SAN BERNARDINO COUNTY

Behavioral Health

Outpatient Chart Manual

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Introduction

Purpose

The medical record is a legal document that:

- Provides a means of communication among care providers
- Documents compliance with standards of care
    - Complies with standards of care,
    - Is safe for all participants,
    - Is monitored for effectiveness, and
    - Meets legal requirements
- Documents compliance with insurance requirements (medical necessity)

Documentation:

- Provides a written record of client care
- Assists care providers in identifying problem areas and facilitates planning and evaluating care
- Creates a venue for communication between care providers
- Provides evidence for reimbursement
- Provides legal protection for the care provider and the department
- May be used in research or quality improvement activities

Documentation practices that validate safe, effective and high quality care include:

- Be clear, concise and provide supporting detail
- Be accurate and nonjudgmental
- Be logical and sequential in recording events
- Review documentation of care provided by others for continuity of care
- Document assessment of risk, your interventions and disposition/resolution (don't chart a symptom, such as "client reports suicidal ideation", without also charting what you did about it)
- Use only approved abbreviations
- Do not leave blank lines, draw a diagonal line if needed
- If documenting information reported by others, name the person providing the information and use quotation marks

Services

The Outpatient Chart Manual applies to all non-inpatient services whose medical records are governed by Medi-Cal requirements. This includes all of the Department's outpatient, day treatment, case management, and medication services.

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Introduction, Continued

Manual Priority	This manual, rather than the Department's Standard Practice Manual, governs charting and record keeping in the Department.
Manual Maintenance	The Department's Quality Management (QM) division maintains the Manual. Revisions are issued periodically, and it is important to file them appropriately so that your Manual is up-to- date. If you find things in the Manual that are not clear, or look for things in the Manual but cannot find them, please inform QM so that we can improve the Manual: DBH-QualityManagementDivision@dbh.sbcounty.gov.

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Chapter 1 – Initial Entry of Clients into the System

Overview

Chapter 1 will provide information on necessary actions needed to complete for initial entry of new clients.

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Care Necessity Form

Purpose

The Care Necessity Form provides documentation of the Departmental and programmatic reasons why an individual qualifies for Department services.

Procedure for Completion

The following procedure is followed when completing this form:

Step	Action
1	Complete the form upon admission during intake.
2	Check all boxes that apply to the client, even if the client does not currently have the type of coverage implied.
3	The form must be signed by an LPHA: • Physician • Registered Nurse • Licensed or Waivered Psychologist • Licensed/Registered/Waivered Social Worker • Licensed/Registered/Waivered Marriage and Family Therapist • Licensed/Registered/Waivered Professional Clinical Counselor

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Client Resource Evaluation

Purpose

The Client Resource Evaluation is completed on the first or the second client visit to identify basic resource needs, so that efforts can be made immediately to help clients obtain needed resources.

Form Completion

The following considerations are made when completing the Client Resource Evaluation:

- The client's sense of what his/her needs are is the basis of the evaluation (which includes what the client views as appropriate in his/her culture).
    - Staff may, however, identify needs that the client denies due to fear or psychopathology, even though the client refuses help with these needs at the time.
- In each section check "no need", or describe how the:
    - Need is currently being met;
    - Any additional need level, and
    - An initial plan for how to meet that need better.
- Obtain the client's signature on the form, if possible. The client may be given a copy of the completed form.

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Diagnosis

Requirement

A DMS-5 and ICD-10-CM Diagnosis are required and must be written out in full with:

- DSM-5 and ICD-10-CM Code numbers
- DSM-5 and ICD-10-CM Diagnosis names
- All applicable qualifiers

Additionally, the diagnosis must be consistent with and supported by the descriptive of the history and symptoms detailed in the Clinical Assessment.

Initial Time Frame

The following time requirements apply to the diagnosis:

- No billing can be done without a diagnosis, so a diagnosis must be made on the first visit (including an initial medications visit), even if it is provisional.
- This diagnosis must be entered on the blue diagnosis page dated before or on the date of the first billable service.
- A physician or clinician may complete the initial diagnosis.

Official Diagnosis

The official diagnosis of a client is the diagnosis on the diagnosis “blue” sheet.

- Any clinician or physician wishing to change that diagnosis must make the change on that page, with appropriate coordination with other open charts for the client.
    - (See **UNIFORMITY OF DIAGNOSIS IN MULTIPLE OPEN CHARTS** below.)

Important: A diagnosis entered in an **ID note** without a change of diagnosis on the diagnosis page is ***not*** an operative diagnosis.

Provisional and Rule-Out Diagnoses

Any provisional, deferred, or rule-out diagnoses must be clarified within 60 days after they are first written/given.

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Diagnosis, Continued

Deferred or Z03.89 Diagnoses	The SIMON system will accept a “deferred diagnosis,” Illness Unspecified (R69) on opening an episode, but will not accept a deferred diagnosis on closing an episode. “No diagnosis,” or Encounter for observation for other suspected diseases and conditions ruled out (Z03.89) will be accepted by SIMON for opening and closing.
Substance Use and Intellectual Disability	The Department will not usually be reimbursed for mental health treatment of persons with principal diagnoses of alcohol or drug problems or intellectual disability, so some other mental disorder should be the principal diagnosis. Substance use and intellectual disability diagnoses can be appropriate secondary diagnoses.
Ensuring that all Secondary Diagnoses are made	All applicable diagnoses **ARE** to be made (especially substance diagnoses), since this is the only way that our management information system can provide accurate information for program planning. Substance-related and intellectual disability diagnoses should not be primary diagnoses for mental health billing (although substance-related diagnoses are primary billing diagnoses for ADS).
Co-Signature: staff authorized to diagnose	The diagnosis and any changes in diagnosis must be signed or co-signed by a person qualified to diagnose. The following staff are authorized to co-sign: • Licensed Physicians • Licensed Clinical Therapists • Licensed Clinic Supervisors • Licensed Program Managers
Consistency of Diagnosis with medications	Physicians will ensure that the diagnosis on the blue Diagnosis Sheet is consistent with medications being prescribed.

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Diagnosis, Continued

Uniformity of Diagnosis in Multiple Open Charts

All service sites should operate under a uniform diagnosis for any given client. This diagnosis will normally be the diagnosis in the chart that was opened first among the currently open chart (episodes) for that client. This concept is demonstrated by the following procedure:

Step	Action
1	When other sites open charts on a client, they will: • Obtain a copy of the Diagnosis Sheet from the first opened chart (if there are other currently open charts), and • Will either use the diagnosis as is, or confer with the first opened clinic regarding any changes in diagnosis?
2	Discuss the situation with the first-opened clinic, if staff wishes later to change the diagnosis.
3	Reach diagnostic consensus with all provider sites so that there is a consistent diagnosis in all client charts at any given time.
4	Involve treatment teams in diagnostic discussions to reach consensus, if necessary.

Using the form and changing a diagnosis

The Diagnosis Sheet is used in the following ways when changing a diagnosis:

- The form contains sections for two complete diagnoses. Any change in diagnosis requires re-writing the diagnosis in full, using either the second section on the form, or a new Diagnosis Sheet with the same date and a signature below.
- A “P” is placed in front of the code number of the principal diagnosis, if that principal diagnosis is not the first listed diagnosis.

Professional disagreement on diagnosis

Diagnoses may be changed by clinicians or by physicians, however the following guidelines should be adhered to:

- Consultation should occur regarding the most appropriate diagnoses.
- Neither clinicians nor physicians should by implication invalidate the treatment that the other is providing by changing a diagnosis without consultation.
- ICD-10-CM will serve as the bases for diagnosis in all cases.
- Diagnostic disagreements which cannot be resolved may be appealed in the chain of command, with final decision by the Chief of Medical services.

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Diagnosis, Continued

Explanatory Note

Changes in Diagnosis must be explained in a regular session note or in a separate ID note labeled “Diagnosis Change” on the same date as the diagnostic change.

Annual Update

There is no requirement for a scheduled diagnosis update. The diagnosis will be updated as needed in conformance with the client’s condition.

Principal diagnoses which meet Medi-Cal medical necessity rules

The diagnoses listed in section Accepted/ Included Diagnosis identifies those diagnoses that are acceptable as principal diagnoses in justifying treatment according to Medi-Cal’s medical necessity criteria. The other, “excluded” diagnoses may still be present as non-treated secondary diagnoses if an “included” diagnosis is the principal diagnosis.

Diagnoses from other facilities

If it is necessary for a staff person who is not qualified to determine a diagnosis to open an episode with only in-the-field contact (no clinic visit), the episode may be opened using a copy of a written diagnosis made within the last 45 days by another reputable institution inpatient hospital, clinic, etc. The DBH Diagnosis Sheet must be completed within the intake period by a person qualified to diagnose.

