Monterey County Behavioral Health Policies and Procedures

Policy Number	23-068
Policy Title	Documentation Requirements for all Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services Treatment for Individuals with Mental Health Disorders
References	DHCS Behavioral Health Information Notice (BHIN) 23-068
Attachments	Department of Health Care Services (DHCS) Enclosure 1a: Care Planning Requirements that Remain in Effect; Enclosure 1b: Other Data and Documentation Requirements that Remain in Effect
Effective	July 1, 2022 REVISION: January 1, 2024

Purpose

This policy and procedure outline new guidelines and requirements that streamline clinical documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. The information in this policy and procedure supersedes guidance from the Department of Health Care Services' (DHCS) Information Notice 22-019.

Background

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to update Medi-Cal behavioral health documentation requirements to improve the member experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective member care; address equity and disparities; and ensure quality and program integrity.

To achieve this, DHCS is streamlining and standardizing clinical documentation requirements across SMHS and DMC-ODS. These updated documentation requirements better align with the Centers for Medicare and Medicaid Services' (CMS) national coding standards and physical health care documentation practices.

BHIN 23-068 updates chart documentation requirements for most SMHS and DMC-ODS

services (exceptions are noted below). These updated standards are effective January 1, 2024. This documentation policy was initially developed and published in 2022 and subsequently updated.

Policy

The documentation standards identified in this policy apply to SMHS and DMC-ODS services except for the following:

- Narcotic Treatment Programs,
- Psychiatric inpatient services provided in hospitals, Psychiatric Health Facilities, or Psychiatric Residential Treatment Facilities, and
- DMC-ODS inpatient services provided in Chemical Dependency Recovery Hospitals and acute psychiatric hospitals.

For authorization policy and documentation standards for psychiatric inpatient services, see BHIN 22-017.

To the extent that there is conflict between the Mental Health Plan (MHP) contract or the DMC-ODS Intergovernmental Agreement terms and BHIN 23-068, BHIN 23-068 supersedes the contract terms.

If there is a conflict between Enclosure 1a requirements and the documentation requirements within BHIN 23-068, then the Enclosure 1a requirements supersede the requirements within BHIN 23-068. When no conflict exists, documentation must comply with both Enclosure 1a requirements and the documentation requirements within BHIN 23-068.

SMHS and DMC-ODS services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.

1. *Standardized Assessment Requirements*

    A. Timely Assessments: SMHS and DMC-ODS

        i. To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.[1]

[1] Some SMHS and DMC/DMC-ODS services, such as residential levels of care, are subject to licensure or certification requirements that include additional standards for member assessments. Such standards remain in effect unless DHCS supersedes them. Please see Enclosure 1b for references to some assessment standards that remain in effect (this Enclosure may not be an exhaustive list). In

ii. Assessments shall be updated as clinically appropriate, such as when the member's condition changes.

iii. As part of a Medi-Cal behavioral health delivery system's Quality Assessment and Performance Improvement Program (SMHS and DMC-ODS), MCBH shall monitor timely completion of assessments to ensure appropriate access to, and utilization of, services. MCBH shall not enforce standards for timely initial assessments, or subsequent assessments, in a manner that fails to permit adequate time to complete assessments when such time is necessary due to a member's individual clinical needs.

iv. Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether SMHS or DMC-ODS access criteria are met, even if the assessment ultimately indicates the beneficiary does not meet criteria for the delivery system in which they initially sought care.[2]

B. SMHS and DMC-ODS Crisis Assessments

i. Crisis assessments completed during the provision of SMHS crisis intervention or crisis stabilization, or a SMHS or DMC-ODS Mobile Crisis Services encounter, need not meet the comprehensive assessment requirements outlined in BHIN 23-068. However, crisis assessments are not a replacement for a comprehensive assessment. When a member who has received a crisis assessment subsequently receives other SMHS or DMC-ODS services, an assessment shall be completed in accordance with the requirements in BHIN 23-068.

a. For assessment and documentation requirements specific to Medi-Cal Mobile Crisis Services, please refer to BHIN 23-025.

