assess a person receiving Medi-Cal and decide that the person does not meet medical necessity and no specialty mental health services will be provided.
B. Services Denied, Beacon (currently Carelon) – Used when there has been a determination that the individual does not meet "medical necessity" criteria and is being referred to a lower level of care, Carelon, to address mental health concerns (note: the Transition of Care tool must be used to transition the person in care to Carelon).
C. Provider Authorization Request Denied – Used when the Behavioral Health Plan denies a request for authorization by a Provider.
D. Provider Authorization Request Modified – Used when the Behavioral Health Plan denies a request for authorization from a Provider as requested, but instead approves a different level of care.
E. Termination of Previously Authorized Services – Used when the previously authorized services are no longer authorized (must be issued at least 10- calendar days prior to date of expiration of authorization).
F. Request for additional information – Used when a provider has submitted a request for authorization of service but there is insufficient information to make a decision on the request. The Behavioral Health Plan has asked for and awaiting additional information from the provider AND the 14-day authorization period has expired.

G. Request for Authorization Late Notice – Used when the Behavioral Health Plan does not provide services within the expected timeframes:
    - 15-calendar days for psychiatry
    - 10-calendar days for outpatient mental health or substance use treatment
    - 5-calendar days for opioid treatment programs
    - 24-hours for substance use treatment residential programs
H. Payment Denial – Used to deny payment for services which have already been delivered to the individual.
I. Dispute Financial Liability Denial – Used to notify the individual when their financial liability dispute has been denied.

Frequently Asked Questions about the Notice of Adverse Benefits Determination Policy

1. Who receives a copy of the NOABD?
    a. All NOABD's are given to the person in care.
2. Is the NOABD still addressed to the person in care when the person is a minor?
    a. Unless it is a minor consent case, the original should be sent to the minor and a copy should be sent to the minor's parent or legal guardian. For minor consent cases, the NOABD should be handled in one of the following ways:
        i. Given to the minor in person
        ii. Given to the minor's eligibility worker to give to the minor next time s/he comes in
        iii. Held by the practitioner until the next time the minor comes into the office/clinic.

    In minor consent cases, the NOABD must not be mailed to the minor's address and the minor's parent/guardian must not receive a copy or be otherwise notified.
3. When do I give the NOABD to the person in care?
    a. With exceptions, the NOABD must be hand delivered or put in the mail no later than the third working day after the action was taken.
4. Must a NOABD be issued when a network provider does an assessment and determines the person in care is no longer eligible for services?
    a. Yes. The person in care must be provided a NOABD regardless of whether the assessment is completed by the COUNTY or its providers.
5. Must a NOABD be issued when a person calls for general information about services?
    a. No. If only general information about available services and/or the County's authorization process are discussed. However, a NOABD would be required if a screening takes place and, as a result, it is determined that the person is

not eligible for services. We need to be very careful in this area. A caller to the toll-free access number or to one of our clinics should not be hastily turned away just because the caller mentions alcohol or substance abuse problems. It is strongly recommended that, when in doubt, a face-to-face assessment should be arranged.

6. Must a NOABD be issued every time a person requests a service that the county has decided is not medically necessary?
    a. No. The county has to issue a NOABD to a person after an assessment has been completed, and it is determined that the person is not eligible for any specialty mental health service from behavioral health.
7. Must a NOABD be issued when a provider determines that a reduction or termination of services is needed?
    a. Yes. A Notice of Adverse Benefit Determination (NOABD) must be given to a person in care whenever services are denied, changed, or terminated, even for contracted provider programs.
8. Can we simply issue a NOABD when the county does not provide a particular specialty mental health service the person needs?
    a. No. If we determine the person is in need of a particular specialty mental health service, we have an obligation to provide or arrange for that service. The issuing of an NOABD does not excuse behavioral health from meeting its contractual obligation to provide medically necessary specialty mental health services to its persons in care.
9. Must a NOABD be issued if the county offers a specialty mental health service, but not necessarily the service requested by the person?
    a. No. However, the person must participate in the development of the person in care plan. The county should ensure that services, to the extent possible, are person directed. A person who believes additional services are necessary has the right to challenge the county and provider decisions through the appeal and state fair hearing processes.
10. Must a NOABD be issued when the person is not approved for a service he/she has requested?
    a. No, unless the county determines that no specialty mental health services will be provided.
11. Must a NOABD be issued if a treatment team determines a lack of criteria for specialty mental health services?
    a. Yes. A NOABD is required for decisions by the county or its providers. The treatment team, acting as a provider, is deciding that the person will not receive services from the county.
12. Must a NOABD be issued when a person, who originally asked for services, changes his/her mind during the assessment process and, as a result, no services were offered?

a. No, assuming the decision that services are not necessary was made by the person. The trigger for an NOABD is the decision by the county or its providers that no services are needed. When the county or its providers explain to the person why no services are needed and the person then agrees, a NOABD is required.

13. In particular, if a person is found to not meet criteria for specialty mental health services after a few assessment sessions or by the end of the assessment period, do we need to issue a NOABD?
    a. Yes. The county needs to issue a NOABD, if a person is found not to meet criteria for specialty mental health services after a few assessment sessions or by the end of the assessment period. An assessment to determine medical necessity criteria for specialty mental health services is a specialty mental health service covered by the county. A person does not need to meet eligibility criteria to receive such an assessment. (See CCR, Title 9, Section 1810.345.) The NOABD applies to a determination that future services will not be provided because the person being assessed does not meet criteria for specialty mental health services.

Problem Resolution Process

Monterey County Behavioral Health is committed to solutions to the problems and concerns persons in care may encounter during the course of receiving services with us. Persons in care will not be subjected to discrimination, intimidation, or any other retaliation for expressing concerns, filing a Grievance or Appeal. If a person in care is unhappy with any issue related to the mental health services they receive or have received, they have the following options to try and find a resolution. All Problem Resolution Information can be found on QI website.

Change of Clinician

The form is used to request a change in psychiatrist, psychologist, social worker, or case coordinator is located in all outpatient clinic lobbies. A person in care may complete this form in the clinic and place it in the secure box or they may ask for it to be mailed to their address. The Change of Clinician form is reviewed by the Supervisor or Program Manager (within 10 business days) who make efforts to address the person in care's concerns/complaint. The program makes a decision on steps to take to address the concerns, completes the outcomes section of this form, and submits the form to QI department. It may be sent via inter-office or email.

Grievance

A grievance is an expression of the person in care's unhappiness or dissatisfaction with the mental health plan. Any person who receives mental health services through the mental health plan may file a grievance. There is no deadline to file a Grievance, but it is best to do it soon after the issue arises in order to provide more specific and detailed information. A person in care may file a grievance in writing, calling, or in person with the QI department located at 1611 Bunker Hill Way, Suite 120, Salinas, CA 93906, (831) 755-4545 (TTY/TDD: 831-796-1788). The person in care will receive a written confirmation of filing a grievance and the mental health plan will make a decision within 90-calendar days from the date the grievance was filed.

Appeal

An appeal is a request for a review of a problem you have with the mental health plan regarding a denial or changes in your mental health services as mentioned in the NOABD section. Persons in care who have Medi-Cal and disagree with the decision or action taken by the mental health plan can request an Appeal. There are two types of appeals. A Standard and an Expedited Appeal.

Standard Appeal

A person in care may file an appeal in writing, on the phone, or in person. If filing by phone, the person MUST follow up with a written appeal as well however the date of the phone call is considered the filing date. If filing verbally in person, the person MUST follow up with a written appeal. The mental health plan will send the person a written confirmation that an appeal was received and is being processed. The mental health plan may take up to 30 calendar days to review a standard Appeal. The person in care must file an appeal within 60 days from the date the action or decision was taken. This usually means the date on the NOABD.

Expedited Appeal

This type of appeal process is similar to the Standard Appeal, but an Expedited Appeal must meet certain requirements below:

- The person in care may request an Expedited Appeal verbally and does NOT have to put your request in writing.
- If the person in care thinks that waiting up to 30 days for a standard Appeal decision will jeopardize their life, health, or ability to attain, maintain, or regain maximum function.
- If the mental health plan agrees that the person's appeal meets the requirements for an Expedited Appeal, then the mental health plan will resolve the expedited appeal within 72 hours from the date the expedited appeal as received.
    - The mental health plan will notify the person and all affected parties orally and in writing of the decision of the expedited appeal.
- If the mental health plan decides that the appeal does not qualify for an expedited appeal, then the mental health plan will notify the person right away (verbally) and in writing within two (2) calendar days from the date the appeal was received.

To file a Standard or Expedited Appeal, the person in care may call or come into the QI Office located at 1611 Bunker Hill Way, Suite 120, Salinas, CA 93906, (831) 755-4545(TTY/TDD: 831-796-1788).

State Fair Hearing Process

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure the person in are receives the specialty mental health services to which they are entitled under the Medi-Cal program. The person in care may request a Fair Hearing if her/she is a Medi-Cal recipient. The person in care has 120- days to ask for a hearing from the day the mental health plan personally issued the Notice of Adverse Benefit Determination, or the day after the postmark date of the NOABD if it was mailed, or if an appeal was filed, 120 days after the postmark date of an appeal. The person in

care must follow these steps to request a State Fair Hearing:

1. Fill out the form provided with the Notice of Adverse Benefit Determination (NOABD)
2. Keep a copy for records
3. Send the completed form to:

   Mental Health Services State Hearing Division
   California Department of Social Services
   P.O. Box 944243, Mall Station 19-37,
   Sacramento, CA 94244
4. Or Call 1-800-952-5253 (TTY/TDD: 1-800-952-8349).

Patient's Rights Advocate

Persons in care and/or support persons may contact the Patient's Rights Advocate at any time by calling (831) 755-4518 to assist with grievances, appeals, and state fair hearings.

Controlled Substances Utilization Review System (CURES)

Monterey County Behavioral Health is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care. The Controlled Substance Utilization Review and Evaluations System (CURES 2.0) and Prescription Drug Monitoring Program (PDPM) database can assist health practitioners to identify, intervene, and deter abuse and diversion of Schedule II through IV controlled substances (MCBH Policy 509).

California law (Health and Safety Code Section 11165.1) requires all California licensed prescribers authorized to prescribe scheduled drugs to register for access to CURES 2.0 by July 1, 2016, or upon issuance of a Drug Enforcement Administration Controlled Substance Registration Certificate, whichever occurs later. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and confidentiality and disclosure provisions of California law cover the information contained in CURES 2.0. Access to CURES 2.0 is limited to licensed prescribers and licensed pharmacists strictly for patients in their direct care, and regulatory board staff and law enforcement personnel for official oversight or investigatory purposes.

All Monterey County Behavioral Health prescribers shall register for CURES. Applicants must complete the online registration form and provide a valid email address, medical or pharmacist license number, and DEA registration certificate number (prescribers only). DOJ will validate identity and license electronically with the Department of Consumer Affairs and the Drug Enforcement Administration.

MCBH physicians are responsible for accessing the database and reviewing the patient activity reports (PAR) prior to providing any Schedule II, III and IV controlled substance prescriptions (MCBH Policy 509):

1. Once the PAR has been reviewed, the prescribing physician is responsible for documenting a complete assessment in the electronic medical record.
2. Assessment should include all relevant clinical information (diagnosis, prognosis and need for treatment), risk and protective factors, and data from the PAR, in support of the physician’s decision to prescribe or not prescribe a Schedule II through IV controlled substance for the treatment of a primary mental health disorder.
3. Document information on electronic submission of controlled substance data.