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Crosswalk DSM IV to ICD-10-CM

Crosswalk

**** Diagnosis criteria & codes covered by Medi-Cal for Specialty Mental Health Outpatient Services are subject to change. Please refer to the DBH Info Notice 17-09 & the DHCS website for guidance and updates. ****

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
		F20.0	Paranoid Schizophrenia
		F20.1	Disorganized Schizophrenia
		F20.2	Catatonic Schizophrenia
		F20.3	Undifferentiated Schizophrenia
		F20.5	Residual Schizophrenia
295.40	Schizophreniform Disorder	**F20.81**	Schizophreniform Disorder
		F20.89	Other Schizophrenia
295.90	Schizophrenia	**F20.9**	Schizophrenia, Unspecified
301.22	Schizotypal Personality Disorder	**F21**	Schizotypal Disorder
297.1	Delusional Disorders	**F22**	Delusional Disorders
298.8	Brief Psychotic Disorder	**F23**	Brief Psychotic Disorder
		F24	Shared Psychotic Disorder
295.70	Schizoaffective Disorder, Bipolar Type	**F25.0**	Schizoaffective Disorder, Bipolar Type
295.70	Schizoaffective Disorder, Depressive Type	**F25.1**	Schizoaffective Disorder, Depressive Type
		F25.8	Other Schizoaffective Disorders
		F25.9	Schizoaffective Disorder, Unspecified
298.8	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	**F28**	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
298.9	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	**F29**	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
		F30.10	Manic Episode without Psychotic Symptoms, Unspecified

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
		F30.11	Manic Episode without Psychotic Symptoms, Mild
		F30.12	Manic Episode without Psychotic Symptoms, Moderate
		F30.13	Manic Episode, Severe, without Psychotic Symptoms
		F30.2	Manic Episode, Severe, with Psychotic Symptoms
		F30.3	Manic Episode in Partial Remission
		F30.4	Manic Episode in Full Remission
		F30.8	Other Manic Episodes
		F30.9	Manic Episode, Unspecified
296.40	Bipolar I Disorder, Current or Most Recent Episode Hypomanic	F31.0	Bipolar Disorder, Current Episode Hypomanic
		F31.10	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Unspecified
296.41	Bipolar I Disorder, Current or Most Recent Episode Manic, Mild	F31.11	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Mild
296.42	Bipolar I Disorder, Current or Most Recent Episode Manic, Moderate	F31.12	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Moderate
296.43	Bipolar I Disorder, Current or Most Recent Episode Manic, Severe	F31.13	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Severe
296.44	Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features	F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
		F31.30	Bipolar Disorder, Current Episode Depressed Mild or Moderate Severity, Unspecified
296.51	Bipolar I Disorder, Current or Most Recent Episode Depressed, Mild	F31.31	Bipolar Disorder, Current Episode Depressed, Mild
296.52	Bipolar I Disorder, Current or Most Recent Episode Depressed, Moderate	F31.32	Bipolar Disorder, Current Episode Depressed, Moderate

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
296.53	Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe	**F31.4**	Bipolar Disorder, Current Episode Depressed, Severe, Without Psychotic Features
296.54	Bipolar I Disorder, Current or Most Recent Episode Depressed, With Psychotic Features	**F31.5**	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
		F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
		F31.61	Bipolar Disorder, Current Episode Mixed, Mild
		F31.62	Bipolar Disorder, Current Episode Mixed, Moderate
		F31.63	Bipolar Disorder, Current Episode Mixed, Severe, Without Psychotic Features
		F31.64	Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features
		F31.70	Bipolar Disorder, Currently in Remission, Most Recent Episode Unspecified
		F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
		F31.72	Bipolar Disorder, in Full Remission, Most Recent Episode Hypomanic
296.45	Bipolar I Disorder, Current or Most Recent Episode Manic, In Partial Remission	**F31.73**	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
296.46	Bipolar I Disorder, Current or Most Recent Episode Manic, In Full Remission	**F31.74**	Bipolar Disorder, in Full Remission, Most Recent Episode Manic
296.55	Bipolar I Disorder, Current or Most Recent Episode Depressed, In Partial Remission	**F31.75**	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
296.56	Bipolar I Disorder, Current or Most Recent Episode Depressed, In Full Remission	F31.76	Bipolar Disorder, in Full Remission, Most Recent Episode Depressed
		F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
		F31.78	Bipolar Disorder, in Full Remission, Most Recent Episode Mixed
296.89	Bipolar II Disorder	F31.81	Bipolar II Disorder
296.89	Other Specified Bipolar and Related Disorder	F31.89	Other Bipolar Disorder
296.40	Bipolar I Disorder, Current or Most Recent Episode hypomanic, Unspecified	F31.9	Bipolar Disorder, Unspecified
296.40	Bipolar I Disorder, Current or Most Recent Episode manic, Unspecified	F31.9	Bipolar Disorder, Unspecified
296.50	Bipolar I Disorder, Current or Most Recent Episode Depressed, Unspecified	F31.9	Bipolar Disorder, Unspecified
296.7	Bipolar I Disorder, Current or Most Recent Episode Unspecified	F31.9	Bipolar Disorder, Unspecified
296.80	Unspecified Bipolar and Related Disorder	F31.9	Bipolar Disorder, Unspecified
296.21	Major Depressive Disorder, Single Episode, Mild	F32.0	Major Depressive Disorder, Single Episode, Mild
296.22	Major Depressive Disorder, Single Episode, Moderate	F32.1	Major Depressive Disorder, Single Episode, Moderate
296.23	Major Depressive Disorder, Single Episode, Severe	F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
296.24	Major Depressive Disorder, Single Episode, with Psychotic Features	F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
296.25	Major Depressive Disorder, Single Episode, in Partial Remission	F32.4	Major Depressive Disorder, Single Episode, in Partial Remission

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
296.26	Major Depressive Disorder, Single Episode, in Full Remission	F32.5	Major Depressive Disorder, Single Episode, in Full Remission
311	Other Specified Depressive Disorder	F32.89	Other Specified Depressive Episodes
296.20	Major Depressive Disorder, Single Episode, Unspecified	F32.9	Major Depressive Disorder, Single Episode, Unspecified
296.31	Major Depressive Disorder, Recurrent Episode, Mild	F33.0	Major Depressive Disorder, Recurrent, Mild
296.32	Major Depressive Disorder, Recurrent Episode, Moderate	F33.1	Major Depressive Disorder, Recurrent, Moderate
296.33	Major Depressive Disorder, Recurrent Episode, Severe	F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
296.34	Major Depressive Disorder, Recurrent Episode, with Psychotic Features	F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Features
		F33.40	Major Depressive Disorder, Recurrent, in Remission, Unspecified
296.35	Major Depressive Disorder, Recurrent Episode, in Partial Remission	F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
296.36	Major Depressive Disorder, Recurrent Episode, in Full Remission	F33.42	Major Depressive Disorder, Recurrent, in Full Remission
		F33.8	Other Recurrent Depressive Disorders
296.30	Major Depressive Disorder, Recurrent Episode, Unspecified	F33.9	Major Depressive Disorder, Recurrent, Unspecified
301.13	Cyclothymic Disorder	F34.0	Cyclothymic Disorder
300.4	Persistent Depressive Disorder (Dysthymia)	F34.1	Dysthymic Disorder
296.99	Disruptive Mood Dysregulation Disorder	F34.81	Disruptive Mood Dysregulation Disorder
		F34.89	Other Specified Persistent Mood Disorders
		F34.9	Persistent Mood (Affective) Disorder, Unspecified

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
		F39	Unspecified Mood (Affective) Disorder
300.22	Agoraphobia	F40.00	Agoraphobia, Unspecified
		F40.01	Agoraphobia With Panic Disorder
		F40.02	Agoraphobia Without Panic Disorder
300.23	Social Anxiety Disorder (Social Phobia)	F40.10	Social Phobia, Unspecified
		F40.11	Social Phobia, Generalized
		F40.210	Arachnophobia
300.29	Specific Phobia, Animal	F40.218	Other Animal Type Phobia
		F40.220	Fear of Thunderstorms
300.29	Specific Phobia, Natural Environment	F40.228	Other Natural Environment Type Phobia
300.29	Specific Phobia, Fear of Blood	F40.230	Fear of Blood
300.29	Specific Phobia, Fear of Injections and Transfusions	F40.231	Fear of Injections and Transfusions
300.29	Specific Phobia, Fear of Other Medical Care	F40.232	Fear of Other Medical Care
300.29	Specific Phobia, Fear of Injury	F40.233	Fear of Injury
		F40.240	Claustrophobia
		F40.241	Acrophobia
		F40.242	Fear of Bridges
		F40.243	Fear of Flying
300.29	Specific Phobia, Situational	F40.248	Other Situational Type Phobia
		F40.290	Androphobia
		F40.291	Gynephobia
300.29	Specific Phobia, Other	F40.298	Other Specified Phobia
		F40.8	Other Phobic Anxiety Disorders
		F40.9	Phobic Anxiety Disorder, Unspecified
300.01	Panic Disorder	F41.0	Panic Disorder [Episodic Paroxysmal Anxiety Disorder]
300.02	Generalized Anxiety Disorder	F41.1	Generalized Anxiety Disorder
		F41.3	Other Mixed Anxiety Disorder
300.09	Other Specified Anxiety Disorders	F41.8	Other Specified Anxiety Disorders
300.00	Unspecified Anxiety Disorder	F41.9	Anxiety Disorder, Unspecified

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
300.3	Obsessive-Compulsive Disorder	F42.2	Mixed Obsessional Thoughts and Acts
300.3	Hoarding Disorder	F42.3	Hoarding Disorder
698.4	Excoriation (skin picking) Disorder	F42.4	Excoriation Disorder
300.3	Other Specified Obsessive-Compulsive and Related Disorder	F42.8	Other Obsessive-Compulsive Disorder
300.3	Unspecified Obsessive-Compulsive and Related Disorder	F42.9	Obsessive-Compulsive Disorder, Unspecified
308.3	Acute Stress Disorder	F43.0	Acute Stress Reaction
309.81	Post Traumatic Stress Disorder	F43.10	Post-Traumatic Stress Disorder, Unspecified
		F43.11	Post-Traumatic Stress Disorder, Acute
		F43.12	Post-Traumatic Stress Disorder, Chronic
309.9	Adjustment Disorder, Unspecified	F43.20	Adjustment Disorder, Unspecified
309.0	Adjustment Disorder with Depressed Mood	F43.21	Adjustment Disorder With Depressed Mood
309.24	Adjustment Disorder with Anxiety	F43.22	Adjustment Disorder With Anxiety
309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood	F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
309.3	Adjustment Disorder with Disturbance of Conduct	F43.24	Adjustment Disorder With Disturbance of Conduct
309.4	Adjustment Disorder with mixed Disturbance of Emotions and Conduct	F43.25	Adjustment Disorder With mixed Disturbance of Emotions and Conduct
		F43.29	Adjustment Disorder With Other Symptoms
309.89	Other Specified Trauma and Stressor-Related Disorder	F43.8	Other Reactions to Severe Stress
309.9	Unspecified Trauma and Stressor-Related Disorder	F43.9	Reaction to Severe Stress, Unspecified
300.12	Dissociative Amnesia	F44.0	Dissociative Amnesia