C. DMC-ODS Assessments

i. The Medi-Cal documentation guidance in this policy does not change or supersede existing requirements for DHCS Level of Care (LOC) Designations for providers of Residential Treatment Services or Withdrawal Management Services. As described in DHCS' LOC Designation requirements: [3]

a. Providers of Residential Treatment Services shall ensure each member receives a multidimensional LOC assessment

some cases, BHIN 23-068 seeks to clarify how assessment standards tied to licensure or certification relate to the comprehensive Medi-Cal SMHS and DMC/DMC-ODS assessment requirements in BHIN 23-068. DHCS will provide additional technical assistance for stakeholders on this topic as needed.

[2] For additional information on this policy please refer to BHIN 21-071; BHIN 21-073; BHIN 22-011; BHIN 23-001; or subsequent guidance. For information on diagnostic coding during the assessment refer to BHIN 22-013.

[3] See BHIN 21-001 Exhibit A, or subsequent Level of Care certification guidance.

within 72 hours of admission.[4]

b. A resident receiving Withdrawal Management services is exempt from the requirement to conduct a multidimensional assessment within 72 hours of admission, as described in Exhibit A of BHIN 21-001 or subsequent DHCS LOC Designation guidance.

ii. Licensed or certified SUD recovery or treatment programs are required to conduct evidence-based assessments of clients' needs for Medications for Addiction Treatment (MAT). MAT assessments, as described in BHIN 23-054 or subsequent guidance, need not meet the comprehensive ASAM assessment requirements described in this BHIN.

iii. MCBH shall require providers to use an ASAM Criteria assessment for DMC and DMC-ODS members[5]

iv. MCBH shall accept an ASAM assessment completed by a qualified provider using either the free ASAM Criteria® Assessment Interview Guide[6] or ASAM CONTINUUM software.

v. Effective January 1, 2025, DMC-ODS providers shall use one of the ASAM assessment tools described in (iv) above or a validated tool subsequently approved by DHCS and added to the list of approved DMC-ODS ASAM assessment tools.[7]

vi. The assessment shall include a typed or legibly printed name, signature of the service provider, provider title (or credentials), and date of signature.

vii. The assessment shall include the licensed provider's recommendations for ASAM LOC and medically necessary services, and additional provider referrals, as clinically appropriate.

viii. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

ix. Both licensed and non-licensed providers, including those not qualified to diagnose an SUD, may contribute to the assessment consistent with their scopes of practice, as described in the State Plan[8].

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[4] This initial Level of Care assessment for residential treatment should be used to ensure the member has been admitted into the right level of care but need not meet the comprehensive ASAM assessment requirements described in this Policy. Following the initial Level of Care assessment, a comprehensive assessment should be completed as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.

[5] W&I § 14184.402 (a), (e), and (i)

[6] The free ASAM Criteria® Assessment Interview Guide may be integrated within an Electronic Health Record and need not be paper based.

[7] DHCS will provide additional guidance and technical assistance as needed to address questions about how approved tools may and may not be modified when integrated into an Electronic Health Record.

[8] California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan, Section 3, Att. 3.1-B, Supp. 3

x. If the assessment of the member is completed by a registered or certified counselor, then a Licensed Practitioner of the Healing Arts (LPHA) shall review that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

D. SMHS Assessments

i. MCBH requires providers to use the uniform assessment domains as identified below. The assessment may be in any format so long as the assessment domains and components are included, and the assessment information is comprehensive, consolidated, and can be produced and shared as appropriate to support coordinated care, in accordance with applicable state and federal privacy laws.

ii. The assessment shall include the licensed provider's recommendations for medically necessary services and additional provider referrals, as clinically appropriate.

iii. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

iv. The diagnosis, current Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the member's physical and mental health must be completed by a provider, operating within 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[9].

v. Both licensed and non-licensed providers, including those not qualified to diagnose a mental health condition, may contribute to the assessment consistent with their scopes of practice, as described in the State Plan[10] (California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att. 3.1-B, Supp. 2).