Employee Activity Resources

Sustainability

Monterey County Behavioral Health is dedicated in its effort to excel at providing quality services for the benefit of all its persons in care and their families. Monterey County Behavioral Health has established a sustainability standard for all staff providing mental health services. These standards have been created so that all employees can be fully informed as to the level of sustainability they are expected to meet and on what basis their quantity of work will be evaluated. Revenue generating activities are an important source of income for the agency. This income, along with other sources of income, such as grants, allows the agency to offer a broad range of services to persons in care. The standard level of productivity for all Behavioral Health clinical staff, defined generally as "billable time", is no less than seventy five percent (75%). This means that a minimum of 75% of work hours must be spent on tasks and services that are considered "billable" (treatment planning, case management, assessment, etc.). Other indirect service codes are also factored into the sustainability report as part of the 75% sustainability standard (i.e. vacation time, QI time, etc.).

Monterey County Behavioral Health recognizes that portions of tasks completed by practitioners are non-billable and that certain positions require more time focused on non-billable services. Therefore, up to twenty-five percent (25%) of work hours may be spent on non-billable activities, such as meetings, committee participation, and other indirect services, and activities. Supervisors and staff may track sustainability using the 310 Sustainability Report by Staff on Avatar (MCBH Policy 145).

Here is some basic information regarding sustainability:

What counts as "productive minutes"?

- All direct services provided to persons in care that are entered through progress notes including non-billable (330CA) services
- All time entered in appointment scheduler as service code 802 (QI Time)
- All MHSA outreach codes authorized, entered in appointment scheduler, in MHSA programs (810, 811, 812, 813, 814)
- Service codes involving critical community support and training (815, 816, 817)

How many productive minutes do I need?

- No less than 75% of total work minutes
- This means that up to 25% of total work minutes may be spent on non-billable activities

What are non-billable activities?

- Meetings
- Committee participation
- Indirect services and activities
- Trainings

How many work minutes are in a day?

- There are 480 minutes in an 8-hour day
- Once two 15-minute breaks are subtracted, the total number of work minutes in a day is 450

What happens when I am sick/on vacation?

- There are several service codes used to calculate “back out” minutes so that minutes not spent at work don’t negatively impact sustainability percentage
- Holidays are automatically backed out
- Service code 803 is used when an employee is sick or on vacation, and 450 minutes back out should be used
- For part-time employees, service code 809 indicates non-working hours. These should be backed out of the appointment scheduler so that percent sustainability is only calculated for the hours an employee actually spends at work

Employee Activity Tool

This tool is NOT intended to communicate sustainability standards. Please contact your direct supervisor for expectations.

Monterey County Behavioral Health (MCBH) has developed the Employee Activity Report (only available to MCBH) which reflects finalized services and calendar activities captured in Avatar. This report includes (1) a summary level of services and (2) detailed sub reports that reflect various activities staff complete throughout their workday for a selected date range.

The Employee Activity Report will capture activities entered in Avatar starting 7/1/2023 via a finalized progress note and Avatar Scheduling Calendar. This report will not run for dates prior to 7/1/2023.

Please refer to QI Memo: 314 Service Activity Report on the QI website for full details.

Other QI Codes

Indirect Service Codes

These codes are used to document all indirect service codes in the Scheduling Calendar option of Avatar. These codes are necessary to accurately reflect the practitioner's services that are not a part of the direct services.

801=Staff Meeting: This code is used for meetings such as the all-staff system of care meetings or other non-Quality Improvement meetings.

802=Utilization Review/Quality Improvement (UR/QI):
In general, Team meetings, conducting UR, Quality Improvement Trainings, and Quality Improvement Committee meetings are all part of the UR/QI time. The activities considered appropriate to code as Quality Improvement time are listed below:

1. Utilization review and training activities related to monitoring of mental health plan program integrity standards, including services provided by subcontractors (i.e. chart review);
2. Utilization review and training activities required as part of clinical performance improvement projects (e.g. utilization committee)
3. Quality Improvement (QI) Committee meetings, preparation time, documentation of minutes, and follow-up of clinical QI issues;
4. Clerical time spent supporting utilization review chart selection, gathering of chart and billing documentation, and follow-up of clinical QA issues; QA activities required for development, implementation, evaluation, and revision of clinical practice guidelines;
5. Utilization review activities required for Therapeutic Behavioral Services (TBS), assistance with state audits, and federal audits of TBS (i.e. chart review);
6. Personnel time for assisting state and federal auditors with county audits for compliance with External Quality Review standards, and other related Medi-Cal specialty mental health services standards;
7. Utilization review activities required as part of medication monitoring;
8. Training of SPMP (Skilled Professional Medical Provider) and staff who are directly supporting SPMP for utilization review and QA activities;
9. Personnel time required for the operation of management information systems that are necessary for completion of utilization review activities (Policy 454)

Note: Only authorized activities and trainings should be coded using 802.

803=Vacation/Education Leave/Sick: This code is used to reflect time when a staff member was on vacation, used educational leave, or was out sick. This time should match the time entered on your timecard.

804=Holiday (**NEW**)*: This code is used to reflect a county holiday. Staff who do not work on county holidays must enter the 804 code for 8 hours/480 minutes to account for a full day.

805=Indirect Services: This service code is used for services that are not person in care specific or should not be entered in the medical record. Examples include; staff who take vehicles to maintenance or some payee-ship activities. Please enter details of these services in the notes tab of this form.

807=Supervision: This service code is used for supervision received by the practitioner that is not billed to a person's chart.

808=Committee Work: This service code is used for committee work that staff participates in that is not otherwise accounted for as a Quality Improvement Committee. Please enter details of these services in the notes tab of this form which gives specific details on the committee's name and function.

809=Jury Duty: This code is used when staff participate in jury duty or other activities as indicated (i.e. union).

For Programs allocated MHSA funding, the following service codes are available:

811=Outreach and Engagement: This funding was established in recognition of the special activities needed to reach underserved populations. Outreach and engagement can be one component of an overall approach to reducing ethnic disparities.

812=Early Intervention: This code is used for early intervention activities designed to provide interventions to individuals before they enter services.

813=Indicated/Selected (Prevention): Address certain population (neighborhood, school, community, etc.)

814=Universal (Prevention): Addresses entire population (neighborhood, school, community, etc.)

815=Critical Incident Debriefing: Critical Incident Team members use this code to specify time spent in response to community-based critical events.

816=Hostage Negotiation: Hostage Negotiations Team members use this code for time spent providing this specialized service.

817=Community Training: Community-based training provided through Behavioral Health.

819=Access Team-Officer of the Day: This is used exclusively by the Access to Treatment program to block time on the calendar for assessment purposes.

823=Training: This category is used to record trainings that are not part of Quality Improvement. See next chapter for a list of training sub-codes.

826=Milieu Work: This code is designed to capture the specific institution work essential to the mental health service array in Monterey County Juvenile detention settings that are not able to be captured in a progress note. For example: group observation, in the moment group re-direction, de-escalation modeling for Institution staff, collaborative problem solving, safety and security observations and staff feedback, joining milieu activities, assessing for unit and facility safety needs or concerns and those communication efforts, and activities that support the integration of mental health supports into the detention settings as required by Title 15 and SB 823. Staff approved to use this code are Juvenile Justice staff assigned to Juvenile Hall, Secure Track, and Youth Center programs and are providing in-person care within the facilities.

828=Abbreviated Schedule: This code is only permissible for staff who have a reduced work schedule (less than 80 hours per pay period). This code reduces the number of minutes an employee works a day. This code must not be used to account for vacation, sick, or county holiday.

- Staff members who are a part-time employees (i.e. 20 hours a week) or has an officially adjusted work schedule (i.e. 32 hour work week versus a 40 hour work week) will use the 828 code on the scheduling calendar to account for the non-working days.

829=Court On Site: Time spent when a staff is present at court (in person or via zoom) on behalf of a person in care; Includes travel time to and from court.

830=Court Admin: Time spent, outside of direct treatment, on court related administrative activities including developing court reports, meetings with the court/justice partners/social services partners.

831=Placement Team Use Only: Time spent collaborating with community and contracted providers (or potential contracted providers) for placement options (including site visits) as related to LPS conservatorship; reviewing Jail/State/Hospital records; coordinating interim services while awaiting a disposition of placement and/or services with Behavioral Health.

5000=DEIB (Diversity, Equity, Inclusion, Belonging): This code is used when staff participate in DEIB related activities (i.e. Committee meetings, travel). DEIB is about fostering a supportive work environment that promotes diversity, equity, inclusion, and belonging and combats institutionalized racism and any power imbalances in systems of care.

5001=MISTI: This code is used when staff participate in MISTI related activities (i.e. Change Agent meetings, work on Compass EZ activities). The goal of the MISTI initiative

is to improve system interactions in order to provide welcoming, hopeful, and integrated services to individuals and families experiencing mental health and substance use challenges, as well as other health and human service needs.

5002=Interpretation: This code is used for a third-party providing sign language/oral interpretation during a service with a person in care for another rendering provider and is NOT considered translation (i.e. interpretation is oral; translation is written).

Codes That Factor Into the 75% Sustainability	
Service Code	Part of 75%
801=Staff Meeting	No
802=Utilization Review/Quality Improvement (UR/QI)	Yes
803=Vacation/Education Leave/Sick	Yes
805=Indirect Services	No
807=Supervision	No
808=Committee Work	No
809=Non-Working Time/Jury Duty	Yes
811=Outreach and Engagement	Yes
812=Early Intervention	Yes
813=Indicated/Selected (Prevention)	Yes
814=Universal (Prevention)	Yes
815=Critical Incident Debriefing:	Yes
816=Hostage Negotiation	Yes
817=Community Training	Yes
819=Access Team-Officer of the Day	No
823=Training	Yes

Training Back Out Program

MCBH staff are eligible to participate in training to help develop their professional and documentation expertise. The purpose of the training program is to:

- Develop a balance between training needs of staff and service needs of persons in care.
- Focus training on attitudes, knowledge and skills that support the improved well-being of MCBH persons in care, who have moderate to severe mental health and/or substance use challenges.
- Establish a financially sustainable training budget, to include payment of instructors, fees for books and other training materials, and partial reimbursement by MHSA of staff time spent in training.

There are two types of trainings, Required or Allotted. Required/System coursework is coursework required for all staff, all clinical staff, or all clinical staff in a particular System of Care (SOC). Allotted/Program coursework is coursework approved or directed by one's Supervisor. This may be coursework that staff choose to take, coursework everyone in the program takes or coursework identified for a particular staff as part of their plan to meet standards in all performance categories of the annual performance evaluation.

Each fiscal year MCBH staff will be able to participate in training which contributes to their development. Below is the break-down of required and allotted training:

- As needed hours of Required coursework.
- Up to 40 hours of Allotted coursework, broken down into:
    - 6 Hours of Cultural Competence Allotted coursework
    - 6 Hours of Law & Ethics Allotted coursework
    - 28 Hours of General Allotted coursework
- Bargaining Unit K unit staff have 24 hours of Educational Leave per fiscal year to use as they would like. Staff must get prior time-off approval from their supervisor; however, staff do not need to provide proof of coursework.

Training hours will be tracked in Avatar and staff will receive notices through Avatar of remaining Allotted hours. Additionally, staff and supervisors will be able to track training hours in Avatar using report 887.

Avatar Scheduler Instructions

In order to account for this activity accurately in the Avatar Scheduler, you need to enter only the time you spent in training. This is the same amount of time that you would earn for CE credits.