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
300.13	Dissociative Amnesia, with Dissociative Fugue	**F44.1**	Dissociative Fugue
		F44.2	Dissociative Stupor
300.11	Conversion Disorder (functional neurological symptoms disorder), with Abnormal Movement	**F44.4**	Conversion Disorder with Motor Symptom or Deficit
300.11	Conversion Disorder (functional neurological symptoms disorder), with Speech Symptoms	**F44.4**	Conversion Disorder with Motor Symptom or Deficit
300.11	Conversion Disorder (functional neurological symptoms disorder), with Swallowing Symptoms	**F44.4**	Conversion Disorder with Motor Symptom or Deficit
300.11	Conversion Disorder (functional neurological symptoms disorder), with Weakness / Paralysis	**F44.4**	Conversion Disorder with Motor Symptom or Deficit
300.11	Conversion Disorder (functional neurological symptoms disorder), with Attacks or Seizures	**F44.5**	Conversion Disorder with Seizures or Convulsions
300.11	Conversion Disorder (functional neurological symptoms disorder), with Anesthesia or Sensory Loss	**F44.6**	Conversion Disorder with Sensory Symptom or Deficit
300.11	Conversion Disorder (functional neurological symptoms disorder), with Special Sensory Symptoms	**F44.6**	Conversion Disorder with Sensory Symptom or Deficit
300.11	Conversion Disorder (functional neurological symptoms disorder), with Mixed Symptoms	**F44.7**	Conversion Disorder with Mixed Symptom Presentation
300.14	Dissociative Identity Disorder	**F44.81**	Dissociative Identity Disorder
300.15	Other Specified Dissociative Disorder	**F44.89**	Other Dissociative and Conversion Disorders
300.15	Unspecified Dissociative Disorder	**F44.9**	Dissociative and Conversion Disorder, Unspecified

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
		F45.0	Somatization Disorder
300.82	Somatic Symptoms Disorder	F45.1	Undifferentiated Somatoform Disorder
		F45.20	Hypochondriacal Disorder, Unspecified
300.7	Illness Anxiety Disorder	F45.21	Hypochondriasis
300.7	Body Dysmorphic Disorder	F45.22	Body Dysmorphic Disorder
		F45.29	Other Hypochondriacal Disorders
		F45.41	Pain Disorder Exclusively Related to Psychological Factors
		F45.42	Pain Disorder with Related Psychological Factors
300.89	Other Specified Somatic Symptom and Related Disorder	F45.8	Other Somatoform Disorders
300.82	Unspecified Somatic Symptom and Related Disorder	F45.9	Somatoform Disorder, Unspecified
300.6	Depersonalization / Derealization Disorder	F48.1	Depersonalization-Derealization Syndrome
		F50.00	Anorexia Nervosa, Unspecified
307.1	Anorexia Nervosa, Restricting Type	F50.01	Anorexia Nervosa, Restricting Type
307.1	Anorexia Nervosa, Binge Eating / Purging Type	F50.02	Anorexia Nervosa, Binge Eating / Purging Type
307.51	Bulimia Nervosa	F50.2	Bulimia Nervosa
		F50.8	Other Eating Disorders
307.51	Binge Eating Disorder	F50.81	Binge Eating Disorder
307.59	Avoidant / Restrictive Food Intake Disorder	F50.82	Avoidant / Restrictive Food Intake Disorder
307.52	Pica in Adults	F50.89	Other Specified Eating Disorder
307.59	Other Specified Feeding or Eating Disorder	F50.89	Other Specified Eating Disorder
307.50	Unspecified Feeding or Eating Disorder	F50.9	Eating Disorder, Unspecified
		F53.0	Postpartum Depression
		F53.1	Puerperal Psychosis
301.0	Paranoid Personality Disorder	F60.0	Paranoid Personality Disorder
301.20	Schizoid Personality Disorder	F60.1	Schizoid Personality Disorder

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
301.83	Borderline Personality Disorder	F60.3	Borderline Personality Disorder
301.50	Histrionic Personality Disorder	F60.4	Histrionic Personality Disorder
301.4	Obsessive-Compulsive Personality Disorder	F60.5	Obsessive-Compulsive Personality Disorder
301.82	Avoidant Personality Disorder	F60.6	Avoidant Personality Disorder
301.6	Dependent Personality Disorder	F60.7	Dependent Personality Disorder
301.81	Narcissistic Personality Disorder	F60.81	Narcissistic Personality Disorder
301.9	Unspecified Personality Disorder	F60.9	Personality Disorder, Unspecified
312.31	Gambling Disorder	F63.0	Pathological Gambling
312.33	Pyromania	F63.1	Pyromania
312.32	Kleptomania	F63.2	Kleptomania
312.39	Trichotillomania	F63.3	Trichotillomania
312.34	Intermittent Explosive Disorder	F63.81	Intermittent Explosive Disorder
		F63.89	Other Impulse Disorders
		F63.9	Impulse Disorder, Unspecified
302.85	Gender Dysphoria in Adolescent and Adults	F64.0	Transsexualism
302.6	Gender Dysphoria in Children	F64.2	Gender Identity Disorder of Childhood
302.6	Other Specified Gender Dysphoria	F64.8	Other Gender Identity Disorders
302.6	Unspecified Gender Dysphoria	F64.9	Gender Identity Disorder, Unspecified
302.81	Fetishistic Disorder	F65.0	Fetishism
302.3	Transvestic Disorder	F65.1	Transvestic Fetishism
302.4	Exhibitionistic Disorder	F65.2	Exhibitionism
302.82	Voyeuristic Disorder	F65.3	Voyeurism
302.2	Pedophilic Disorder	F65.4	Pedophilia
		F65.50	Sadomasochism, Unspecified
302.83	Sexual Masochism Disorder	F65.51	Sexual Masochism
302.84	Sexual Sadism Disorder	F65.52	Sexual Sadism
302.89	Frotteuristic Disorder	F65.81	Frotteurism
302.89	Other Specified Paraphilic Disorder	F65.89	Other Paraphilias

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
302.9	Unspecified Paraphilic Disorder	**F65.9**	Paraphilia, Unspecified
300.19	Factitious Disorder	**F68.10**	Factitious Disorder Imposed on Self, Unspecified
		F68.11	Factitious Disorder Imposed on Self, with Predominantly Psychological Signs and Symptoms
		F68.12	Factitious Disorder Imposed on Self, with Predominantly Physical Signs and Symptoms
		F68.13	Factitious Disorder Imposed on Self, with Combined Psychological and Physical Signs and Symptoms
F68.A	Factitious Disorder Imposed on Another	**F68.A**	Factitious Disorder Imposed on Another
315.39	Social (Pragmatic) Communication Disorder	**F80.82**	Social (Pragmatic) Communication Disorder
307.9	Unspecified Communication Disorder	**F80.9**	Developmental Disorder of Speech and Language, Unspecified
***	See exception listed below, for instructions on diagnosing.	**F84.2**	Rett's Syndrome
***	See exception listed below, for instructions on diagnosing.	**F84.3**	Other Childhood Disintegrative Disorder
***	See exception listed below, for instructions on diagnosing.	**F84.5**	Asperger's Syndrome
***	See exception listed below, for instructions on diagnosing.	**F84.8**	Other Pervasive Developmental Disorders
***	See exception listed below, for instructions on diagnosing.	**F84.9**	Pervasive Developmental Disorder, Unspecified
314.00	Attention-Deficit / Hyperactivity Disorder, Predominantly Inattentive Presentation	**F90.0**	Attention-Deficit / Hyperactivity Disorder, Predominantly Inattentive Type
314.01	Attention-Deficit / Hyperactivity Disorder, Predominantly Hyperactive / Impulsive Presentation	**F90.1**	Attention-Deficit / Hyperactivity Disorder, Predominantly Hyperactive Type

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
314.01	Attention-Deficit / Hyperactivity Disorder, Combined Presentation	**F90.2**	Attention-Deficit / Hyperactivity Disorder, Combined Type
314.01	Other Specified Attention-Deficit / Hyperactivity Disorder	**F90.8**	Attention-Deficit / Hyperactivity Disorder, Other Type
314.01	Unspecified Attention-Deficit / Hyperactivity Disorder	**F90.9**	Attention-Deficit / Hyperactivity Disorder, Unspecified Type
		F91.0	Conduct Disorder Confined to Family Context
312.81	Conduct Disorder, Childhood-Onset Type	**F91.1**	Conduct Disorder, Childhood-Onset Type
312.82	Conduct Disorder, Adolescent-Onset Type	**F91.2**	Conduct Disorder, Adolescent-Onset Type
313.81	Oppositional Defiant Disorder	**F91.3**	Oppositional Defiant Disorder
312.89	Other Specified Disruptive, Impulse-Control, and Conduct Disorder	**F91.8**	Other Conduct Disorders
312.89	Conduct Disorder, Unspecified Onset	**F91.9**	Conduct Disorder, Unspecified
312.9	Unspecified Disruptive, Impulse-Control, and Conduct Disorder	**F91.9**	Conduct Disorder, Unspecified
309.21	Separation Anxiety Disorder	**F93.0**	Separation Anxiety Disorder of Childhood
		F93.8	Other Childhood Emotional Disorders
		F93.9	Childhood Emotional Disorder, Unspecified
312.23	Selective Mutism	**F94.0**	Selective Mutism
313.89	Reactive Attachment Disorder	**F94.1**	Reactive Attachment Disorder of Childhood
313.89	Dishibited Social Engagement Disorder	**F94.2**	Disinhibited Social Engagement Disorder
		F94.8	Other Childhood Disorder of Social Functioning
		F94.9	Childhood Disorder of Social Functioning, Unspecified
307.21	Provisional Tic Disorder	**F95.0**	Transient Tic Disorder

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
307.22	Persistent (chronic) Motor or Vocal Disorder	F95.1	Chronic Motor or Vocal Tic Disorder
307.23	Tourette's Disorder	F95.2	Tourette's Disorder
307.20	Other Specified Tic Disorder	F95.8	Other Tic Disorders
307.20	Unspecified Tic Disorder	F95.9	Tic Disorder, Unspecified
307.6	Enuresis	F98.0	Enuresis Not Due to a Substance or Known Physiological Condition
307.7	Encopresis	F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
307.53	Rumination Disorder	F98.21	Rumination Disorder of Infancy
		F98.29	Other Feeding Disorders of Infancy and Early Childhood
307.52	Pica, in Children	F98.3	Pica of Infancy and Childhood
307.3	Stereotypic Movement Disorder	F98.4	Stereotyped Movement Disorders
		F98.8	Other Specified Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence
		F98.9	Unspecified Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence
333.92	Neuroleptic Malignant Syndrome	G21.0	Neuroleptic Malignant Syndrome
332.1	Neuroleptic-Induced Parkinsonism	G21.11	Neuroleptic-Induced Parkinsonism
		G24.4	Idiopathic Orofacial Dystonia
333.1	Medication-Induced Postural Tremor	G25.1	Drug-Induced Tremor
		G25.70	Drug-Induced Movement Disorder, Unspecified
333.99	Tardive Akathisia	G25.71	Medication-Induced Acute Akathisia
		G25.9	Extrapyramidal and Movement Disorder, Unspecified
		R15.0	Incomplete Defecation
787.60	Other Specified Elimination Disorder, with Fecal Symptoms	R15.9	Full Incontinence of Feces