vi. The assessment shall include a typed or legibly printed name, signature of the service provider, provider title (or credentials), and date of signature.

vii. For members under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool continues to be required and may be utilized to help inform the assessment domain requirements. An initial CANS shall be completed or an existing CANS shall be updated by a CANS certified provider. For additional

[9] California State Plan, Sec. 3, Att. 3.1-A, Supp. 3

[10] California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att. 3.1-B, Supp. 2

guidance on CANS requirements, please refer to MHSUDS IN 17-052 and MHSUDS IN 18-007.

2. *SMHS Assessment Domain Requirements*

For the purposes of this BHIN, a domain is a reference to categories of information that should be captured within the SMHS assessment. To the extent the information is available, all components listed within each of the seven domains shall be included as part of a comprehensive assessment.

Domain 1:
- Presenting Problem(s)
- Current Mental Status
- History of Presenting Problem(s)
- Member-Identified Impairment(s)

Domain 2:
- Trauma

Domain 3:
- Behavioral Health History Co-occurring Substance Use

Domain 4:
- Medical History
- Current Medications
- Co-occurring Conditions (other than substance use)

Domain 5:
- Social and Life Circumstances
- Culture/Religion/Spirituality

Domain 6:
- Strengths, Risk Behaviors, and Protective Factors

Domain 7:
- Clinical Summary and Recommendations
- Diagnostic Impression
- Medical Necessity Determination/LOC/Access Criteria

3. *SMHS and DMC-ODS Problem List*

A. The provider(s) responsible for the member's care shall create and maintain a problem list.

B. The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include, but is not limited to, the following:

   i. Diagnosis/es identified by a provider acting within their scope of practice, if any.

      a. Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) shall be included with the diagnosis, when applicable.

   ii. Current International Classification of Diseases (ICD) Clinical Modification (CM) codes.

   iii. Problems identified by a provider acting within their scope of practice, if any.

   iv. Problems identified by the member and/or significant support person, if any.

   v. The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.

C. A problem identified during a service encounter (e.g., crisis intervention encounter) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.

D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the member. Providers within their scopes of practice shall add to, amend, or resolve problems from the problem list when there is a relevant change to a member's condition.

   i. DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

E. For members that were receiving services prior to July 1, 2022 (the date that problem list requirements first took effect), a problem list is not required to be created retroactively. However, a problem list should be started when the member receives a subsequent SMHS or DMC-ODS service after July 1, 2022.

4. *SMHS and DMC-ODS Progress Notes*

A. Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s).[11]
   i. Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service.

B. Progress notes for all non-group services shall include:
   i. The type of service rendered.
   ii. The date that the service was provided to the member.
   iii. Duration of the direct patient care for the service.[12]
   iv. Location/place of the service.
   v. A typed or legibly printed name, signature of the service provider, and date of signature.
   vi. A brief description of how the service addressed the member's behavioral health needs (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.
   vii. A brief summary of next steps (e.g., as clinically indicated next steps may include planned action steps by the provider or by the member; collaboration with the member; 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).

C. For Group Services:
   i. When a group service is rendered, a list of participants is required to be documented and maintained by the provider.
   ii. Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in (B)(i-v) above.[13]

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[11] For valid Medi-Cal claims, appropriate ICD-CM diagnostic codes, as well as HCPCS/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note. However, current ICD-CM codes and HCPCS/CPT codes are not required to be included in the progress note narrative. For further guidance on use of ICD-10 codes during the assessment process, refer to BHIN 22-013: Code Selection Prior to Diagnosis.

[12] Direct patient care time is defined in the SMHS and DMC/DMC-ODS billings manuals; see the DHCS website

[13] As noted above, if a group service is rendered by more than one provider, one progress note shall be completed for each member that participates in a group session and the note shall be signed by at least one provider. The progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity.

iii. The progress note for the group service encounter shall also include a brief description of the member's response to the service (e.g., 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 member's participation, comments, or reactions during the treatment session).

D. Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described in (A) or (B) above, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others (e.g., 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). If information is located elsewhere in the clinical record (e.g., a treatment plan template), it does not need to be duplicated in the progress note.

E. Providers shall complete progress notes within 72-hours of providing a service, with the exception of notes for crisis services, which shall be completed within 1 calendar day. The day of the service shall be considered day zero.

F. Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled services), such as Crisis Residential Treatment, Adult Residential Treatment, DMC-ODS Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation). Weekly summaries are no longer required for Day Rehabilitation and Day Treatment Intensive, nor for residential levels of care or other bundled services. If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.

5. *Care Planning Requirements*

DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal SMHS, or prospectively completed, standalone treatment plans for DMC-ODS services. The intent of this change is to affirm that care planning is an ongoing, interactive component of service delivery rather than a one-time event.[14] Where possible, DHCS has

[14] For purposes of BHIN 23-068, the terms "care planning" and "care plans" are used as general terms to describe the activities and

modified, or may modify, state-level requirements for care, client, service, and treatment plans (hereafter referred to as “care plans”) to eliminate additional care planning specifications and align with the Medi-Cal requirements described in BHIN 23-068.

There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities (see Enclosure 1a). For SMHS and DMC-ODS services, programs, or facilities for which care plan requirements remain in effect:

A. Providers must adhere to all relevant care planning requirements in state or federal law.
B. The provider shall document the required elements of the care plan within the member record. For example, required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an EHR.
C. To support delivery of coordinated care, the provider shall be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws.
D. MCBH shall not enforce requirements for the location, format, or other specifications for documentation of the care plan that differ from those described within this BHIN and referenced in its Enclosures.

6. *Documentation of Telehealth Services*

Please refer to BHIN 23-018 (or subsequent telehealth policy guidance) for complete information on telehealth services, including documentation of member consent for telehealth services.

7. *Compliance Monitoring*

Deviations from the documentation requirements may require corrective action plans. This oversight will include verifying that services provided to Medi-Cal members are medically necessary, and that documentation complies with the applicable state and federal laws, regulations, the MHP contract, and the DMC-ODS Interagency Agreement. Recoupment shall be focused on identified overpayments and fraud, waste, and abuse.

requirements listed in Enclosure 1a, inclusive of references to “client plans,” “treatment plans,” or “service plans” that appear in other state or federal authorities.

Forms/Attachments

Enclosure 1a: Care Planning Requirements that Remain in Effect

This Enclosure provides guidance to Medi-Cal behavioral health delivery systems on specific standards for care planning that remain in effect under state or federal law (including secondary guidance like policy or practice manuals). It may not be an exhaustive list of all relevant state or federal requirements, and the guidance it cites may be subject to changes. Member records for programs, services, and facilities that are subject to care planning requirements cited in this Enclosure must comply with all applicable care planning requirements. Care planning may be documented as described above in this policy, with required care plan elements documented within the member record. For example, care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an EHR. While DHCS does not require a specific format or location for care plan information, to support delivery of coordinated care the provider shall be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws. Generally speaking, documentation shall comply with both Enclosure 1a requirements (which may be more specific than the requirements above in this policy) and the standards in BHIN 23-068. DHCS will provide technical assistance as needed to clarify how compliance will be monitored for Enclosure 1a services, programs, and facilities.

Program, Service, or Facility Type	**Authority/ Background**
Children's Crisis Residential Programs (CCRP)	Children's Crisis Residential Mental Health Program Interim Standards
Community Treatment Facilities (CTF)	9 CCR § 1927, subds. (a)(6), (e)
DMC-ODS Residential Treatment Services and Withdrawal Management Services provided in DHCS LOC designated AOD Treatment Facilities	BHIN 21-001 and attachments
Enhanced Care Management (ECM) [15]	ECM Policy Guide

[15] This service is covered through CCAH, not MCBH or its Contracted Providers. However, it is included here for ease of reference, given many specialty behavioral health members are eligible to receive ECM and MCBH and its Contracted Providers may contract with Carelon to provide this service.