Training Codes

1. Professionalism				
	Avatar		Timecard	Back Out Category
	Service	Training	Override	
Law & Ethics				
Law & Ethics: 6-hour Requirement	802	1110	8###5	Elective – L&E
HIPAA – Annual		1210	8###5	Required – Annually
HIPAA – Other (Not Annual)	802	1250	8###5	Elective – General
Law & Ethics: Beyond 6-hr Requirement	802	1290	8###5	Allotted – General
Work Performance				
Timeliness	823	1310	81440	Elective – General
Collaboration	823	1410	81440	Elective – General
Communication	823	1450	81440	Elective – General
Customer Service	823	1510	81440	Elective – General
Critical Thinking	823	1610	81440	Elective – General
Review of Policies/Guidelines	802	1710	8###5	Required – As Needed
Professional Identity				
Self Care - Everyone	823	1810	81440	Elective – General
Self Care - Clinicians	823	1850	81440	Elective – General
Self Reflection & Growth	823	1910	81440	Elective – General
2. Culturally Rooted Care				
Cultural Humility				
Humility Toward Others	823	2110	81440	Elective – CC
Cultural Self-Reflection	823	2210	81440	Elective – CC
Cultural Knowledge				
Cultural Concepts NOS	823	2310		
Bias	823	2320	81440	Elective – CC
Cultural Populations NOS	823	2510	81440	Elective – CC
Latinx	823	2530	81440	Elective – CC
African American	823	2580	81440	Elective – CC
Indigenous Peoples	823	2610	81440	Elective – CC
LGBTQ+	823	2640	81440	Elective – CC
Veterans	823	2670	81440	Elective – CC
Immigrants	823	2680	81440	Elective – CC
Differently Abled	823	2690	81440	Elective – CC
Cultural Practices/Skills				
Culturally Responsive Assessment	823	2710	81440	Elective – CC
Cultural Conversations	823	2730	81440	Elective – CC
Interpretation	823	2750	81440	Elective – CC
Cross-Cultural Work	823	2770	81440	Elective – CC

Cultural Practices/Skills NOS	823	2790	81440	Elective – CC
Culturally Rooted Care: Beyond 6-hr Requirement	823	2990	81440	Allotted – General
3. Trauma Informed Care				
Trauma Compassion				
Impact of Trauma on Behavioral Health Functioning	823	3110	81440	Required – Once
Trauma Knowledge				
Trauma Concepts NOS	823	3310	81440	Elective – General
Trauma Foundations	823	3340	81440	Elective – General
ACES	823	3350	81440	Elective – General
Trauma and the Brain	823	3370	81440	Elective – General
Trauma Impacted Populations NOS	823	3410	81440	Elective – General
Child Abuse & Neglect	823	3450	81440	Elective – General
Elder & Dependent Adult Abuse	823	3480	81440	Elective – General
Domestic Violence	823	3510	81440	Elective – General
Sexual Violence	823	3530	81440	Elective – General
Human Trafficking	823	3550	81440	Elective – General
Trauma Practice/Skills				
Trauma Stewardship (Self-Care)	823	3610	81440	Elective – General
Trauma Practice/Skills NOS	823	3710	81440	Elective – General
4. Clinical Fundamentals				
Non-Therapy Interventions				
Case Management	823	4110	81440	Required – As Needed
Working with Collaterals	823	4150	81440	Elective – General
Psychoeducation	823	4170	81440	Elective – General
Pharmacology	823	4210	81440	Elective – General
Treatment Settings				
Home Visits	823	4310	81440	Elective – General
School Interventions	823	4330	81440	Elective – General
Correctional Facilities	823	4350	81440	Elective – General
Field Work NOS	823	4370	81440	Elective – General
Telehealth	823	4380	81440	Elective – General
Safety Management				
Non-Violent Crisis Intervention (CPI)	823	4410	81440	Required – Annually
Safety Planning – Foundations	823	4450	81440	Required – Once
Safety Planning – Electives	823	4460	81440	Elective – General
Mandated Reporting	823	4510	81440	Elective – General
Grave Disability/Conservatorship	823	4530	81440	Elective – General
Involuntary Holds – Qualification	823	4550	81440	Required – Once
Involuntary Holds – Non Qualification	823	4560	81440	Elective – General
Risk Assessment & Management Topics NOS	823	4580	81440	Elective – General
Suicide Prevention				

Columbia – Suicide Severity Rating Scale (C-SSRS) – Foundations	823	4610	81440	Required – As Needed
Columbia – Suicide Severity Rating Scale (C-SSRS) – Electives	823	4620	81440	Elective – General
Suicide Assessment & Treatment (Not C-SSRS)	823	4710	81440	Elective – General
5. Clinical Conceptualization				
Assessment & Treatment Planning				
MH Assessment & Treatment Planning	823	5110	81440	Elective – General
SUD American Society for Addiction Medicine (ASAM)	823	5210	81440	Required – As Needed
SUD Assessment & Treatment Planning (Non ASAM)	823	5250	81440	Elective – General
Diagnosis	823	5310	81440	Elective – General
Clinical Formulation	823	5370	81440	Required – Once
Evidence Supported Practice	823	5390	81440	Elective – General
Physical Health Care Integration	823	5410	81440	Elective – General
Level of Care				
Stages of Change	823	5510	81440	Required – As Needed
Child & Adolescent Needs & Strengths (CANS)	823	5530	81440	Required – Annually
Clinical Communication				
Clinical Presentation	823	5610	81440	Elective – General
Clinical Consultation	823	5710	81440	Elective – General
Miscellaneous				
MH Topics NOS	823	5910	81440	Elective – General
SUD Topics NOS	823	5950	81440	Elective – General
6. Therapeutic Interventions				
Rehabilitation Services/Skill Building				
Seeking Safety	823	6110	81440	Required – Once
Wellness Recovery Action Plan (WRAP)	823	6130	81440	Elective – General
Mental Health First Aid (MHFA)	823	6140	81440	Elective – General
Circle of Security	823	6150	81440	Elective – General
Parent Education	823	6160	81440	Elective – General
Rehabilitation Services/Skill Building NOS	823	6190	81440	Elective – General
Therapy Modalities				
Individual Therapy	823	6210	81440	Elective – General
Group Work	823	6230	81440	Elective – General
Family Work	823	6250	81440	Elective – General
Therapy Modalities NOS	823	6290	81440	Elective – General
Core Therapeutic Interventions				

Motivational Interviewing (MI) – Foundations	823	6310	81440	Required – As Needed
Motivational Interviewing (MI) – Electives	823	6320	81440	Elective – General
Cognitive Behavioral Therapy (CBT) – Foundations	823	6370	81440	Required – As Needed
Cognitive Behavioral Therapy (CBT) – Electives	823	6380	81440	Elective – General
Dialectical Behavioral Therapy (DBT) – Foundations	823	6430	81440	Required – As Needed
Dialectical Behavioral Therapy (DBT) – Electives	823	6440	81440	Elective – General
Trauma-Based Treatment Interventions				
Integrative Treatment of Complex Trauma (ITCT)	823	6510	81440	Elective – General
Trauma Focused CBT	823	6520	81440	Elective – General
Eye Movement Desensitization & Reprocessing (EMDR)	823	6530	81440	Elective – General
Trauma-Based Treatment Interventions NOS	823	6550	81440	Elective – General
Culturally-Based Treatment Interventions				
La Cultural Cura	823	6560	81440	Elective – General
Culturally-Based Treatment Interventions NOS	823	6590	81440	Elective – General
Child/Youth/Family Interventions				
Modular Approach to Therapy for Children (MATCH) – Foundations	823	6610	81440	Required – As Needed
Modular Approach to Therapy for Children (MATCH) – Electives	823	6620	81440	Elective – General
Child-Parent Psychotherapy (CPP)	823	6640	81440	Elective – General
Attachment Based Interventions	823	6650	81440	Elective – General
Parent-Child Interaction Therapy (PCIT)	823	6660	81440	Elective – General
Play Therapy	823	6670	81440	Elective – General
Child/Youth Family Interventions NOS	823	6690	81440	Elective – General
Adult Focused Interventions				
Solution-Focused Brief Therapy	823	6710	81440	Elective – General
Adult ST Therapy NOS	823	6750	81440	Elective – General
Adult SMI Interventions NOS	823	6790	81440	Elective – General
SUD Interventions				
Matrix	823	6810	81440	Elective – General
Seven Challenges	823	6830	81440	Elective – General
Medication Assisted Treatment (MAT)	823	6870	81440	Elective – General
SUD Interventions NOS	823	6890	81440	Elective – General
Interventions, NOS, & Specialty Populations				
Eating Disorders	823	6910	81440	Elective – General
Correctional Setting Interventions	823	6920	81440	Elective – General

Expressive Arts	823	6930	81440	Elective – General
Relaxation/Mindfulness Techniques	823	6940	81440	Elective – General
Interventions NOS	823	6990	81440	Elective – General
7. Clinical Documentation				
Electronic Health Records (EHR)				
EMR – Mental Health	802	7110	8###5	Required – As Needed
EMR – SUD	802	7150	8###5	Required – As Needed
Clinical Documentation Integration				
Clinical Documentation Integration – Classroom	802	7210	8###5	Elective – General
Psychosocial Assessment				
Psychosocial Assessment – Intro	802	7310	8###5	Required – Once
Psychosocial Assessment – Classroom	802	7320	8###5	Required – Once
Psychosocial Assessment – Consultation	802	7330	8###5	Elective – General
Treatment Planning				
Treatment Planning – Intro	802	7410	8###5	Required – Once
Treatment Planning – Classroom	802	7420	8###5	Required – Once
Treatment Planning – Consultation	802	7430	8###5	Elective – General
Progress Note Writing				
Progress Note Writing – Intro	802	7510	8###5	Required – Once
Progress Note Writing – Classroom	802	7520	8###5	Required – Once
Progress Note Writing – Consultation	802	7530	8###5	Elective – General
8. Professional Development				
Mentoring				
Recruitment of Interns	823	8110	81440	Required – As Needed
Orientation & Training of Field Instructors	823	8150	81440	Required – As Needed
Training & Supervision of Interns	823	8210	81440	Required – As Needed
MCBH Staff Internship	823	8250	81440	Required – As Needed
Supervision				
Supervision – Administrative	823	8320	81440	Elective – General
Clinical Supervision Licensure Course	802	8410	8###5	Elective – General
Supervision Clinical	823	8420	81440	Elective – General
Management				
Management	823	8510	81440	Elective – General
Leadership				
Leadership Academy	823	8610	81440	Elective – General
Franklin Covey	823	8620	81440	Elective – General
Leadership NOS	823	8670	81440	Elective – General
Performance Improvement				

Plan Do Study Act	802	8710	8###5	Elective – General
Performance Improvement Project (PIP)	802	8750	8###5	Elective – General
9. Other Training Codes				
On Boarding (OB)				
OB: Orientation to Training & Professional Development	802	9110	8###5	Required – Once
OB: Public Behavioral Health	802	9130	8###5	Required – Once
OB: Quality Management	802	9150	8###5	Required – Once
OB: Risk & Safety Management	802	9170	8###5	Required – Once
Back Out Coding Expectations & Adjustments				
Required Training – Repeated	823	9410	81440	Allotted – General
Mandatory County Wide Trainings				
Mandatory County Wide Trainings	823	9610	81440	Required – As Needed

Language Services

Monterey County offer services and support to a diverse community. We believe it is everyone's responsibility to provide the best service to our community members. So often we hear how language can be a barrier for people seeking services and oftentimes the individual making the call or seeking services is doing so for the first time. Taking this step can be scary and the person may be feeling vulnerable, this is why we need to take the necessary steps to assess the individual's needs, even when they may speak a language other than English.

Language Line

All MCBH staff members (ONLY) have access to the **Language Line 1-(800) 874-9426** to help assess the individual's needs. Remember that when helping the individual, it is your responsibility to make a risk assessment to ensure the person is not in imminent danger.

When the Person is in the OFFICE:
If you are calling from your office phone *and the person in care is present with you*, you can use the speaker phone function and follow the directions below.