DSM-5	Medi-Cal Covered DSM-5 Descriptions	ICD-10	Medi-Cal Covered ICD-10 Descriptions
787.60	Unspecified Elimination Disorder, with fecal Symptoms	**R15.9**	Full Incontinence of Feces
		R69	Diagnosis Deferred
V71.09	No Diagnosis or Condition	**Z03.89**	No Diagnosis

- **IMPORTANT NOTE:** An exception to the DSM-5 Cross-Walk exists for Autism Spectrum Disorder.
  Providers should use the diagnostic criteria found in the DSM-IV to establish these diagnoses:

299.00	Autistic Disorder	**F84.0**	Autistic Disorder (not covered on latest SMHS Outpatient list)
299.80	Rett's Disorder	**F84.2**	Rett's Syndrome
299.10	Childhood Disintegrative Disorder	**F84.3**	Other Childhood Disintegrative Disorder
299.80	Asperger's Disorder	**F84.5**	Asperger's Syndrome
299.80	Other Specified Pervasive Development Disorder, Current or Active State	**F84.8**	Other Pervasive Developmental Disorders
299.90	Unspecified Pervasive Development Disorder, Current or Active State	**F84.9**	Pervasive Developmental Disorder, Unspecified

*A client who has medical necessity may receive treatment for an included diagnosis even if the client also has an excluded diagnosis.

Initial Contact Form

Policy

The current, approved Initial Contact Form will be used by all DBH sites as the basic tool for gathering information from potential clients upon first contact.

Procedure for completion

The following procedure shall be followed when completing the **Initial Contact Form.**

If the potential client …	Then the potential client may …
Is able and cooperative,	Be asked to fill out the form on their own. Clerical staff may assist them in completing this form. Clerical staff or designee will provide a beneficiary guide and a current provider list to the client at the initial contact.
Unable to complete the form or refuses to do so,	Not be required to complete the form. The client's inability or refusal to complete the form will not be used as a reason not to evaluate the person.
Staff will gather only information needed for their own tasks, using or not using the form.	
IN ALL CASES: Upon subsequent visits, the client may request additional copies of a beneficiary guide and provider list.	

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Medical Necessity

Criteria	The Medi-Cal medical necessity criteria are printed in the Care Necessity Form. Each client must be evaluated with regard to medical necessity when the client is first seen. Changes in medical necessity must be documented in the ID notes.
Clients not Meeting Medical Necessity	See current Department policy regarding whether any services may be provided to those who do not meet Medi-Cal medical necessity criteria.

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Chapter 2 – Documentation of Services (Except OT Services)

Overview

Chapter 2 discusses specific issues regarding documentary services in each client chart.

Contents

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Closing the Chart

Definition

A chart is "closed" when all services at that site are terminated.

Intake Period Closure

If a chart is closed within the initial two-month intake period, then the Clinical Assessment, Client Plan, and Discharge Summary do not need to be completed. The Care Necessity Form and Diagnosis Sheet should be completed for every client if enough information has been gathered to enable completing these forms.

However, in some very unusual circumstances treatment may be delivered without these completed forms. If this action is taken, then services must be appropriately justified by the description in the chart of the client's problems and medical necessity in the:

- ID notes and/or
- Partially completed Clinical Assessment

Charts with a recorded "no-show" after the intake period must have all of the usual paperwork elements mentioned above completed.

Timing of SIMON Closures

Since open episodes are necessary for billing, episodes should not be closed in SIMON until all case billing has been completed.

Documentation

In all cases there will be a closing ID note, noting the fact of the closure.

If the…	And…	Then…
Chart is closed during the intake period,	Discharge Summary form is not used,	The closing ID note will include the: • Reason for the client's treatment • Course of treatment • Reason for discharge • Client's condition on discharge
Chart is closed with only one service,	There is no clinical discussion of the closure needed in the closing ID note,	A clerk may write the closing ID note, but it must be co-signed by the Clinic Supervisor.

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Schedule of Essential Chart Forms and Due Dates

Introduction	The following documents are required in all client charts by the due dates noted.
Prior to any Billing	Diagnosis Sheet completed and dated before or on the date of the first billable service is required.
By the End of the First Two Months	The following documents are required: • Clinical Assessment • Care Necessity Form • Diagnosis Sheet (must be completed at the time of the first visit) • Consent of Outpatient Form • Advance Directives Form • Client Resource Evaluation • Client Recovery Plan (Spanish)
Start of a New Service	Recommended practice, is that the Client Plan is completed prior to or at the start of a new planned services or as soon as possible.
In the 30 days before the end of Every Services Period	A new (re-written) Client Plan for any continuing services is required.
As Needed	The following documents are required as needed, an update of: • Diagnosis Sheet, when changes occur • Clinical Assessment, when appropriate • Care Necessity criteria, when appropriate • Client Plan elements, when appropriate

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Schedule of Essential Chart Forms and Due Dates, Continued

Charts including Medication(s)	For charts that include medication(s), include all of the above-mentioned documents as well as the following.
By the End of the First Two Months	Chart must include: • Medication Consent Form (Spanish; Vietnamese)(when medications are started) • Physical Assessment Form • Abnormal Involuntary Movement Scale (AIMS) Form
Annually in the First 30 Days Before the DOE Anniversary Date	Chart must include: • Update of Physical Assessment and Abnormal Involuntary Movement Scale (AIMS) Forms • New Client Plan for MSS (unless not expiring because already done in last 12 months)
As Needed	Chart must include the following as needed: • Update of Medication Consent Form (Spanish; Vietnamese) and client signature (when medications change) • Update of meds plan as appropriate in Client Plan • Physician check diagnosis to ensure consistency with medications given

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Time Period Definitions

Definitions The following chart provides time period definitions used in charting.

<table>
<tr><th>Time Period Name</th><th colspan="2">Definition</th></tr>
<tr><td>Date of Entry (DOE)</td><td colspan="2">The date of opening of the episode. This is sometimes called the “date of registration.”</td></tr>
<tr><td rowspan="4">Intake Period</td><td colspan="2">The two-month period starting with the date of entry.</td></tr>
<tr><td>If the...</td><td>Then the...</td></tr>
<tr><td>Client’s date of entry is 02/15/95,</td><td>End of the intake period is 04/14/95.</td></tr>
<tr><td colspan="2"><u>Note:</u> For an entry date of 12/30 or 12/31, the end of the intake period is the last day of February.</td></tr>
<tr><td rowspan="3">Annual Period</td><td colspan="2">Exactly twelve (12) complete months, starting on the date of entry:</td></tr>
<tr><td>If the date of entry is...</td><td>Then the annual period is...</td></tr>
<tr><td>12/31/01,</td><td>12/13/01 through 12/12/02</td></tr>
<tr><td rowspan="3">Annual Window Period</td><td colspan="2">The twelfth month of the annual period the month period prior to the end of the annual period:</td></tr>
<tr><td>If the annual period...</td><td>Then...</td></tr>
<tr><td>Started 09/16/00 and ends 09/15/01,</td><td>The window period is 08/16/01 through 09/15/01.</td></tr>
<tr><td rowspan="3">Authorization Window Period</td><td colspan="2">The month period prior to the expiration of an authorization:</td></tr>
<tr><td>If the authorization period is...</td><td>Then the window period for re-authorization is...</td></tr>
<tr><td>08/02/00 – 11/01/00</td><td>10/02/00 – 11/01/00</td></tr>
</table>

Continued on next page

Transfer Paperwork

Transfer Episode Defined

When a client transfers from one site to another, a new episode is opened at the new site.

A transfer is considered a transfer under this section if there is a gap of no more than one month between the closing of the first clinics' episode and the opening of the second clinic's episode.

Note: The Date of Entry (DOE) for the new episode will be the 'date of registration' or date of first service at the new clinical unit. There is an option of using the original DOE from the first location; however, this is only utilized with approval from the Program Manager II and is typically only done when the first unit is merging with the second unit.

Documents Transferred

To facilitate this transfer, the first clinic will send the second clinic copies of the most recent:

- SIMON Registration form
- Outpatient Consent for Treatment
- Diagnosis Sheet
- Clinical Assessment
- CalWORKs check sheet and JESD release (if present)
- Client Recovery Plan
- Care Necessity Form
- Meds Order Sheet
- Client Resource Evaluation
- Discharge Summary

Document Distribution

Transfer documents are distributed in the following manner:

- Originals will remain in the first clinic's chart.
- Copies will be a permanent part of the new chart and will be marked as follows: **COPY STAYS IN [name of clinic] EPISODE.**

Continued on next page

Transfer Paperwork, Continued

Second Clinic Responsibilities

The second clinic does not need to re-do the following forms:

- Clerical (blue) Initial Contact Form
- SIMON registrations
- Care Necessity Form
- Outpatient Consent for Treatment

But will re-do the following forms:

- Episode Opening form (SIMON)
- Meds Consent for Treatment
- Client Plan (if the current Plan is not used)

The second clinic will add new information, if applicable, to the Clinical Assessment (or complete a Clinical Assessment Update).

Form Completion Schedule

Forms that are transferred to the new chart by copy will then be on a completion schedule determined by the new date of registration.

Chart Closure

When a chart is closed and episode ended, the following steps occur:

Step	Who completes	Action
1	First clinic	Sends the chart itself to Medical Records.
2	Medical Records	Sends that episode on to the new clinic as needed.

Concurrent Episodes

The same procedures stated above apply when a client starts services at a new site and the previous clinic continues its services.