Mental Health Rehabilitation Centers (MHRC)	9 CCR § 786.15, subds. (a), (d), (e)
Mental Health Services Act Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP)	9 CCR § 3620
Peer Support Services	CMS Directors' Letter 07-011; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att. 3.1-B, Supps. 2, 3
Short-Term Residential Therapeutic Programs (STRTPs)	Interim STRTP Regulations Version II, Section 10
Social Rehabilitation Programs (SRPs). Includes programs certified by DHCS for: • Short-Term Crisis Residential Treatment; • Transitional Residential Treatment; and • Long Term Residential Treatment	9 CCR § 532.2, subds. (c), (d)
Substance Abuse Block Grant (SABG) Programs/Services[16]	45 CFR § 96.136(d)(3)
Targeted Case Management (TCM); Intensive Care Coordination (ICC)[17] [18]	42 CFR § 440.169(d)(2)
Therapeutic Behavioral Services (TBS) [19]	DMH IN 08-38; *Emily Q. v. Bonta,* Nine-Point Plan (Appendix D).

[16] SABG treatment planning may be documented in the manner described in BHIN 23-068. Federal regulations that apply to services funded with federal Substance Abuse Block Grants refer to treatment planning activities, but do not specify that treatment planning must be documented in any specific format or location.

[17] TCM and ICC care planning may be documented in the manner described in BHIN 23-068. CMS has approved the following: "DHCS' new documentation standards outlined in BHIN 22-019, or any subsequent guidance require providers to incorporate the TCM care plan elements outlined in 42 CFR § 440.169(d)(2) into the clinical record. Under the new standards for SMHS, care planning is documented through a treatment plan or a combination of the assessment record, a problem list, progress notes, or another section of the clinical record for each encounter (Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM), Amendment Submitted November 4, 2022, Updated June 23, 2023)".

[18] Requirements for ICC care planning are also discussed in the Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries. The ICC requirements in this manual were developed to be consistent with the TCM requirements in federal regulation cited in this Enclosure. Federal requirements applicable to ICC care planning remain in effect and must be observed. DHCS will not enforce the use of a care plan, or specific care planning requirements, as part of compliance monitoring specific to IHBS or TFC (however, children receiving these services are likely to have a care plan developed as part of ICC).

[19] Court documentation for Emily Q. v. Bonta is available via DHCS' website.

Enclosure 1b: Other Data and Documentation Requirements that Remain in Effect

This Enclosure was developed to provide guidance to Medi-Cal behavioral health delivery systems on additional service delivery, data reporting, or documentation standards that remain in effect under state or federal law (including secondary guidance like policy or practice manuals). Unlike Enclosure 1a, these requirements are not limited to care planning. To the extent that these authorities reference clinical documentation, DHCS will provide technical assistance as needed to clarify how compliance will be monitored. This Enclosure is not an exhaustive list of all relevant state or federal requirements, and the guidance it cites may be subject to changes.

Requirement	**Authority/ Background**
Adolescent Substance Use Disorder Services • Generally speaking, these guidelines remain in effect. DHCS will not enforce the use of a care plan or specific care planning requirements for adolescent SUD services.	Adolescent Substance Use Disorder Best Practices Guide
American Society of Addiction Medicine (ASAM)	MHSUDS IN 18-046; BHIN 21-071; BHIN 23-001 (or subsequent guidance)
CalOMS Treatment (CalOMS)	Data Collection Guide; Data Compliance Standards; Data Dictionary
Certification of Alcohol and Other Drug Programs	HSC § 11832; See forthcoming BHIN and enclosure(s)
Child and Adolescent Needs and Strengths (CANS)	MHSUDS IN 17-052; MHSUDS IN 18-007
Children's Crisis Residential Programs (CCRP) • See standards for assessment and other service activities. Standards for CCRP care planning are addressed in Enclosure 1a.	Children's Crisis Residential Mental Health Program Interim Standards
Client and Service Information (CSI)	MHSUDS IN 19-020