NEW ACCESS PROCEDURES
Language Line® Over-the-Phone Interpretation Service

CALLING AN INTERPRETER FROM ANY PHONE:

DIAL: Your assigned toll-free number: 1- (800) 874-9426
ENTER: Your "Client ID" or "Access Code" #: 201763
SELECT: Your language by pressing: 1 for Spanish
2 for all other languages and state the language you need
0 for assistance if you don't know the language
ENTER: Numeric Access Code(s) 201763

You will be connected to an interpreter who will provide his/her name and ID number. Summarize what you wish to accomplish and give any special instructions.

RECEIVING A CALL FROM A LIMITED ENGLISH-PROFICIENT INDIVIDUAL:

1. Use the conference feature on your phone
2. Dial your assigned toll-free number: 1 (800) 874-9426 and follow the steps above

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When the Person is *not in the office* and is on the TELEPHONE:

You will need to use the conference feature on your telephone to complete the call. To initiate a conference call:

- With the call in progress, press the Line 2 button. 

- Call your next intended participant.
- Once both parties are connected, press 3, or the conference button  to merge all parties into a conference.
- You can add up to seven (7) parties to your conference call.

Indigenous Interpreting

Binational Center for the Development of Oaxacan Indigenous Communities;
Centro Binacional para el Desarollo Indigena Oaxaqueno:

CBDIO will provide interpretation services from Mixteco Bajo/Alto, Triqui Bajo/Alto, Zapoteco Alto, Chatino, Amuzgo, Purepecha/Tarascan and Tlapaneco to Spanish or English.

Instructions to request Indigenous Interpreters:

Before making a request for service, please have the following information if possible:

- Name of staff making the request and agency (Behavioral Health)
- Location (clinical full address and/or Zoom details)
- Actual language needs should be specific, for example Mixteco Alto or Mixteco Bajo

For scheduling or additional information, please contact Eulogio Espinoza at (559) 499-1178 or Direct (559) 840-9384 or Email: eulogio@centrobinacional.org

Avantpage Translations:

- Languages available include: Mixteco and Triqui (via Spanish-English-Triqui relay)
- Must be requested 3 days in advance of the appointment by contacting the Program Manager
    - Montzerrat Alva Thompson
    - montzerrat@avantpage.com
    - 530.750.2040 Ext 20

Over-the-phone Interpretation for

Monterey County Health Department – Behavioral Health Bureau

1. Dial **+1 530-292-7374**
2. Input your PIN #: **72933054**
3. State the language required for interpretation.
   See language list for reference ⇨

Quick Dials:

- For Spanish, press 1.

You will be connected to an Operator to answer some pre-call questions.

4. State your First Name.
5. State your Last Name.
6. State your Client's Initials.

- For 3-way calls: Ask the interpreter to place the call and provide corresponding phone # needed to be dialed.
- To repeat the process, **press 0**
- If you are having difficulties with our interpreter phone menu or if you want to speak to an Avantpage representative, please call **530.750.2040** extension **110**.

AVANTPAGE
empathy beyond words

LANGUAGES

Albanian	Greek	Pashto
Amharic	Gujarati	Persian
Arabic	Haitian Creole	Polish
Armenian	Hebrew	Portugese
Bengali	Hindi	Punjabi
Bosnian	Hmong	Romanian
Bulgarian	Igbo	Russian
Burmese	Indonesian	Samoan
Cambodian (Khmer)	Italian	Serbian
Chin	Japanese	Serbo-Croatian
Chin (Hakachin)	Karen	Somali
Chin (Tedim)	Karenni (Kayah)	Spanish
Chinese (Cantonese)	Kinyarwanda	Swahili
Chinese (Hakka)	Kirundi	Tagalog
Chinese (Mandarin)	Korean	Tamil
Croatian	Kurdish	Thai
Czech	Lao	Tibetan
Dari	Lithuanian	Tigrinya
Farsi	Mai Mai	Tongan
Filipino	Malayalam	Turkish
French	Mandinka	Twi
French – Canadian	Marshallese	Ukranian
Fulani	Mongolian	Urdu
Georgian	Nepali	Vietnamese
German	Oromo	Yoruba
		All other languages

AllWorld Language Consultants Inc.:

1. Languages available include: Mixteco
2. Must be requested 2-3 days in advance of the appointment
3. To request services for Mixteco, please complete the attached form and email it to request@alcinc.com. (Note: Contract Number should remain blank)
4. To use other languages, follow the instructions below.

AllWorld Language Directions

1. Dial: 1-855-692-8355
2. Access Code:
   10689
3. Select an Interpreter:
   - For Spanish, press 1
   - For all other languages, enter the 2-digit language code (see chart on following page)

The live agent will ask for:

1. Your first and last name
2. Your department
3. LEP initials

Third party dial-out

Notify the first person who answers (interpreter or call coordinator). International calls outside the USA and Canada are subject to additional fees.

Client support: Press '0'
Back-up Interpreter Number: 1-866-386-1284

TOP LANGUAGE CODES

CODE	LANGUAGE	CODE	LANGUAGE	CODE	LANGUAGE
47	Albanian	95	Hakha-Chin	74	Persian
39	Amharic	87	Hakka-Chinese	42	Polish
23	Arabic	90	Hebrew	35	Portuguese
59	Armenian	43	Hindi	49	Punjabi
58	Bangla	44	Hmong	19	Quiche
48	Bengali	65	Ibo	16	Rohingya
37	Bosnian	70	Indonesian	52	Romanian
67	Bulgarian	56	Italian	27	Russian
21	Burmese	63	Japanese	79	Samoan
51	Cambodian	34	Karen	62	Serbian
55	Canadian French	60	Karenni	64	Serbo-Croatian
31	Cantonese	94	Kinyarwanda	29	Somali
13	Castellano	53	Kirundi	1	Spanish
32	Chin	98	Kisii	38	Swahili
18	Chuukese	38	Kiswahili	46	Tagalog
92	Croatian	30	Korean	85	Tamil
91	Czech	76	Kurdish	86	Teddim
80	Dari	50	Laotian	57	Thai
84	Dutch	69	Lithuanian	83	Tibetan
33	Farsi	93	Macedonian	45	Tigrinya
73	Filipino	78	Mai Mai	97	Tongan
26	French	75	Malayalam	54	Turkish
36	Fulani	24	Mandarin	66	Twi
20	Fuzhounese	89	Mandingo	71	Ukrainian
82	Georgian	81	Marshallese	41	Urdu
61	German	72	Mongolian	22	Vietnamese
68	Greek	25	Nepali	88	Yoruba
40	Gujarati	96	Oromo	15	Zomi, Zou
28	Haitian Creole	77	Pashto	99	All Other

American Sign Language Interpretation LanguageLine Solutions:

For American Sign Language Interpretation (ASL), the following services will provide live interpretation on a video platform. There are two ways to access these services through LanguageLine Solutions.

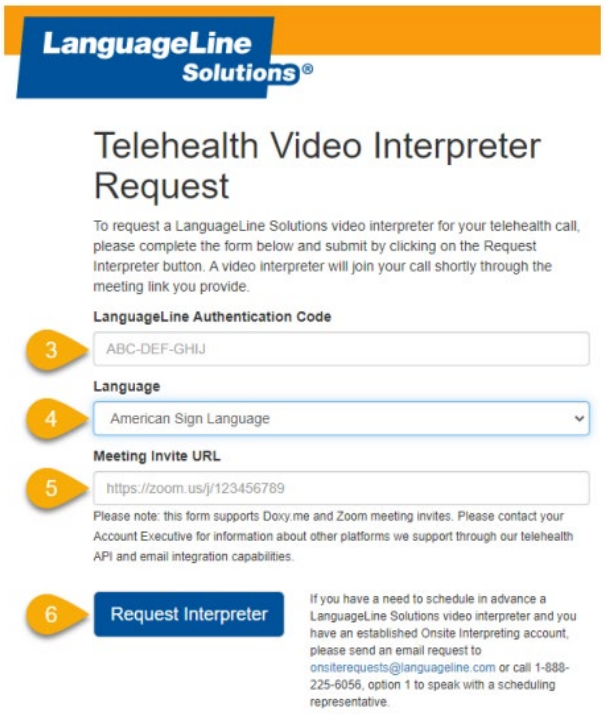
Method 1

This method invites an interpreter to join your platform. The process of connecting an interpreter to your platform can take up to 5 minutes. There is no need for an appointment, services are available on demand.

1. Prepare Zoom to allow the interpreter to join your session.
2. Using Chrome enter this URL: http://telehealth.languageline.com
3. Enter the LanguageLine Authentication Code: **P4M7MGD3KQ**
4. Select "**American Sign Language**" from the "**Language**" drop down menu.
5. Copy the Zoom Link information for the room you want the interpreter to join and paste into **"Meeting Invite URL**".

   HELPFUL HINT: If you are inviting the interpreter to join a psychiatry appointment, give the Zoom link for the psychiatrist's room. Make sure to communicate with the psychiatrist letting them know an interpreter will be joining and they will need to let them in. If you are inviting them to your own Zoom appointment, give them the information for your Zoom.

6. Select "**Request Interpreter**" and wait for them to join you.



Method 2

This method is good for use when meeting face to face with the person in care using a PC/Laptop. This routes the video chat through the LanguageLine Site.

1. Using Chrome enter this URL: http://insight.languageline.com
2. Enter the Authentication Code: P4M7MGD3KQ
3. Enter into "Device Name": MCBH (your program)
4. Click on "Activate Device"
5. Click on "Allow" for access to your camera and microphone.

Questions or need assistance? Contact LanguageLine Account Executive
CustomerCare@LanguageLine.com or call 1-800-752-6096
For 24/7 Technical Support call 1-844-373-1951

Conclusion

We hope that this manual has given you useful tools to implement the service delivery system transformation and documentation redesign concepts foundational to the delivery of Specialty Mental Health Services. Through coordination of care and strong engagement with the person in care we can streamline documentation and provide higher-quality care and further the goals of improving access for all Californians.

Appendix
Social Determinants Health Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Approved Abbreviations List

Full Word or Term	Abbreviation
Individual Session	1:1
A	
Absent Without Leave	AWOL
Access Resource Center (MPC)	ARC
Activities of Daily Living	ADL
Adult Needs and Strengths Assessment	ANSA
Adult Protective Services	APS
Against Medical Advice	AMA
Alcoholics Anonymous	AA
Appointment	Appt
As necessary	prn
As Soon As Possible	ASAP
At night	HS
At Once	STAT
B	
Be on the lookout	BOL or BOLO
Behavioral Health	BH
Blood Pressure	BP
Board and Care	B&C
Boyfriend	BF
Brought in by	BIB
Brother	bro
C	
Case Coordinator	CC
Case Manager	CM
Center for Employment Training	CET
Central Coast Alliance for Health	CCAH
Central Coast Center for Independent Living	CCCIL
Child Assessment of Needs and Strengths	CANS
Child Protective Services	CPS
Client	Cl or Clt
Community Hospital of the Monterey Peninsula	CHOMP
Creating New Choices Program	CNC
Critical Incident Stress Management	CISM
Crisis Negotiations Team	CNT
D	
Danger to Others	DTO
Danger to Self	DTS
Delirium Tremens	DT
Department of Rehabilitation	DOR
Department of Social and Employment Services	DSES

Department of Social Services	DSS
Department of Supportive Programs and Services (Hartnell College)	DSPS
Developmentally Disabled	DD
Diagnosis	Dx
Disorder	D/O
Divorced	div
E	
Electroconvulsive Therapy	ECT
Electroencephalogram	EEG
Emergency Department	ED
Emergency Room	ER
Employment Development Department	EDD
Evaluation	eval
Every day	QD
Every hour	Qh
Every morning	QAM
Every night	QPM, QHS
Example	e.g.
Extrapyramidal Symptoms	EPS
F	
Family Support Specialist	FSS
Father	Fa
Foster Father	FFa
Foster Mother	Fmo
Four times a day	QID
Full-Service Partnership	FSP
G	
Gastrointestinal	GI
Girlfriend	GF
Grandfather	GFa
Grandmother	GMo
Grave Disability or Gravely Disabled	GD
H	
High Blood Pressure	HBP
History	Hx
Home Visit	HV
Hostage Negotiations Team	HNT
I	
Individual	Ind
Individualized Education Plan	IEP
Information	info
Institution for Mental Disease	IMD
Intramuscular	IM
Intravenous	IV
L	
Left message	LM