Continued on next page

Transfer Paperwork, Continued

Unanticipated Services Provided at Another Site

When another site (where the client does not have an open episode) provides an unanticipated service to a client, the clinic with the client's already open episode will provide appropriate paperwork to the second clinic, by fax if necessary.

In the case of an emergency medication support service, this consists of copies of the:
- Outpatient Medication Record
- Last Medication Visit ID Note

Note: If a service is provided at a site without an open episode, a copy of a chart note for that service will be sent to the client's regular clinic.

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Transfers

Policy

When an episode is to be closed and the client transferred to another DBH or contract unit, all providers at the current site are consulted before the decision to close is made.

If…	Then the…
There are questions about the appropriateness of transfer,	Supervisor or Team is consulted.

New Site

The site of new services consulted. Use the **"IF/Then"** table for possible outcomes:

If…	Then…
That site does not wish to accept transfer,	The respective Clinic Supervisors and Program Manager IIs can be requested to create a solution.
Receiving Clinic Supervisor, Clinical Therapist II, Licensed Program Manager II or Team agrees to the transfer,	An appointment may be made for the client at the receiving clinic.

Discharge Summary

The following procedure is followed when the transfer has been approved and client is being discharged from the first clinical unit:

Step	Action
1	A Discharge Summary is done, if the case has been open at the site for more than 60 days, and
2	The chart episode is closed before transfer, and
3	The episode is closed in SIMON. (This closure need not be coordinated with other sites.)
4	The chart is then sent to Medical Records, which will send it on to the receiving clinic.

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Dual-Diagnosis Services in DBH Outpatient Clinics

Definition

Dual-diagnosis services may be provided for clients with both mental illness and substance-related problems.

Focus of Service

Dual-diagnosis services provided by the mental health clinics of the Department of Behavioral Health ***must focus*** on the mental/behavioral health needs of the client. Dealing with mental/behavioral health concepts and needs is acceptable including how the client:

- Recognizes and attempts to meet needs
- Deals with emotions
- Makes plans
- Carries out responsibilities, etc.

If…	Then…
Services provided which ***focus on sobriety or dealing with aspects of the client's substance use or dependence*** (whether to use, how much to use, how to quit, etc.).	Services will be subject to ***audit disallowance.***

Diagnosis

Substance-related diagnoses must be secondary diagnoses for these clients.

Dual-Diagnosis Groups

Billable groups of dual-diagnosis clients must be either:

- Rehab-ADL groups (MHS-rehab/ADL-group)
- Psychotherapy groups (MHS-group)

Only these services may be provided to clients in these groups. Charting and billing clients in these groups for Collateral or Case Management (instead of for group) is not allowed.

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Clinical Assessment

Use of Previous Assessments

If opened episode is...	Then...
Less than 2 years old,	Assessment may be updated.
More than 2 years old,	New Assessment must be completed.

The previous assessment is stapled behind a fresh Clinical Assessment form. On this fresh Clinical Assessment form, update various sections as needed, and write, "See previous intake attached" in sections where information is unchanged.

In all cases, the sections for Presenting Problem and Mental Status must be done completely anew.

Additional Information During an Episode

When additional assessment information becomes known during an episode, it is written on the Assessment Update section, which is the final page of the Clinical Assessment, with the writer's signature and date.

When the Form is Filled Up

If there is not enough room on the form for additional information, insert the needed single blank page of the Assessment Addendum into the page sequence, immediately in front of the already full page, write "ADDENDUM" beside the page number at the bottom of the page, and enter any new or changed information, with the date and the writer's initials, and a signature in the Assessment signature block with that date. To add information to the already-printed on-screen version, type or write it on a blank piece of paper, labeled with the client's name, chart number, date of birth, and program name, date and sign it (along with your printed name), and add it to the Clinical Assessment.

Continued on next page

Clinical Assessment, Continued

Clinical Re-Assessment Guidelines

In order to ensure a high standard of effective treatment based on a complete, accurate, and current assessment, it is mandatory that all DBH clinical staff and contract agency staff review the following criteria and utilize it as a guide to determine the medical necessity and clinical need to conduct and document a re-assessment. The following list is only an abbreviated list which illustrates the status changes that would potentially trigger a re- assessment. Ultimately, sound clinical judgment must be used by clinicians to determine the need to re-assess their clients.

Triggers for a re-assessment include but are not limited to:

1. Hospitalizations (especially if the hospitalization was for symptoms not previously identified).
2. An unexplained significant change in the global assessment of functioning.
3. Occurrence of significant clinical features of another diagnosis (not previously identified, considered, and ruled-out), or considered upon initial assessment and ruled out.
4. Ongoing ineffectiveness of an engaged treatment plan (Client Recovery Plan; Spanish) to an expected degree of progress or stabilization.
5. Significant psychosocial stressors (e.g., arrest, lost housing, physical disability, job loss, etc.), impacting the current level of functioning or impairing the progress towards treatment goals.
6. Loss of significant other, or primary support person(s), through death, divorce, or other separation (other instances that potentially increase the degree of personal isolation, may be included here as well).
7. Significant healthcare changes/medical conditions. This would include an unexplained weight gain or loss, an unexplained change in sleep pattern or the appearance of previously non-identified sleep disturbances, and/or unexplained significant deterioration of cognitive functioning.
8. Occurrences of “danger to others” incidences (such as those which require a determination of the issuance of a “Tarasoff” warning).
9. An unscheduled/unexplained gap in services and no contact with the clinic for 90 days or more.
10. It is expected that a most recent assessment that is beyond three years old would constitute the necessity of documentation of a more current re-assessment.

Note: The emphasis on “unexplained”, as many of these items occur as symptomatic of various mental disorders. Clinical judgment should ultimately determine the necessity to document a fresh clinical update, and the occurrence of one item alone, that is explored, explained and documented in progress notes would not necessarily dictate a fresh update, but the occurrence of one or several of these items, simply mentioned in progress notes, within a chart, that has an assessment several years old, will draw necessary scrutiny.

Continued on next page

Clinical Assessment, Continued

Completing the Form

ALL sections and items must be completed for the assessment to be considered adequate. Enter N/A if the item is somehow not applicable, or "N/AV" if the information is not available (e.g., because the client or collateral persons cannot give the information). In general, checking "None" or "No problem" eliminates the need for a written entry for that item, whereas checking that some aspect of the item is present does require a written explanation if space for writing is provided.

***The Goal*:** A Clinical Assessment that describes the client in depth and comprehensively, that illustrates any medical necessity present, and that provides a good symptomatic and historical basis for a ICD-10-CM diagnosis

Section A-1 Assessment for Medical Necessity

A. **PRESENTING PROBLEMS** (Including Mental Status Exam): Include when the presenting problems began and what behaviors or circumstances led to the need for the present assessment. The presenting problems lead into an assessment of dysfunction resultant of the mental disorder.

B. **DYSFUNCTION:** An assessment of how the symptoms of a mental disorder impair functioning must be documented in the five global areas. As you evaluate each area, be thinking about how you will answer the following questions:
   - Does the client have, as a result of a mental disorder, a significant impairment in an important area of life functioning?
   - Is there a probability of significant deterioration in an important area of life functioning?
   - Is there a probability that the client (for children only) will not progress developmentally as individually appropriate?
   - For full scope Medi-Cal beneficiaries under the age of 21, is there a condition as a result of a mental disorder that Specialty Mental health services can correct or ameliorate?

   1. Health/Self-Care: If applicable, how does the mental disorder impair the consumer's ability to care for his or her health? Document how the consumer is unable to manage his/her health and or self-care. For example, poor hygiene, medical conditions are left untreated and that are potentially serious in nature. Multiple visits to the Emergency room for pseudo-medical reasons, (i.e. the consumer believes he/she is having a heart attack when in fact; he/she is experiencing a panic attack).

Continued on next page

Clinical Assessment, Continued

Section A-1 Assessment for Medical Necessity (continued)

2. Occupation/Academic: If applicable, describe how the mental disorder impairs occupational functioning. For example, the consumer is unable to work, has been fired from jobs, and/or has repeated workplace conflicts or significant work performance problems.
3. Legal/Community Functioning: If applicable, discuss legal difficulties as a result of the mental health symptoms. For example, the consumer has repeated encounters with law enforcement, has had involuntary hospitalizations, and/or is on conservatorship.
4. Financial: If applicable, describe financial difficulties that have a relationship to the mental disorder. For example, a bipolar disordered consumer may result in the client engaging in shopping sprees which results in his or her inability to pay the bills.
5. Interpersonal/Family: If applicable, describe interpersonal relationship difficulties among family members, work associates, and or friends. For example, the consumer may have alienated his/her family, has conflicts with peers, has few or no friends, and/or has been victimized repeatedly.

C. **ASSESSMENT OF RISK:** In all cases, a risk assessment must be conducted.

1. Examine whether a consumer is a danger to himself. Are there suicidal ideations? Is there a plan? Does he or she have the means to carry out the plan, (i.e. he/she has access to a gun). Sometimes people feel like life isn't worth living or wish he/she were dead. While this is a risk, it is not as high of a risk as someone with suicidal ideations with a plan. Explore the history of previous suicide attempts. If the risk is high, there needs to be consideration for psychiatric hospitalization.
2. A risk assessment for a danger to others must be conducted. Sometimes consumers have paranoid delusions or command hallucinations which may put others at risks. There does not need to be an intended victim for the consumer to be considered high risk. However, if there is an intended victim, then the Duty to Warn and Protect Third Parties in Response to a Client Threat (Tarasoff) Policy and Duty to Warn and Protect Third Parties in Response to a Client Threat (Tarasoff) Procedure must be followed. If the risk is high, there needs to be consideration for psychiatric hospitalization.
3. If a client appears gravely disabled as evidenced by the inability to provide food, clothing and shelter as a result of a mental disorder (adult) or unable to accept food, clothing, or shelter as a result of a mental disorder (child) then psychiatric hospitalization should be considered.
4. Suicide HX: Include history or ideations and/or gestures and resultant consequences.
5. Homicide HX: Include history or ideation and/or gestures and resultant consequences.