Community Treatment Facilities (CTF) • See standards for assessment and other service activities. Standards for CTF care planning are addressed in Enclosure 1a.	9 CCR § 1927
Drug and Alcohol Treatment Access Report (DATAR)	45 CFR § 96.126 DATAR Web User Manual
DHCS LOC Designations for AOD Treatment Facilities (applies to DMC/DMC-ODS Providers of Residential Treatment Services and Withdrawal Management Services)	BHIN 21-001 and attachments
Enhanced Care Management (ECM)[20] See Policy Guide for ECM-specific service delivery, documentation, and reporting standards. Standards for ECM care planning are addressed in Enclosure 1a.	ECM Policy Guide
Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC) See general standards for service delivery. Care planning requirements specific to ICC are addressed in Enclosure 1a. DHCS will not enforce the use of a care plan or specific care planning requirements for IHBS or TFC.	Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries
Mental Health Rehabilitation Centers (MHRC) • See standards related to assessment and other service activities. Standards for MHRC care planning are addressed in Enclosure 1a.	9 CCR § 786.11, subd. (b) 9 CCR § 786.15
Physical Exam Requirements (DMC & DMC-ODS)	22 CCR § 51341.1, subd. (h)(1)(A)(iv)(a-c)
Primary Prevention SUD Data Service (PPSDS)	Primary Prevention SUD Data Service Data Quality Standards

[20] This service is covered through CCAH, not MCBH and its Contracted Providers. However, it is included here for ease of reference, given many specialty behavioral health members are eligible to receive ECM and MCBH and its Contracted Providers may contract with Carelon to provide this service.

Pediatric Symptom Checklist (PSC)	MHSUDS IN 17-052
Perinatal Substance Use Disorder Services Generally speaking, these guidelines remain in effect. DHCS will not enforce the use of a care plan or specific care planning requirements for perinatal SUD services.	Perinatal Practice Guidelines
Short-Term Residential Therapeutic Programs (STRTPs) • See standards for assessment and other service activities. Standards for STRTP care planning are addressed in Enclosure 1a.	Interim STRTP Regulations Version II, Section 10
Social Rehabilitation Programs (SRPs) • See standards related to assessment and other service activities. Standards for care planning for SRPs that hold DHCS certifications for short-term, transitional, or long-term residential treatment are addressed in Enclosure 1a.	9 CCR § 532.2, subds. (b), (g)

Enclosure 2: Superseded Regulations

Regulation Title and Section Number	**Superseded Part of Regulation**
Title 9 Section 1810.205.2 Client Plan.	Superseded entirely.
Title 9 Section 1810.206 Collateral.	Requirement that the needs of the member are understood "in terms of achieving the goals of the member's client plan" is superseded.
Title 9 Section 1810.232 Plan Development.	Superseded entirely.
Title 9 Section 1810.440 MHP Quality management Programs.	Subdivisions (c)(1)(A)-(C) and (c)(2)(A)-(B) are superseded.
Title 9 Section 1840.112 MHP Claims Certification and Program Integrity.	Subdivision (b)(5) is superseded.
Title 9 Section 1840.314 Claiming for Service Functions - General.	Subdivision (e)(2)'s requirements related to approval of client plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(2)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(3)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(4)'s requirements related to treatment planning are superseded.

Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(5)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (g)(1)(B)(ii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (g)(2)(A-E) is superseded. Sign-in sheets are no longer required for DMC/DMC-ODS group counseling; however, the provider must maintain a participant list as described above in the body of this BHIN.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(iv)(c)'s requirements related to updated treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(v)(a-b)'s requirements related to diagnosis and evaluation of a substance use disorder within 30 days of admission to treatment. Note: only the timeline is superseded, not the requirement to diagnose and evaluate the member.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(v)(b)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(i) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(ii)(a-c) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(iii)(a-c) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(A-B) is superseded.

Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(A)(ii)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(B)(i)'s requirements related to treatment plans are superseded.