M	
Maternal Grandfather	MGFa
Maternal Grandmother	MGMo
MediCal	MC
Medication	Meds
Mental Health	MH
Mental Health Rehab	MHR
Mental Health Rehabilitation Specialist	MHRS
Mental Health Specialist	MHS
Mental Health Unit	MHU
Monterey County Behavioral Health	MCBH
Monterey County Sheriff's Office	MCSO
Mother	Mo
Multi-disciplinary Team	MDT
N	
Narcotics Anonymous	NA
Natividad Medical Center	NMC
O	
Officer of the Day	OD
Orally	po
P	
Paternal Grandfather	PGFa
Paternal Grandmother	PGMo
Peer Support Specialist	PSS
Penicillin	PCN
Physician Assistant	PA
Police Department	PD
Prescription	Rx
Public Guardian	PG
Psychiatric Social Worker	PSW
Q	
Quality Assurance	QA
Quality Improvement	QI
Quality Management	QM
R	
Regarding	Re:
Re-scheduled	R/S
Rehabilitation	Rehab
Residential Treatment	Res
Return	rtn
Return to Clinic	RTC
Rule Out	R/O
S	
Section 8 Housing	Sec-8
Severely Emotionally Disturbed	SED
Short Doyle/Medi-Cal	SD/MC

Significant Other	S/O
Sister	sis
Skilled Nursing Facility	SNF
Social Security Administration	SSA
Social Security Disability Insurance	SSDI
Social Security Income	SSI
Social Worker	SW
Social Worker III	SWIII
State Disability Insurance	SDI
Supplemental Security Income	SSI
Symptoms	Sx
T	
Tardive Dyskinesia	TD
Targeted Case Management	TCM
Telephone call	TC
Three-times a Day	TID
Timex	x
Treatment	Tx
Two times a day	BID
V	
Veterans Administration	VA
W	
With	w/
Within	w/in
Within Normal Limits	WNL
Without	w/o
Weight	Wt
Y	
Year Old	Y/O
Year	Yr

Sample Progress Notes

Assessment: This clinician conducted an initial intake assessment with person in care. This clinician gathered information about the reason for seeking treatment, from the person's perspective. This clinician asked direct questions to assess for current risk and safety concerns. Clinician evaluated current symptoms of anxiety, irritability, pervasive worrying, and racing thoughts that are significantly impacting person's ability to function at home and work. This evaluation led to a determination that symptoms and impairments are consistent with a provisional diagnosis of Generalized Anxiety Disorder. Discussed challenges person experiences in meeting financial needs and maintaining stable housing. Clinician then worked with person to reach a consensus on the needs to prioritize in treatment. Person was verbal and engaged throughout the session. Clinician will complete assessment documentation and problem list for review at next session. Next session planned in one week.

Plan Development: Clinician collaborated with person to develop his initial problem list. I prompted person to share his life goal and brainstormed how it would be incorporated into his problem list. I reviewed the needs and strengths identified during the assessment and worked with person to determine how to leverage his strengths to support his areas of need. Person was engaged throughout the session, though he struggled to identify strengths. Person agreed with the problem list developed. This clinician will begin individual and family therapy sessions later this week.

Individual Therapy: Person continues to violate the terms of her probation and is engaging in high-risk behaviors (e.g., illicit substance use, high risk sexual behavior). In order to convey concern for person, this clinician inquired about her wellbeing and recent behavior. This clinician provided her with unconditional positive regard and acceptance. Facilitated discussion with person about her thought processes leading to her choices to violate her probation and prompted her to consider what her behavior is communicating to those who are trying to help her. Discussed plan for following through with avoiding high risk situations. Encouraged person to elicit the help of the friend identified by her as a primary support and source of encouragement to do what is in her best interest. Person continues to be very present minded and struggles to connect thoughts to behavior. She was able to independently recognize that her behavior is incongruent with her goals for herself. This clinician plans to continue to meet with person weekly to work toward increasing her ability to manage her impulsive and high- risk behavior.

Mental Health Rehabilitation: In effort to monitor person in care's moods and emotions, I engaged her in an open-ended conversation about her day and how she has been feeling. I praised her for her reported positive day. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (i.e., reading, listening to music, etc.). I normalized her

need to take a break from difficult situations and reminded her to take time outside. Assisted person in practicing how to let others know that she needs to use her safety plan by engaging in a role play. Person was verbal and engaged throughout the session. I will meet with person next week for an individual rehabilitation session to support her with developing and utilizing coping skills.

Case Management: Client is receiving mental health treatment in hopes of achieving their goal to find a way to cope with his voices and depression so that he can return to work. Writer will continue to support client through case management services to address the multi-dimensional needs identified in the assessment until the service goals are met or when there is no longer a need. Writer met with client to provide case management related to employment attainment. Writer supported client by contacting the Employment One-Stop Center and making an appointment for resume development. Upon achievement of the service goals, writer will provide care coordination and/or discharge planning to assist client in sustaining their gains. Client agrees with this plan.

Collateral: Person in care's father and grandmother report that on most days, person closes herself off in her bedroom as soon as she comes home on visits and only leaves her room to meet basic physical needs. These behaviors resulting from person's depression are creating challenges in family relationship, per father. This staff provided empathic and validating statements, acknowledging caregiver's frustration and concern. This staff provided psychoeducation around the various ways that anxiety can manifest behaviorally, especially in adolescents. This staff discussed common challenges amongst families when there are notable differences in the expression of respect between the generations within household. This staff solicited feedback from caregivers about whether or not the experience of generational differences resonated with them. Person's caregivers were forthcoming in expressing their challenges to understand how to best support person. They were receptive to information and expressed willingness to try new approaches with person. This staff will continue to work with person's family in identifying new methods to respond to person's isolative behavior.

Service Comparison: Case Management vs. Rehabilitation

Need	Case Management Service	Mental Health Service
Person wants a job	Staff reviews record and completes referral to employment services.	Staff works with person to try coping skills to manage anxiety
Rep-payee or Budget problems	Making a referral to budget group and coordinating with another provider regarding person's budget needs.	Providing interventions such as helping the person to develop a realistic budget and identifying past barriers to maintaining budget.
School Problems	Consulting with education staff regarding person's school behavior	Working with person and parent to practice behavioral interventions that help person to complete assigned homework.
Risk of losing placement	Consulting with care providers regarding person's changing needs	Meeting with person to discuss triggers to acting out behaviors.
Access to treatment person needs help applying for medical	Filling out paperwork for the person or consulting with DSES on behalf of the person.	Working with person to identify how anxiety impacts ability to apply for medical.

Narrative Summary and Treatment Plans Based on Stages of Change

DE is an 8-year old boy living with paternal grandparents and 2 younger siblings. Grandparents were granted guardianship of kids in 1/2010; biological parents were struggling to reunify with children. DE is severely affected by combination of variables, including in-utero exposure to drugs and violence, chronic, emotional, physical, verbal abuse, and neglect for first 4 years of life. As a result, DE shows difficulty in social, emotional, behavioral, and cognitive disturbances as evidenced by difficulty in getting along with peers, expressing his needs without yelling, threatening to harm himself by hitting himself on the head with his hands when he doesn't get his way, often not following directions from adults or authority figures, ignoring directions by grandmother, easily frustrated with situations at home and school, and learning difficulties.

DE has experienced some stability, since living with his legal guardians, but requires much support. He enjoys playing X- Box, watching cartoons, and likes spending time with his siblings. DE stated he enjoys his recess time because he can run around and that makes him feel good. DE reports he would like to play the drums. DE stated he enjoys playing with his little brother and sister, but sometimes they cry too much and grandparents give them what they want.

DE is in the contemplative stage of change as he is agreeable to meeting with school therapist and with psychiatrist. DE states that he has "gone to group" in previous school setting and it was "okay" to go again. DE states that he often gets in trouble with the teacher when "yells things to him from across the room." DE acknowledged that there have been times when he has "just hit his head" [with his hands] because he is frustrated and sad. He describes often time feeling frustrated at home because "they [grandparents] have too many rules.

While the person in care is in the contemplative state of change in treatment for him, challenges in family dynamics (communication patterns) continue to arise and must be addressed in order to help person in care meet his emotional needs. Family challenges include, ineffective communication patterns, setting healthy boundaries and demonstrating consistency in setting consequences or praise, and negative interactional patterns between family members. DE's grandmother's communications patterns/responses appear to trigger DE's trauma responses on a consistent basis, making changes more difficult. The degree of environmental stress is evident as DE describes significant tension in that relationship as evidenced by person in care's statements that grandmother is mean to him. In order to assist DE's progress in treatment, family therapy is warranted. The family is in the pre-contemplative stage of change and they believed the issues lies within DE, his siblings, and the lack of parenting

by his parents. Following are examples of treatment plans based on the stage of change:

Pre-contemplation	
(Problem) **Barrier or Challenge to Wellness**	DE's Grandparents are unsure how they can better help DE to communicate needs/concerns in healthier manner. Grandmother has difficulty with her communication with DE when DE is feeling overwhelmed and hurts himself by hitting his head using his hands.
(Goal) **My Hope Goal**	[Grandmother] I am willing to talk about what is working in my family.
(Objective) **A Step I will take to work towards my goals**	Grandmother and other family members agree to meet with clinician every 2 weeks to discuss what is working well within their family. Family will identify at least 1 thing that may be working, but may be further explored or improved upon that may help DE better express himself.
(Interventions) **Supports to help me reach my goals**	Clinician to meet with Grandmother/family every 2 weeks to explore what is working with the family and explore 1 area for improvement that may help improve communication and decrease DE's feeling overwhelmed.

Contemplation	
(Problem) **Barrier or Challenge to Wellness**	Grandmother's current communication style with DE appear to decrease DE's ability to express himself in healthy manner making symptoms of anxiety, threats of self-harm (using his hands to hit self on head) and feelings of overwhelming worse.
(Goal) **My Hope Goal**	I (Grandmother) want to learn how I can help DE to talk about what he needs. I plan to try to understand how I can help DE and my family.
(Objective) **A Step I will take to work towards my goals**	I (Grandmother) will meet with therapist 1 time every two weeks for family therapy to explore how I can make changes in my responses when DE is trying to communicate with me and express himself. I will learn and use 2 new communication skills to stay in control of my feelings when communicating with DE and other family members.
(Interventions) **Supports to help me reach my goals**	Clinician will meet with Grandmother for family therapy every 2 weeks and provide education on healthy communication. Clinician will focus on effects of family dynamics on DE's responses; Clinician to teach grandmother 2 new communication skills that may help support DE's and family's goals.

Action	
(Problem) **Barrier or Challenge to Wellness**	Support family's effective communication pattern in order to support/model positive (effective) way to deal with feeling/concerns. DE has history trauma and although has improved in ability to express self in healthy ways, needs further support/modeling in communicating needs when feeling overwhelmed to avoid making threats to harm self.
(Goal) **My Hope Goal**	I will continue to build my use of the healthy communication skills when communicate with DE and family. I will be able to identify 2 situations in which "new" communication skills were effective/not effective
(Objective) **A Step I will take to work towards my goals**	I (Grandmother) and family will to use "I statements" and "time outs" as well as other healthy communication skills in order to model healthy behaviors to DE and family members as evidenced by self report. I will meet with therapist 1 time every 2 weeks for family therapy to discuss ways to keep improving my communication skills and how things are going with DE and family.
(Interventions) **Supports to help me reach my goals**	Therapist will meet with Grandmother every 2 weeks for the next 3 months for family therapy in order to help process and understand how her own feelings/emotions affect her ability to communication with others. Therapist will reinforce use of effective communication skills; Therapist will model, practice, and encourage use of communication skills.