Continued on next page

Clinical Assessment, Continued

Section A-1 Assessment for Medical Necessity (continued)

D. **SUBSTANCE ABUSE:** Since a "covered diagnosis" per Title IX must be a mental health diagnosis, it is important to rule out substance abuse or dependence as a primary issue. However, it is extremely important to know about co-occurring or co-existing conditions. Consider if there is a history of mental health symptoms prior to, or in absence of, substance abuse. Always document drugs used and date of last use. A consumer with a primary substance abuse disorder must be referred to an alcohol and drug treatment provider. Remember, Mental Health Services delivered to consumers with a primary substance abuse disorder are not billable to Medi-Cal. For Mental Health Services to be eligible for Medi- Cal reimbursement, the client must have a primary mental health diagnosis. Consumers with secondary substance abuse disorders should be referred to an alcohol and drug treatment provider or a co-occurring provider within the clinic if available.

E. **MEDICATION:** It is useful to know about current and past medication, especially psychotropic medication. A history of psychotropic medications may assist the clinician in determining whether medical necessity is met. Consumers who could have a primary care physician (PCP) prescribe medication (i.e. anti-depressants) should be referred back to their PCP unless the PCP is referring to a DBH psychiatrist because s/he cannot stabilize the clients condition.

F. **DIAGNOSIS**: Provide the DX based on symptom presentation and clinical determination (even if provisional).

G. **DISPOSITION:** This is a synthesis of the evaluation which supports why or why not a case will be opened. Needed modalities can also be addressed in this section.

H. **CASE STATUS:** There are five check boxes that summarize whether a case is being opened or not. If a case is not opened and the consumer has Medi-Cal then a NOA is required. Please see the Standard Practice Manual, policy number QM 06-6007 for further guidance on NOA's. It is also important to document referrals or the rationale that mental health services are not required. Please note the contact information for the referral site you have sent the client to in the Disposition plan. This will be used in follow-up activities with the client if they return to the crisis walk-in clinic.

I. **SIGNATURE:** The person completing the form will sign at the bottom.

Continued on next page

Clinical Assessment, Continued

Section A-2 Additional Assessment Information

A. **HEADING:** Complete the Date, billing Time and Location
B. **AGE:** Self-explanatory
C. **GENDER:** Self-explanatory
D. **MARITAL STATUS** (current): Stands for the following:
   - S – single
   - M – married
   - D – divorced
   - W – widowed
   - Sep – separated
E. **LIVES IN/WITH** refers to the client's living arrangement.
F. **PERSON GIVING TREATMENT CONSENT AND REFERRAL SOURCE:** Self-explanatory
G. **PREVIOUS INPATIENT AND OUTPATIENT TX:** Include when, where, duration, why, and provider
H. **CURRENT HEALTH CONDITIONS PLACING CLIENT A SPECIAL RISK:** Self-explanatory
I. **CURRENTLY PREGNANT:** Self-explanatory
J. **ALLERGIES, SLEEPING/EATING PROBLEMS:** Self-explanatory
K. **OTHER AGENCIES/PROVIDERS CLIENT IS INVOLVED WITH:** Self-explanatory
L. **EDUCATION AND EMPLOYMENT HX, ARRESTS AND LEGAL PROBLEMS:** Self-explanatory
M. **CULTURAL ISSUES:** Follow the instructions regarding the screen questions. If a more thorough assessment for cultural or sexual orientation issues is indicated, there are guideline questions available. It is assumed that understanding every client's cultural background and other diversity issues is necessary in order to provide effective care, so cultural/diversity information relevant to treatment should always be entered, if known. If a more thorough assessment is done, it is written on pink ID note pages or typed on white paper and inserted after page 2.

Continued on next page

Clinical Assessment, Continued

Section A-2 Additional Assessment Information (continued)

N. **SEXUAL ORIENTATION ISSUES:** Self-explanatory
O. **FAMILY SUPPORT:** Determine from the two questions whether the family's support and involvement are important (or necessary) to the client, and whether the client would like to have family involved in some way in his/her treatment.
P. **CLIENT STRENGTHS** should be personal strengths, abilities, etc., (e.g., highly motivated to improve) rather than circumstantial or environmental advantages (e.g., has SSI, can always turn to mother when in trouble)
Q. **MENTAL STATUS:**
    - **a.** THOUGHT PROCESS means the general quality and adequacy of understanding, reasoning, planning, and other cognitive processes.
    - **b.** DELUSIONS. Troublesome thought content, including delusions, is described under Thought Content/Delusions.
    - **c.** HALLUCINATIONS. Perceptual problems and hallucinations are described in Perceptual Processes/Hallucinations.
    - **d.** MOOD. Mood is usually a longer-lasting emotional state, while affect is the instantaneous emotional "feel" or "coloring" of what is expressed. Be sure to differentiate appropriately between mania and hypomania.

R. **DISPOSITION:** document any dispositional actions taken (referral to another clinic or to individual or group therapy, day treatment, medication evaluation, ARMC-BH; mandated reports filed; etc.), and any recommendations and other community referrals given to the client or family.
S. **SIGNATURES:** Each person completing a part of the form will sign at the bottom of the form.

Billing

Both assessment forms stand alone for billing purposes, as long as the top line is completed (date, billing time, location, and service type which is ASSESSMENT). No separate ID note is required; although it is sometimes useful for auditors if a note is entered indicating simply that the Assessment was completed as of the current date. (If a billing time is entered on that ID note, place the time in parentheses, indicating that it is not a separate billing.)

Structure

The Clinical Assessment has two sections. The first two pages are the screening/triage form, and the second part provides additional assessment information about the client. Each section has certain labeled parts that must be filled out by an LPHA. Each section may be billed separately (or the two may be billed as a unit).

Continued on next page

Clinical Assessment, Continued

Time Frame

All sections of the Clinical Assessment (intake) are completed during the initial intake period, before the Client Plan is done, and they are stapled together and placed under the Evaluation Admission in Section 2 of the chart. It is updated at any point if additional significant information becomes available and if the clinical picture changes significantly enough that the first assessment is not consistent with current treatment.

Use of Previous Assessments

If an episode is opened, and the previous Clinical Assessment (or similarly complete assessment from another facility) is less than two years old, an update may be done. The copy of the previous intake is stapled behind a fresh Clinical Assessment form. On this fresh Clinical Assessment form, update various sections as needed, and write, "see previous intake attached" in sections where information is unchanged. In all cases, the sections for Presenting Problem and Mental Status must be done completely anew. If an episode is opened, and the previous Clinical Assessment is more than two years old, then a new, complete Clinical Assessment is done.

Additional Information During an Episode

If additional assessment information becomes known during an episode, it is written on the final page of the Clinical Assessment, which is labeled Assessment Addendum/Update, with the writer's signature and date.

When the Form is Filled Up

If there is not enough room on the form for additional information, insert the needed single blank page of the Assessment Addendum/Update into the page sequence, immediately in front of the already full page, write "ADDENDUM" beside the page number at the bottom of the page, and enter any new or changed information, with the date and the writer's initials, and a signature in the Assessment signature block with that date. (To add information to the already-printed on-screen version, type or write it on a blank piece of paper, labeled with the client's name, chart number, date of birth, and program name, date and sign it (along with your printed name), and add it to the Clinical Assessment.

Continued on next page

Clinical Assessment, Continued

Additional Criteria/Status Changes

In addition to the guidelines for Re-assessment described in the previous section (Clinical Assessment – Adult), other criteria and status changes that would potentially trigger an update, in our population of children and youth served, include but are not limited to:

- Change due to maturation (e.g., puberty and related impact upon interpersonal relationship).
- Changes in school setting (e.g., onset of middle school, increased percentage of mainstreaming).
- Changes in family relationships (e.g., divorce, changes in family structure).
- Changes in residence (e.g., move or foster placement changes).
- Anticipation of Life Milestones (e.g., 6 months prior to reaching age of maturity, 3 months before graduation from high school).

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Psychiatric Evaluation for Children and for Adults

Psychiatric Evaluation Form	The appropriate Psychiatric Evaluation form (for children or for adults) will be used for the required psychiatric evaluation for all clients receiving medication services. It will be completed before medications are prescribed (except in some exceptional or emergency situations) and will be filed in the chart in Section 2 under the Evaluation/Admission tab.
Completing the Form	Every blank must be completed, if only with N/A or N/Av (not available). ***Note:*** See Clinical Assessment section for general instructions for all assessments.
Diagnostic Impression	All staff involved in diagnosing a client should meet to resolve differences in diagnostic impression. ***Note:*** The official diagnosis for the client is the one written on the blue Diagnosis form.
Management	Recommendations in "Management" must be communicated through appropriate channels to other staff if they are to be involved in the care of the client.
Billing	The form stands alone for billing and does not require an accompanying ID note.

Continued on next page

Client Recovery Evaluation

Purpose	The Client Recovery Evaluation (CRE) provides for a structured assessment of client community and other functioning and is one method of clearly documenting medical necessity and need for services.
Form Used as Tool	The CRE is not required but is a useful tool to: • Document medical necessity • Assess a client's needs for service planning
Form Completion	In completing the CRE describe the: • Client • Client's functioning • Client's situation in such a way that makes clear the need for services • Client's problems and strengths ***Note:*** Give examples wherever possible.
Substance Problems	If substance problems are described, consider whether an additional substance-related diagnosis should be added to the client's diagnosis.
Client Functioning and Symptomology	The focus of the form is largely on functioning, but the section for **"Significant Symptomology"** should be used to include significant symptoms, such as: • Mood problems • Dissociative problems • Psychotic features
Billing	The form does NOT stand alone for billing and does require an accompanying ID note.

Continued on next page

Client Recovery Evaluation, Continued

Client Progress	In **"Progress with Recovery and Goals",** describe the client's progress over the past year.
Client Impairments	In **"Impairment…"** tell why the client needs services and describe the dysfunction that justifies payment for those services.
Signatures	The form may be completed and signed by any clinical staff, including: • Mental Health Specialists • Social Worker II's ***Note:*** See **Co-Signatures** section for co-signature instructions.

Continued on next page

Client Recovery Plan

Purpose

The Client Recovery Plan (Spanish) covers the following areas and is required for all planned services:

- Specifies the goals for treatment.
- Describes services to be provided to the client.
- Provides documentation of client participation in treatment planning.
- Serves as a vehicle for review of certain services.