Example Interventions Based on Stage of Change

	Precontemplation (High Risk/Not Engaged)	Contemplation (Poorly Coping/ Engaged)	Action (Coping/ Self-Responsible
Rehabilitation Therapy	Clinician to meet with client and explore ways therapy or counseling may be helpful in dealing with feelings of hopelessness.	Clinician to meet client weekly for individual therapy to identify goals that may help address symptoms of depression and hopelessness; explore and identify alternative coping skills.	Clinician to meet client bi-weekly; use CBT to help client continue to make adaptive and positive changes in management of responses to situation, by increasing understanding of how client can continue to take charge of own behaviors.
Case Management	Staff to meet with client to discuss/explore ways staff may help support client in identifying and/or obtaining life goals.	CM/BHA to support client with basic living and independent skills that are supportive in meeting client's goals.	CM to meet with client bi-weekly to teach and reinforce active role in independent living skills (communication, using bus, picking up prescriptions, and setting medical appointments).
Collateral	Clinician to meet with client and significant support persons to explore and identify 1 way they may help client reach his/her life goals.	Clinician to model, educate, and discuss effectiveness of setting healthy boundaries with client as a means to help client reach life goals.	CM to provide significant support persons with ongoing education, encouragement, validation, and support in their efforts to help client reach and maintain life goals. CM along with supports persons to evaluate effectiveness and impact of support on client's life goals.
Group	Clinician to meet with client to explore and discuss therapeutic groups available, in community and outpatient services, in order to inform client of options, if/when ready. CM to explain and/or discuss ways in which group participation has helped others in similar situations.	Clinician to teach DBT skills in group setting in order to help client understand influence of ineffective responses during stressful situations. Clinician will educate, encourage, assign homework and practice ways to use emotional regulation skills in getting needs met effectively, in order to support life goals.	Clinician to utilize DBT skills in group setting and allow for opportunity to practice skills in group and reinforce use of DBT skills beyond group setting. Process and discuss effectiveness of skills used (diary card) and discuss ways to enhance/modify skills to better meet client's goals.

Medication	Staff to meet with client and explore reasons for hesitation/ambivalence around medication and about meeting with psychiatrist to talk about how medication may be helpful in supporting client's life goals.	During session with psychiatrist, clinician will support client with encouragement to use relaxation skills (deep breathing) to communicate effectively. Clinician to encourage client to verbalize how medication is/is not working to address symptoms of anxiety. Clinician will provide and reinforce psychoeducation.	Clinician to participate in session with psychiatrist and reinforce use of relaxation skills to manage symptoms of anxiety in order to effectively communicate concerns and benefits of taking medication as well as side effects. Clinician to use coaching to encourage use of coping skills.

Add-on Matrix

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
Mental Health Service Codes						
201CA	INTENSIVE CARE COORDINATION	No	Yes	No	No	No
202CA	INTENSIVE CARE COORDINATION 26.5	No	Yes	No	No	No
208CA	INTENSIVE CARE COORDINATION KA	No	Yes	No	No	No
241CA	CFT	No	Yes	No	No	No
242CA	CFT 26.5	No	Yes	No	No	No
248CA	CFT KA	No	Yes	No	No	No
271/272CA	CRISIS INTERVENTION	No	Yes	No	No	No
298CA	THERAPEUTIC FOSTER CARE KA	No	Yes	No	No	No
299CA	THERAPEUTIC FOSTER CARE	No	Yes	No	No	No
301CA	LINKAGE/BROKER AGE	No	Yes	No	No	No
302CA	LINKAGE/BROKER AGE 26.5	No	Yes	No	No	No
311CA	COLLATERAL REHABILITATION	No	Yes	No	No	No
312CA	COLLATERAL 26.5	No	Yes	No	No	No
323CA	PEER ENGAGEMENT	No	Yes	No	No	No
324CA	PEER THERAPEUTIC ACTIVITY	No	Yes	No	No	No
325CA	PEER GROUP EDUCATION AND SKILL BUILDING	No	Yes	No	No	No
331CA	ASSESSMENT AND EVALUATION	Yes	Yes	No	No	No
332CA	ASSESSMENT 26.5	Yes	Yes	No	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
341CA	INDIVIDUAL PSYCHOTHERAPY	Yes	Yes	Yes	No	No
342CA	INDIVIDUAL PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
351CA	GROUP REHABILITATION	No	Yes	No	No	No
352CA	GROUP REHABILITATION 26.5	No	Yes	No	No	No
353CA	GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
354CA	GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
356CA	FAMILY GROUP REHABILITATION	No	Yes	No	No	No
3562CA	FAMILY GROUP REHABILITATION 26.5	No	Yes	No	No	No
357CA	FAMILY GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
3572CA	FAMILY GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
358CA	COLLATERAL GROUP REHABILITATION	No	Yes	No	No	No
3582CA	COLLATERAL GROUP REHABILITATION 26.5	No	Yes	No	No	No
359CA	MULTIPLE FAMILY GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
3592CA	MULTIPLE FAMILY GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
361CA	MEDICATION SUPPORT	Yes	Yes	Yes	Yes	Yes

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
361UCA	URGENT MEDICATION SUPPORT	Yes	Yes	Yes	Yes	Yes
362CA	MEDICATION SUPPORT 26.5	Yes	Yes	Yes	Yes	Yes
363CA	CLINICIAN CONSULTATION	Yes	No	No	No	No
365CA	MEDICATION SUPPORT CONFERENCE	Yes	Yes	Yes	No	No
371CA	CRISIS INTERVENTION (CRISIS TEAM ONLY)	No	Yes	No	No	No
381CA	MENTAL HEALTH REHABILITATION	No	Yes	No	No	No
382CA	MENTAL HEALTH REHABILITATION 26.5	No	Yes	No	No	No
391CA	PLAN DEVELOPMENT	No	Yes	Yes	No	No
392CA	PLAN DEVELOPMENT 26.5	No	Yes	Yes	No	No
581CA	THERAPEUTIC BEHAVIORAL SERVICES	No	Yes	No	No	No
Psychology Service Codes						
90885CA	PSYCHIATRIC EVALUATION OF RECORDS FROM OUTSIDE SYSTEM	Yes	No	No	No	No
961101CA	DEVELOPMENTAL SCREENING, 15 MINUTES	Yes	Yes	Yes	No	No
961102CA	DEVELOPMENTAL SCREENING, 15 MINUTES-26.5	Yes	Yes	Yes	No	No
961108CA	DEVELOPMENTAL SCREENING, 15 MINUTES KA	Yes	Yes	Yes	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
961121CA	DEVELOPMENTAL TESTING, FIRST HOUR	Yes	Yes	Yes	No	No
961122CA	DEVELOPMENTAL TESTING, FIRST HOUR-26.5	Yes	Yes	Yes	No	No
961128CA	DEVELOPMENTAL TESTING, FIRST HOUR KA	Yes	Yes	Yes	No	No
961161CA	NEUROBEHAVIORAL STATUS EXAM, FIRST HOUR	Yes	Yes	Yes	No	No
961162CA	NEUROBEHAVIORAL STATUS EXAM, FIRST HOUR-26.5	Yes	Yes	Yes	No	No
961168CA	NEUROBEH. STATUS EXAM, FIRST HOUR KA	Yes	Yes	Yes	No	No
961251CA	STANDARDIZED COGNITIVE PERF. TEST	Yes	Yes	Yes	No	No
961252CA	STANDARDIZED COGNITIVE PERF. TEST 26.5	Yes	Yes	Yes	No	No
961258CA	STANDARDIZED COGNITIVE PERF. TEST KA	Yes	Yes	Yes	No	No
961271CA	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT	Yes	Yes	Yes	No	No
961272CA	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMT 26.5	Yes	Yes	Yes	No	No
961278CA	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMT KA	Yes	Yes	Yes	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
961301CA	PSYCHOLOGICAL TESTING EVALUATION	Yes	Yes	Yes	No	No
961302CA	PSYCHOLOGICAL TESTING EVALUATION 26.5	Yes	Yes	Yes	No	No
961308CA	PSYCHOLOGICAL TESTING EVALUATION KA	Yes	Yes	Yes	No	No
961321CA	NEUROPSYCHOLOGICAL TESTING EVALUATION	Yes	Yes	Yes	No	No
961322CA	NEUROPSYCH. TESTING EVALUATION 26.5	Yes	Yes	Yes	No	No
961328CA	NEUROPSYCH TESTING EVALUATION KA	Yes	Yes	Yes	No	No
961361CA	PSYCH/NEUROPSYCH TEST ADMIN	Yes	Yes	Yes	No	No
961362CA	PSYCH/NEUROPSYCH TEST ADMIN 26.5	Yes	Yes	Yes	No	No
961368CA	PSYCH/NEUROPSYCH TEST ADMIN KA	Yes	Yes	Yes	No	No
Continuum of Care Service Codes						
CCR241CA	CCR CFT	No	Yes	No	No	No
CCR242CA	CCR CFT 26.5	No	Yes	No	No	No
CCR248CA	CCR CFT KA	No	Yes	No	No	No
Family First Prevention Services Act Service Codes						
FFPSA201CA	FFPSA INTENSIVE CARE COORDINATION	No	Yes	No	No	No
FFPSA202CA	FFPSA INTENSIVE CARE COORDINATION 26.5	No	Yes	No	No	No
FFPSA208CA	FFPSA INTENSIVE CARE	No	Yes	No	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
	COORDINATION KA					
FFPSA241CA	FFPSA CFT	No	Yes	No	No	No
FFPSA242CA	FFPSA CFT 26.5	No	Yes	No	No	No
FFPSA248CA	FFPSA CFT KA	No	Yes	No	No	No
FFPSA312CA	FFPSA COLLABORATIVE REHABILIATAION 26.5	No	Yes	No	No	No
FFPSA331CA	FFPSA QI ASSESSMENT AND EVALUATION	Yes	Yes	No	No	No
FFPSA3318CA	FFPSA QI ASSESSMENT AND EVALUATION KA	Yes	Yes	No	No	No
FFPSA332CA	FFPSA QI ASSESSMENT 26.5	Yes	Yes	No	No	No
FFPSA341CA	FFPSA INDIVIDUAL PSYCHOTHERAPY	Yes	Yes	Yes	No	No
FFPSA3418CA	FFPSA INDIVIDUAL PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No
FFPSA342CA	FFPSA INDIVIDUAL PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
FFPSA351CA	FFPSA GROUP REHABILITATION	No	Yes	No	No	No
FFPSA3518CA	FFPSA GROUP REHABILITATION KA	No	Yes	No	No	No
FFPSA352CA	FFPSA GROUP REHABILITATION 26.5	No	Yes	No	No	No
FFPSA353CA	FFPSA GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
FFPSA3538CA	FFPSA GROUP PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No
FFPSA354CA	FFPSA GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
FFPSA356CA	FFPSA FAMILY GROUP REHABILITATION	No	Yes	No	No	No
FFPSA3562CA	FFPSA FAMILY GROUP REHABILITATION 26.5	No	Yes	No	No	No
FFPSA3568CA	FFPSA FAMILY GROUP REHABILITATION KA	No	Yes	No	No	No
FFPSA357CA	FFPSA FAMILY GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
FFPSA3572CA	FFPSA FAMILY GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
FFPSA3578CA	FFPSA FAMILY GROUP PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No
FFPSA358CA	FFPSA COLLATERAL GROUP REHABILITATION	No	Yes	No	No	No
FFPSA3582CA	FFPSA COLLATERAL GROUP REHABILITATION 26.5	No	Yes	No	No	No
FFPSA3588CA	FFPSA COLLATERAL GROUP	No	Yes	No	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
	REHABILITATION KA					
FFPSA359CA	FFPSA MULTIPLE FAMILY GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
FFPSA3592CA	FFPSA MULTIPLE FAMILY GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
FFPSA3598CA	FFPSA MULTIPLE FAMILY GROUP PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No
FFPSA381CA	FFPSA MENTAL HEALTH REHABILITATION	No	Yes	No	No	No
FFPSA3818CA	FFPSA MENTAL HEALTH REHABILITATION KA	No	Yes	No	No	No
FFPSA382CA	FFPSA MENTAL HEALTH REHABILITATION 26.5	No	Yes	No	No	No
FFPSA391CA	FFPSA PLAN DEVELOPMENT	No	Yes	Yes	No	No
FFPSA3918CA	FFPSA PLAN DEVELOPMENT KA	No	Yes	Yes	No	No
FFPSA392CA	FFPSA PLAN DEVELOPMENT 26.5	No	Yes	Yes	No	No
Intensive Home-Based Services Service Codes						
IHBS3118CA	IHBS COLLATERAL KA NON-BILLABLE	No	Yes	Yes	No	No
IHBS312CA	IHBS COLLATERAL REHABILITATION 26.5	No	Yes	No	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
IHBS331CA	IHBS ASSESSMENT AND EVALUATION	Yes	Yes	No	No	No
IHBS3318CA	IHBS ASSESSMENT AND EVALUATION KA	Yes	Yes	No	No	No
IHBS332CA	IHBS ASSESSMENT 26.5	Yes	Yes	No	No	No
IHBS341CA	IHBS INDIVIDUAL PSYCHOTHERAPY	Yes	Yes	Yes	No	No
IHBS3418CA	IHBS INDIVIDUAL PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No
IHBS342CA	IHBS INDIVIDUAL PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
IHBS351CA	IHBS GROUP REHABILITATION	No	Yes	No	No	No
IHBS3518CA	IHBS GROUP REHABILITATION KA	No	Yes	No	No	No
IHBS352CA	IHBS GROUP REHABILITATION 26.5	No	Yes	No	No	No
IHBS353CA	IHBS GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
IHBS3538CA	IHBS GROUP PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No
IHBS354CA	IHBS GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
IHBS356CA	IHBS FAMILY GROUP REHABILITATION	No	Yes	No	No	No
IHBS3562CA	IHBS FAMILY GROUP REHABILITATION 26.5	No	Yes	No	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
IHBS3568CA	IHBS FAMILY GROUP REHABILITATION KA	No	Yes	No	No	No
IHBS357CA	IHBS FAMILY GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
IHBS3572CA	IHBS FAMILY GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
IHBS3578CA	IHBS FAMILY GROUP PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No
IHBS358CA	IHBS COLLATERAL GROUP REHABILITATION	No	Yes	No	No	No
IHBS3582CA	IHBS COLLATERAL GROUP REHABILITATION 26.5	No	Yes	No	No	No
IHBS3588CA	IHBS COLLATERAL GROUP REHABILITATION KA	No	Yes	No	No	No
IHBS359CA	IHBS MULTIPLE FAMILY GROUP PSYCHOTHERAPY	Yes	Yes	Yes	No	No
IHBS3592CA	IHBS MULTIPLE FAMILY GROUP PSYCHOTHERAPY 26.5	Yes	Yes	Yes	No	No
IHBS3598CA	IHBS MULTIPLE FAMILY GROUP PSYCHOTHERAPY KA	Yes	Yes	Yes	No	No

Service Code	Service Code Description	Interactive Complexity	Interpretation	Collateral	Psychotherapy for Med Support	Case Management for Med Support
IHBS381CA	IHBS MENTAL HEALTH REHABILITATION	No	Yes	No	No	No
IHBS3818CA	IHBS MENTAL HEALTH REHABILITATION KA	No	Yes	No	No	No
IHBS382CA	IHBS MENTAL HEALTH REHABILITATION 26.5	No	Yes	No	No	No
IHBS391CA	IHBS PLAN DEVELOPMENT	No	Yes	Yes	No	No
IHBS3918CA	IHBS PLAN DEVELOPMENT KA	No	Yes	Yes	No	No
IHBS392CA	IHBS PLAN DEVELOPMENT 26.5	No	Yes	Yes	No	No

*Interactive Complexity and Extended Service is only available to licensed/licensed eligible staff and LVN/RN/MA should not use extended service when billing Medication Support services

**Interpretation cannot be used in conjunction with the Interactive Complexity add-on

***Available to any Staff that may use the 361CA code

+Person in care must be present

Change Log

Date	Page	Section	Notes	Reason for Update
12/30/2022	Several	Several	Update grammatical error; ensure consistency of person in care and case coordinator language; updated sentence composition where confusing	To improve the accuracy and consistency of the manual
12/30/2022	42	Person and Family Centered Care	Added language regarding AB 1424	This form was created after the previous version was distributed
12/30/2022	83	Progress Notes	Deleted care plan requirement for case management	Removed care plan language to reduce confusion and moved CM PN requirements to another section
12/30/2022	91	Mental Health Services	Added case management progress note requirements and information regarding right click template on the EHR	CM PN requirements were better aligned with this section of the manual
12/30/2022	43-47	Screening Tools	Added section explain the Adult/Youth Screening Tool for Medi-Cal Mental Health Services and deleted Triage information	This procedure was required after the previous version was distributed
12/30/2022	122-124	Care Transitions	Added section explain the Transition of Care Tool	This procedure was required after the previous version was distributed
1/03/2023	150	Interpretation	Added new contract provider (CBDIO)	Provider was not contracted with MCBH when manual was written
1/04/2023	88	Mental Health Service Codes	Added information on Telehealth Service codes	Codes were overlooked in original version of guide
1/04/2023	99	Mental Health Service Codes	Removed listed telehealth code from Medication Support Codes	Telehealth codes were addressed by correction made on page 87
1/04/2023	69-70	Services Requiring a Treatment Plan	Updated list of FSP and added our current list of STRTP Programs requiring Treatment Plans	To improve clarity around Treatment Plan requirements
1/17/2023	140	Other QI Codes	Added 826 “Milieu Work” code	Codes were overlooked in original

Date	Page	Section	Notes	Reason for Update
				version
11/18/2023	88	Mental Health Service Codes	Added Location explanation	To improve understanding of how location is defined in the progress note form
2/9/2023	167-170	QI Disallowance Codes	Reasons updated by DHCS in 12/19/2022	This updated was provided after the previous version was distributed
2/14/2023 and 3/03/2-23	53-54,126	Assessment and Discharge Planning	Updated the age requirements for CANS-50 & PSC-35	Clarification provided by CalMHSA confirming ages outlined in BHIN 18-048
5/4/2023	102	Mental Health Services	Updated lock out grid to include Multiple Services on the same day	This line item was missing in the code legend in initial release
5/4/2023	53	Assessment	Updated the age requirements for PEARLS	Released Memo on 5/5/2023 requiring Children's Programs to complete PEARLS
6/30/2023	21	Opening an Episode	Added Telehealth Consent Acknowledgement Form	To improve accuracy of requirements
6/30/2023	21	Care Coordination – Timeliness of Admission	Added Telehealth Consent Acknowledgment Form	To improve accuracy of requirements
6/30/2023	20, 29	Advance Directives	Information to be offered to person in care upon initial start of services	This procedure was required after the previous version was distributed
6/30/2023	33	Restraining Orders	Added information on how to respond to Restraining Orders	This protocol was instituted after the previous version was distributed
6/30/2023	Several	Several Sections	Update provider name from Beacon to Carelon	Beacon changed name to Carelon
6/30/2023	48	Screening Tools	Added information about clinical judgement overriding Disposition of Tool	This option was introduced after the previous version was distributed
6/30/2023	56	Additional Assessment Requirements	Added and updated information about ACE and PEARLS tools	These requirements were updated after the previous version was distributed

Date	Page	Section	Notes	Reason for Update
6/30/2023	57	Integrated Assessment	Added that practitioners that use the ASAM must be previously trained	Clarification of prior version
6/30/2023	60	Reaching Recovery	Update timeframe for RMI and CRM from every 3 months to annually	Timelines were updated after that previous version was distributed
6/30/2023	71	Services Requiring a Treatment Plan	Updated list of services requiring a treatment plan; Added Peer Support Services	Updated to be current; removed specific service types and program names to be concise
6/30/2023	77	Problem List Requirements	Added that the case coordinator is responsible to ensure the problem list is accurate	Clarification of prior version
6/30/2023	82	Payment Reform	Added section on payment reform	Payment Reform was instituted after the previous version was submitted
6/30/2023	84	Progress Notes	Added paragraph on Add-Ons	Add-Ons were instituted after the previous version was submitted
6/30/2023	85	Required Note Service Information	Add travel duration	Payment Reform
6/30/2023	85	Group Progress Notes	Include use of Add-ons	Payment Reform
6/30/2023	87-88	Unbundling of Services	New information added	Payment Reform
6/30/2023	89	Confidentiality in Progress Note Content	Added that Mandated Reported obligations to be documented as non-billable	Clarification of information
6/30/2023	90	Mental Health Services	Added Peer Support Services to list	Payment Reform
6/30/2023	91-109	Mental Health Service Codes	Added clarification around the use of Location in Progress Notes; Added CA to all existing service codes; Expanded service code lists and added new codes with descriptions; updated individual and group service names; Update name of code from Individual Therapy to Individual Psychotherapy; Update name of code from	Payment Reform

Date	Page	Section	Notes	Reason for Update
			Mental Health Group Therapy to Group Psychotherapy	
6/30/2023	110-114	Add-Ons	Added new section about Add-Ons	Payment Reform
6/30/2023	108	Mental Health Service Codes - Lock Out Codes	Add section on Lock Out codes	This section was left out of previous version
6/30/2023	104, 117	Mental Health Service Codes - Medication Support Conference	Adding new code	Payment Reform
6/30/2023	123	New DHCS Practitioner Categories	Add new Practitioner Categories	Payment Reform
6/30/2023	135-137	Peer Support Services	Added section on Peer Support Services	These services were not available when previous version was distributed
6/30/2023	146-147	Notice of Adverse Benefit Determination	Updated list of NOABDs	Correction of previous version
6/30/2023	178	Sample Progress Notes	Updated Case Management Progress Note to reflect Right Click Template	To meet TCM requirements
6/29/2023	129-137	Day Treatment Intensive and Day Rehabilitation services	Updated requirements	Ensure requirements meet current regulations
10/27/23	10	Understanding Medi-Cal Programs	Added new verbiage from CALMHSA Doc Guide	To align with CalMHSA's current Guide Language
10/27/23	21-22, 23, 148	Admission and FSP Chapter	Updated to Include Treatment Plan Participation Consent Forms Required for FSP Programs	Per DHCS Audit Finding/Requirement related to MHSA
10/27/23	14	Electronic Signatures	Updated to reflect that all programs need to follow these requirements	Correction of previous version
10/27/23	22-23	Care Coordination – Annual Renewal of Services	Updated to indicate medical necessity applies to services provided	To align with CalAIM
10/27/23	23-24	Care Coordination – Transfer of Services	Updated to indicate annual renewal can be completed by sending *or* receiving program	Clarification of previous version
10/27/23	25	Informed Consent	Added Telehealth Consent Acknowledgement information	Included explanation of telehealth consent