Exceptions

It is not required to have Client Recovery Plans for:

- IMD clients
- State hospital clients

Services Included in the Plan

The following guidelines apply to services provided to the client under the Client Recovery Plan**:**

- All planned services (except TBS, which has its own plan) must have plans using the client's Client Recovery Plan.
- Only services that are provided at a given site will be included on that site's Client Recovery Plan.
- Separate Client Recovery Plan pages may be used for separate services, if desired.
- Occasional, unplanned services do not require a Client Recovery Plan, but documentation must support Medical Necessity for their provision.

The following chart applies to clients who transfer to other DBH sites:

If a …	And…	Then…
Client transfers to another site	There is still authorized time on the Client Recovery Plan,	The new site may continue to provide services according to the old Client Recovery Plan until its expiration.

Continued on next page

Client Recovery Plan, Continued

Timelines

The following timelines/requirements apply when completing the Client Recovery Plan**:**

If…	Then…
Services are to continue past the initial two-month intake period,	The Client Recovery Plan will be completed within two months of entry.
Example: Entry on May 17 would require a Client Recovery Plan no later than July 16. However, the CRP should be completed as soon as possible following the completion of the Assessment.	

- Client Plans drive services.
- In exceptional circumstances, if a service (other than Assessment, Crisis Intervention, and/or Plan Development) is provided during the intake period, before completion of the Client Recovery Plan, it must be documented to demonstrate the Medical Necessity for that service. That is: 1) the Diagnosis Sheet, must include, a covered diagnosis (even if provisional), and the gathered assessment information, to date, should be sufficient to support that Diagnosis; 2) the impairments must be adequately described (in the progress note), and be significant, to justify the service before intake completion; 3) the planned intervention will address the impairment condition (documented in the progress note); and 4) the client had input into the provision of the intervention and was in agreement with its provision (documented in the progress note).
- ***Best Practice:*** *Good clinical practice includes completion of assessment and client planning as soon as possible, so clinicians and doctors are urged to complete plans as soon as possible.*

The Client Recovery Plan for each service must be re-written, at least, every 12 months.

Continued on next page

Client Recovery Plan, Continued

Coordination of Services at Multiple Sites

The process for coordination of services at multiple sites is as follows :

Step	Who Completes	Action
1	Clinic Staff	Before opening a service episode or adding a service, check SIMON for existing services for that client. (This will prevent duplication of services.)

2	Assessing Staff, Supervisor, or Team	• Contact ***all*** sites providing services.
		• Collaborate regarding the advisability of starting or adding proposed services.
		    o This ***must*** be done if other sites are providing **ANY TYPE** of other services).
		    o However, difficulties in obtaining collaboration should not prevent the onset of needed services.
		    o If services need to be initiated without collaboration, then ongoing efforts to collaborate are required
		• Staff need not be in agreement about adding the service, but must discuss the matter.

3	Assessing Staff, Supervisor, or Team	Chart this coordination effort (including the reason for opening the new service, even if the other sites do not recommend doing that).

Continued on next page

Client Recovery Plan, Continued

Clients Who Will Receive Team Oversight

The following criteria applies to those clients who may be considered appropriate for team rather than non-team oversight:

- At any point in the care sequence (but usually during assessment), a client may be identified as a client for whom a team should take responsibility.
- Non-team clients will not become the responsibility of a team and will be overseen by clinic supervisory staff, in accordance with written Department criteria for team versus non-team clients.

The following chart delineates “Team” from “Non-Team” clients:

Team	Non-Team
Clients who have serious disruption of daily community functioning due to mental disorder.	Cases that are “simpler” and can be appropriately managed by a single provider.
Cases of sufficient complexity or severity that the joint care planning of a team or the joint services of various team members is needed if the client is to be properly served.	
Clients receiving DTI or DTR services.	
All clients receiving care coordination activities.	

Who Completes the CRP?

The following staff completes the Client Recovery Plan:

- Service Providers will complete the Client Recovery Plan for services that they are authorized (within their scope of practice) to provide.
- Several staff members may enter information on the Client Recovery Plan.
- Persons signing the Client Recovery Plan as ‘”Provider” must be clinic staff members who are qualified to provide that service, and may include the Service Coordinator Team leader.
- A Physician must sign for MSS services, however:
    - Another staff member may check the box at the top indicating that MSS services are being or will be provided.

Continued on next page

Client Recovery Plan, Continued

Diagnostic Symptoms and Related Impairments

The following are guidelines for completion of the Diagnostic Symptoms and related impairments section of the Client Recovery Plan**:**

- Diagnostic Symptoms should reflect the predominant symptoms, consistent with the Assessment data, and contributory to the functional impairments for the client.
- Functional impairments, related to age appropriate community functioning, should be listed and operationally defined. They should be individually based and represent how diagnostic symptoms present themselves in observable/measurable behavioral events or episodes. Documentation should indicate how symptoms interfere with age appropriate role and functional expectations and success in life.

Clients' Desired Outcomes

The following are guidelines for completion of the Clients' Desired Outcomes section of the Client Recovery Plan:

- Using the client's own words is desirable in this section.
- Should be relevant to presenting problem information gathered from Assessment.
- The client's desired outcomes for services should have priority, as long as they:
    - Are related to community functioning.
    - Require DBH services for their achievement.

Continued on next page

Client Recovery Plan, Continued

Client Driven goals, Behavioral, Measurable, Relevant Objectives, Related to Community functioning

The following criteria apply to charting behavioral, measurable and relevant objectives (negotiated with individual). Include the elements of a well written and complete behavioral goal.

- Relevant to the client's operationally defined functional impairments.
- Measurable by frequency, duration, and/or intensity or some combination thereof.
- Contrast baseline measurement with goal objective when possible.
- Provide a means of measurement.

The following table shows examples of treatment goals and behavioral, measurable and relevant objectives:

Client Desired Outcome	Client Driven Goal
Control my temper.	To be achieved by xx/xx/xx. Client will reduce anger outbursts (as described in Dx Symptoms and related impairments section) from 5 times per wk. to a goal of 0 times per wk and sustain for 3 mos. as measured by teacher/parent report.
To get a job.	To be achieved by xx/xx/xx. Client will increase productive job seeking behaviors (describe in Dx Symptoms and related impairments, how the current condition impairs this action, and operationally define "productive job seeking behavior") from 0 times per week to a goal of 4 times per week and sustain for 3 months, as measured by client report.
Get out of the house. Not be so alone.	To be achieved by xx/xx/xx. Client will reduce isolative episodes *(as described in Dx Symptoms and related impairments section)* from 7 times per week to a goal of less than 2 times per week and sustain for 3 months as measured by self-report and caregiver report.
Not think about suicide.	To be achieved by xx/xx/xx. Client will reduce suicidal ideations and gestures *(as described in Dx Symptoms and related impairments section)* from 7 times per week to a goal of 0 times per week and sustain for 6 months as measured by self-report and provider observation.

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Client Recovery Plan, Continued

Objective Specifics Reviewed

Objectives must:

- Be time-framed in terms of when:
    - They are expected to be accomplished.
    - It will be measured as to whether or not they have been accomplished.
    - An actual date or dates, must be entered.
- Include a method of measurement, which could be stated in any of the following ways:
    - “By client report“
    - “As indicated in the chart”
    - “By parent report”
- Operate within Medi-Cal guidelines per Title 9
    - Requires that objectives be related to the client’s community functioning, rather than to changes in symptoms (except by Physician in MSS plan where symptoms are clearly described as connected to community functioning) or subjective state.
- Be relevant
    - Clearly and reasonably connected to the client’s presenting issues, central complaint, symptoms, or areas of dysfunction and related to the client’s community functioning.
- Be measurable
    - The provider’s judgment or opinion regarding reaching the treatment goal or readiness to terminate treatment cannot substitute for an observable criterion. Since they are measurable, the objectives could theoretically be assessed by an outside observer based on the objective’s language.

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Client Recovery Plan, Continued

Other Considerations

Other things to consider when developing an objective are:

- One treatment modality and objective are sufficient for a treatment episode.
- One objective may be sufficient:
    - Even if there are multiple goals, depending on the client's readiness to change.
    - For several modalities.
- Clients should participate in determining the objectives, so that they will know how to take greatest advantage of the services available, and clients will normally be given a copy of their Client Recovery Plan.
- The amount of services available to any one client will depend on:
    - Client need.
    - Resources available at that time, as determined by the Department, the supervisor, or the team.

The following table applies to when a client reaches their goal or maximum benefit:

If...	Then...
Objectives are reached before: • Goal dates, or • End of the authorization period	Treatment will stop at that point unless new objectives are written in the Client Recovery Plan.
Client has reached maximum benefit from treatment, regardless of whether the end of the authorization period has been reached.	

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Client Recovery Plan, Continued

Service Coordinator/ Provider Actions

Use the following steps when completing the Service coordinator/Provider Actions section of the Client Recovery Plan:

Step	Section	Action
1	Type of Treatment	Enter each type of treatment to be provided in a separate Client Recovery Plan modality section. Enter the sub-type as well • MHS – individual therapy • MHS – group therapy • CM – L&C Use the abbreviations specified in the General Instructions for All Interdisciplinary Notes section of this handbook ("provide link to section") It is recommended that only one modality and subtype be placed in each modality section of the CRP in order for the frequency, to be clearly discernable.
2	Enter the frequency of client/provider contact for each proposed modality (once/wk., etc.)	• If more than one service in a modality is planned, clearly list the frequency for each. • For services in which unpredictable variation is expected, enter the expected frequency along with PRN (e.g., "once a month and PRN". The focus of treatment should relate clearly to accomplishing the treatment goal). • For most cases one, two, or three modalities of treatment will be sufficient.
3	Focus/Purpose of treatment	Enter the focus/purpose of the treatment, which is what the provider will focus on or work on in treatment that will help the client to make progress toward the objectives and goals (e.g., "anger management," or "reduce suicidal ideation and subsequent gestures").

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Client Recovery Plan, Continued

Service Coordinator/ Provider Actions (continued)

Step	Section	Action

4	Plan start date and end date (duration of treatment) considerations:	• Providers are expected to make services efficient (i.e. to reach client goals as soon as possible).
		• With some exceptions, treatment of **non-team clients** should be planned from the beginning with an aim toward termination before the end of the first services period.
		  o It is recommended that a termination date be set with these clients, so that both provider and client gauge their work within this time frame.
		  o Clients are informed of this expected termination date and are involved in keeping track of progress and of what remains to be done in the remaining time.