Date	Page	Section	Notes	Reason for Update
10/27/23	58	Additional Assessment Requirements	Indicated that both ACE and PEARLS forms are available in Avatar or on the QI website	Previously forms were only available in paper form
10/27/23	60	Other Requirements	Update that the assessment will determine eligibility for services rather than medical necessity of person in care	To align with CalAIM
10/27/23	82	Problem List Requirements	Clarified when a problem list should be created and updated	Correction of prior language
10/27/23	93-94	Progress Notes	Unbundling section updated to clarifying direct service	Updated guidance from DHCS
10/27/23	98	Assessment (331CA/332CA)	Added language clarifying what types of providers can complete different parts of an assessment	Corrected to reflect BHIN 22-019
10/27/23	99-101	Case Management (301CA/302CA)	Clarified language of what constitutes case management	Updated to reflect Title 9
10/27/23	101	Clinician Consultation (363CA)	Added section describing this service	Payment Reform
10/27/23	109	Family Psychotherapy (357CA/357-2CA)	Removed “Group” from name of code	Clarification of prior language
10/27/23	115-116	“No Medical Necessity” Codes (No-MN)	Changes wording to indicate this code to be used when services provided are not medically necessary	To align with CalAIM
10/27/23	97-117	Mental Health Service Codes	Clarified that the Review of Records from Outside System can be used by licensed/licensed eligible staff; clarified 358CA code usage; updated 311CA/312CA name and guidance related to code usage throughout section; updated 330CA Non-billable duration threshold for claiming a service	Clarification around usage and as a result of new DHCS guidance related to Collateral
10/27/23	118-123	Add-On	Clarified who the specific staff are that can use the Collateral Add-On; clarified who cannot use Extended Services; added clarification for Extended Service for Crisis Intervention; clarified Interpretation examples used	Clarification of prior language and additions made
10/27/23	124	Clinical Supervision and Billing	Added Clinician Consultation (363CA) to list of available codes and provided an example	Payment Reform

Date	Page	Section	Notes	Reason for Update
10/27/23	127-133	Scope of Practice	Corrected language to indicate Scope of Practice is applicable to all mental health services; added to DHCS Practitioner Categories: Master's Level Interns and Psychologist Intern	Correction of prior language and new categories added that were not in previous guide
10/27/23	139-144	Day Treatment Intensive and Day Rehabilitation	Updated language to match current state requirements	Per MHP Contract, BHIN 22-019, and MHSUDS 17-040
10/27/23	134	Provider Eligible Code grid	Added Clinician Consultation (363CA)	Payment Reform
10/27/23	157-159	Frequently Asked Questions about NOABD	Updated language to indicate a NOABD would need to be sent if person does not meet criteria for SMHS for contracted providers	To align with CalAIM
10/27/23		Sustainability	Removed section	This is no longer a MCBH standard for county employees
10/27/23		Quality Improvement Disallowance Codes	Removed section	This is no longer a DHCS requirement
10/27/23	161-166	Other QI Codes	Clarified the use of 809; added Interpretation code; added new holiday code; added new abbreviated schedule code; removed grid related to sustainability	Codes were updated and new codes added to the guide
10/27/23	174-175	Language Line	Added language to clarify that only MCBH staff members have access to Language Line; clarified steps; deleted duplicate instructions	Clarification of prior version
10/27/23	182-185	Abbreviations	Added 'MHR' (Mental Health Rehab) to list of Abbreviations	Not in previous guide
10/27/23	194-201	Add-On Matrix	Updated to include Extended Service Add-On requirements for 271CA/272CA and 371CA; clarified available FFPSA and IHBS codes	Payment Reform
10/27/23	181	Appendix	Added DHCS Priority SDOH Codes	Not in Previous Guide
12/29/23	Several	Several	Added BHIN 23-068 as a reference throughout	Updated to reflect BHIN 23-068
2/15/24	58	Domain 7	Added Information about what	Updated instructions

Date	Page	Section	Notes	Reason for Update
			else may also be included in Domain 7 with regards to TCM/ICC requirements	in response to BHIN 23-068
12/29/23	76	Services Requiring a Treatment Plan	Removed Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Foster Care, Narcotic Treatment Program, Psychiatric Health Facilities, Special Treatment Programs within Skilled Nursing Facilities from list. Added Children's Crisis Residential Programs, Enhanced Care Management, Transitional Residential Treatment to list.	Updated to reflect BHIN 23-068
12/29/23	91	Required Progress Note Service Information	Updated requirements for narrative section of note. Updated definition of 'location' to reflect: location/place of service. Updated requirement for plan section of note.	Updated to reflect BHIN 23-068
12/29/23	91	Group Progress Notes	Added requirement for brief response of person in care.	Updated to reflect BHIN 23-068
12/29/23	92	Progress Note Timeliness	Changed timeliness requirement for Crisis notes from 24 hours to 1 calendar day; Added clarification regarding daily notes and the removal of weekly summaries for Day Rehab/Day Treatment Intensive/Residential	Updated to reflect BHIN 23-068
12/29/23	98	Location	Update that "Location" means location of service being provided; clarified definition of Telehealth further to align with Revised Policy 149	Updated to reflect BHIN 23-068 and Revised Policy 149
2/07/24	100	Case Management (301CA/302CA)	Clarified where documentation of requirements may occur	Updated to reflect BHIN 23-068; Inclusion of new instructions
12/29/23	98-99	Assessment (331CA/332CA)	Updated that other qualified staff may contribute to the assessment within their scope of practice	Updated to reflect BHIN 23-068
12/29/23	N/A	Triage (336CA)	This code was removed	The code is no longer valid
12/29/23	102-103	Intensive Care	Added requirement for ICC notes	Updated to reflect

Date	Page	Section	Notes	Reason for Update
and 2/07/24		Coordination (ICC)	to include specific information. Described availability of right-click template to aid in note writing; Clarified where documentation of requirements may occur	BHIN 23-068; Inclusion of new instructions
12/29/23	103-104	Intensive Home-Based Services (IHBS)	Corrected description of IHBS codes; Removed IHBS 313CA which is no longer used	Correction to prior version
12/29/23	128	Chart of Billing Daily Maximum per Person	Remove 336CA (Triage)	Update to prior version
2/05/24	148	Peer Support Specialist	Added language in to clarify that Peer Support Specialists are based on an approved Plan of Care and may be documented using the Treatment Plan Form	Not in previous version; Updated to reflect BHIN 23-068 guidance/Federal requirements
1/29/24	136-38	Provider Eligible Codes	Clarified the exclusions for Peer Support Specialist	Not in previous version
1/11/24	167	Employee Activity Resources	Re-named chapter from previous name of 'Sustainability'; Added back Section about Sustainability Requirements & added info about Employee Activity Tool	Sustainability section removed in error; Updated to include info about the new Employee Activity Tool
12/29/23 & 1/11/24	169-172	Indirect Service Codes	Added new codes (829 and 830; Added note to refer to next chapter for additional training codes; Added back in Sustainability Grid	Update to prior version
12/29/23	173	Training Back Out Programs	Updated Adjusted Scheduler instructions	Update to prior version
12/29/23	178	Training Codes	Added code for MCBH Staff Internship	Update to prior version
2/07/24	194	Sample Progress Notes	Updated Case Management Progress Note Example	Updated from prior version
12/29/23	201	Add-On Matrix	Added 311CA (Collateral Rehabilitation) Removed 336CA (Triage)	Update from prior version
1/11/24	186	Language Services	Added Information about American Sign Language	Not in prior version
1/12/24	189-192	Abbreviations	Added abbreviations: ARC – Access Resource Center (MPC); CCCIL – Central Coast Center for Independent Living CCAH – Central California	Update from prior version

Date	Page	Section	Notes	Reason for Update
			Alliance for Health; DOR – Department of Rehabilitation DSPS – Department of Supportive Programs and Services (Hartnell College); EDD – Employment Development Department FSS – Family Support Specialist PSS – Peer Support Specialist SSI – Supplemental Security Income; SSDI – Social Security Disability Insurance; SDI – State Disability Insurance; TCM – Targeted Case Management	
7/10/2024		Admission, Reaching Recovery & Training Back Out Program	Removed Reaching Recovery requirements	Sunsetting of Reaching Recovery requirements starting 7/1/2024
7/10/2024		Admission	Removed Mental Status MC from list of requirements	Sunsetting of Mental Status MC form (as of 6/01/2024).
7/10/2024		Admission	Removed Mental Status MC from list of requirements	Sunsetting of Mental Status MC (MSE) form
7/10/2024		Admission	Omission of Mental Status Exam (MSE) from list of responsibilities of individual tasks to complete when a case is transferred	Sunsetting of Mental Status MC (MSE) form
7/10/2024	55 & 58	Assessment	Moved description of MSE from pg. 58 (Additional Assessment Requirements) into Assessment Domain Requirements (Domain 1) on pg 55.	Sunsetting of Mental Status MC (MSE) form
7/10/2024	60	Additional Assessment Requirements	CANS-50: Added who may administer and timelines for completion after initial completed	Clarification of prior version
7/10/2024	60	Additional Assessment Requirements	PSC-35: Added information on timelines of completion after initial completed	Clarification of prior version
7/10/2024	60	Additional Assessment Requirements	C-SSRS & Safety Plan: Added description of tools and timelines of completion	New requirement starting 1/1/2024 per Policy 338
7/10/2024	89	Progress Notes	Updated language on location/place of service to provide further clarification	Clarification of prior version
7/10/2024	105	Mental Health	Updated information to	Correction to prior

Date	Page	Section	Notes	Reason for Update
		Service Codes	Psychology Code 96127CA on age limit removal	version
7/10/2024	103-104 204 & 206	Mental Health Service Codes & Add-On Matrix	Added 312CA code to FFPSA & IHBS codes	Correction to prior version
7/10/2024	83	Evidenced Based Practices	Added Child & Family Traumatic Stress Intervention (CFTSI)	Not in Prior Version
7/10/2024	142	Day Treatment Intensive and Day Rehabilitation Service: Continuous Hours of Operations	Added clarification on MCBH not offering half-day option	Clarification of Prior Version
7/10/2024	141	Day Rehabilitation & Intensive Services	Updated Provider Types in Staffing Requirements Section	BHIN 24-023
7/10/2024	120	Add-Ons	Updated Case Management Add-on can be used by Anyone that can bill 361	Updated from prior version
7/10/2024	207	Add-on Matrix	Updated Case Management Add-on footnote: can be used by Anyone that can bill 361	Updated from prior version
7/10/2024	99, 110, 113, 120, 126, 130 & 132-133	Mental Health Service Codes, Add-Ons & Scope of Practice	Added Info re: MAs: -May use 3631, 301 & 311 codes -Added in Scope of Practice & Practitioner Type Grid	BHIN 24-023
7/10/2024	199-207	Add-Ons & Add-On Matrix	Removed extended service add-on requirements	As of 7/1/2024 this is no longer required
7/10/2024	6	Introduction	Added MCBH Mission, Vision, Values Statement	Not in prior version
7/10/2024	29-30	Informed Consent	-Updated Minor Consent -Added chart to support with documentation of sensitive services	To align with AB 665
7/10/2024		Assessment	Removed integrated assessment portion	Replaced with SUD Screening
7/10/2024	61	Assessment	Added the following Screening Tools: ICC/TFC/IHBS, FSP Eligibility, SUD, Crisis Residential, Adult Transitional Residential, Day Rehab, and Day Treatment Intensive	New tools since prior version
7/10/2024	97	Mental Health Service Codes	Added examples for how Other Qualified Staff may contribute to	Clarification of prior version & BHIN 23-

Date	Page	Section	Notes	Reason for Update
			assessment	068
7/10/2024	167	Other QI Codes	Added Back Out Code specific to Placement Team	Updated from prior version