5	Amenability for treatments proposed:	The client must have the cognitive and emotional abilities to be able to participate actively and benefit from the proposed treatment.
6	Signatures	The following requirements apply to staff signature on the Client Recovery Plan. Every: • Staff member who enters part of the Client Recovery Plan will sign the Client Recovery Plan. • Each time a staff member signs the Plan, he/she affirms that the client participated in developing the Plan. • Service Coordinator (Service Coordinator and Provider may be the same). • Supervisor signature required if Service Coordinator is not an LPHA licensed, registered, or waivered Professional.

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Client Recovery Plan, Continued

Service Coordinator/ Provider Actions (continued)

Step	Section	Action
7	Add/Amended Services	• Best practice: Any time Services are added or amended after the initial signatures on a CRP the client and Service Provider must to sign the CRP. An ID note needs to explain the need for the change in the CRP.
8	Client/Caregiver Involvement in the Recovery Plan	• The client is to be involved in determining the treatment goals and objectives, so that he/she can participate most effectively in the treatment effort. • The client's signature will be obtained on every plan, including the initial Client Recovery Plan. • Clients will normally be given a copy of their Client Recovery Plan (with notation of the date it is given). • ***Best Practice:*** It is good clinical practice for parents/guardians of minor clients to be informed about the plan of care and to sign the Client Recovery Plan, but if this is not feasible then the signature of the minor child is acceptable.

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Client Recovery Plan, Continued

Service Coordinator/ Provider Actions (continued)

Step	Section	Action
9	Effective Period for the Client Recovery Plan:	When entering the effective date of the Client Recovery Plan, the following rules shall be followed: • The services period for all services may be up to 12 months long. • All planned services are authorized for the same time period. • The initial date (effective date) of the Client Recovery Plan is the: o Plan Start Date, with appropriate signatures. • Date of signature of the Client Recovery Plan if completed at any other time. The ending date of a period is entered after "end date." • Each Client Recovery Plan will be rewritten on a new form. ***Note:*** Out-of-County Medi-Cal cases will follow the authorization periods given by those other counties.

The table below shows what to do with the Client Recovery Plan:

If the Client...	Then...
Refuses to sign the Client Recovery Plan,	As best as possible, ascertain the reason. Renegotiate the goal, if that is the reason.
Agrees with the goal, and the treatment proposed but still refuses to sign the Client Recovery Plan,	Note that fact in the signature space, and address the issue in a progress note and obtain the client's signature as soon as it is possible to do so.
Does not agree with the treatment goal or treatment methods,	Consult with the supervisor or team regarding whether treatment should be provided (except for crisis services).

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Client Recovery Plan, Continued

Changing the Plan

During any services period, providers, supervisors and teams may alter the Client Recovery Plan.

- Providers altering a Client Recovery Plan need not get approval for the change but must:
  - Document the planned services change in the Client Recovery Plan, and
  - Explain the change in an ID note.
- A current Client Recovery Plan may be amended to reflect a reduction in the current services period without a re-write of the Client Recovery Plan.
- Changes are noted on the current Client Recovery Plan by:
  - Adding new information and crossing out deleted information, with date and provider initials and signature below.
  - Chart note on that same date explaining the change.
- A service added during a current authorization period will expire at the end of that authorization period.

Location in Chart

All Client Recovery Plans will be filed together in the chart at the top of the front left section of the chart, with current services on top, so that providers may check expiration dates easily before each service.

Client Recovery Plans will be filed on top of the Diagnosis Sheet, which will be filed on top of the Care Necessity Form.

Providers are urged to review the Client Recovery Plan at every client session, for goals and expiration dates.

Termination Period

If it is directed that services be terminated, a one-month period will be allowed for appropriate client termination. This does not mean the clinician can do services beyond the client plan end date. It simply means that once the decision has been made to terminate services, as documented in notes, services are terminated within 30 calendar days.

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Medication Support Services Service Plan

Included Documents

The Medication Support Services (MSS) Service Plan (Client Plan) includes the following documents:

- Medication Support Services Client Plan
- MSS ID notes
- Medication Consent Form (Spanish; Vietnamese)
- Outpatient Medication Record

Document Specifics

Specific information on the service plan documents is included below:

Document Name	Purpose
Medication Support Services Plan	• A plan for all ongoing, planned MSS services must be documented using the Medication Support Services Plan. • The Medication Support Services plan shall be completed by a provider within their scope of practice. • All clients, including Meds only (MSS), require the client's signature in addition to the signatory requirements in DBH Information Notice 08-02.
Medication Consent Form	• In the Medication Consent Form (Spanish; Vietnamese), documentation of the following information are essential aspects of his/her medications: o Information provided to the client and o The client's indication of participation in the planning for his/her medications • Clients must sign for every change in medication.
Outpatient Medication Record	The Outpatient Medication Record (or "Meds Order sheet") documents the medications actually provided and the client's ability to participate appropriately in his/her medication planning.
Medication Support Services ID Notes	The MSS ID notes may contain documentation of any of the above plan items and are therefore viewed as part of the MSS plan.

Documentation for MSS Cases

See Schedule of Chart Form Due Dates section regarding charting and forms requirements for Medication Cases.

Continued on next page

Out-of-County Authorization Form

Overview

The Department's Out-of-County Authorization Form will be used in all charts that are funded by out-of-county Medi-Cal. The following information outlines procedures for initial services and extension of services.

Initial Services

New clients with out-of-county Medi-Cal are directed to call their county's access unit for initial approval (usually of a few evaluation visits), or the DBH Access Unit will call the other county. The Access Unit will initiate the out-of- county authorization form (OOCA) and, when the other county's initial authorization is received, the Access Unit will send the OOCA to the clinic as the documentation of the other county's initial authorization. It will be filed in the chart (see filing instructions below).

Extension of Services

After the initially authorized evaluation visit or other visits, in order to request further authorization, the provider will complete the initial DBH forms (Clinical Assessment, Client Plan, Care Necessity Form, and Diagnosis Sheet) and send them to the Access Unit along with the OOCA. The Access Unit will forward them to the other county, and when the authorization is returned, the Access Unit will forward that and the updated OOCA to the clinic, which will file it in the chart.

Note: Whenever further out-of-county extensions are needed, the clinic will send to the Access Unit an OOCA along with either the existing Client Plan, Care Necessity Form, and Diagnosis Sheet, or an updated Client Plan, Care Necessity Form, and Diagnosis Sheet. See “The Controlling Authorization if There are Differences” below.

The Controlling Authorization if there are Differences

If the Out-of-County Authorization and the DBH authorization differ, services will be delivered to the client according to the DBH authorization. The DBH re-authorizations will proceed according to DBH procedures and schedule. Clinics will ensure that Out-of-County Authorization expirations are monitored separately from DBH authorizations. (A card-file tickler system for all of a clinic's out-of-county clients, that was checked weekly, could be sufficient.) Clinicians will check the Out-of-County Authorization frequently and will submit re-authorization requests at least three weeks before the Out-of-County Authorization expires. If the Out-of-County Authorization expires before the DBH authorization, the existing DBH paperwork (Client Plan, etc.) will be submitted with the OOCA at that time, rather than preparing new DBH paperwork early.

Filing

The OOCA will be filed in the chart in the front left section, on top of the "blues."

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Day Treatment Intensive Interdisciplinary Notes

General Instructions

See "General Instructions for All Interdisciplinary Notes" section for general instructions applying to all Interdisciplinary (ID) notes.

Requirement

The following notes are required:
- Brief daily ID notes
- Weekly summary of treatment

Other treatment notes may be entered as desired.

Form Completion Procedure

The following table instructs the user in completion of the Day Treatment Intensive ID notes form.

Step	Section	Action
1	General	The daily notes will be entered on the pink ID note form specifically designed for intensive day treatment only.
2	Day Treatment Intensive – Daily/Weekly ID Notes	At the top of the form, enter the week and locations.
3	Status Matrix	• Enter for each day the client's condition or status as observed. • This should provide justification for further treatment, if further treatment is needed. • Additional symptoms/problems may be added in the blank lines.

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Day Treatment Intensive Interdisciplinary Notes, Continued

Form Completion Procedure (continued)

Step	Section	Action
4	Program Matrix	• Enter all planned and available therapeutic activities for the week. • Write in after the headings provided any further specification of the type of group or treatment (such as "AMAC group"). • Add other groups and activities in the blank lines at the bottom. • After this section is filled in, the form may be copied for staff use for that week. • After each activity, write the expected or typical length of the activity (1 hr., 1.5 hrs. etc.). • Under each day of the week, place a check mark in the box of each activity in which the client participated. • The location of the service may be noted in the box for each service performed outside the clinic. • Significant absences or partial participation should be explained in the ID notes.
5	Daily Interdisciplinary Notes	• In the "Daily Interdisciplinary Notes" portion of the form, write a brief, one to three sentence note for each day the client attended that week, commenting on the client's condition and the client's participation. • Date each note in the left column. • No heading is needed on the daily notes. • If more space is needed for one week of daily notes than is available on one page, continue on the second page of the structured form.

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Day Treatment Intensive Interdisciplinary Notes, Continued

Form Completion Procedure (continued)

Step	Section	Action

6	Weekly Summary Notes	• In the portion of the structured DTI ID note headed "Weekly Summary," write the weekly summary note.
		• ID note content is basically the same as for MHS ID notes, but the note must be more extensive and specific enough to justify the intensive service.
		• Every note should contain:
		  o A description of the clients current condition and problem being addressed,
		  o The staff's various interventions throughout the week,
		  o The client's responses to the interventions,
		  o The client's treatment–related efforts between sessions if, applicable,
		  o The connection between the treatment provided and the measurable objectives of the client,
		  o Enough indication of medical necessity to justify further treatment, if that is indicated.
		• Notes need not describe every intervention or meaningful therapeutic interaction for the week, but auditors will expect more than just one, and they will expect specifics rather than generalities.
		  o The description of several interventions and client responses in different activities will probably be sufficient.
		• Day treatment staff who have treated a given client should share their information with the person writing the weekly summary note before the note is written each week.
		• The weekly summary note must be written by (or reviewed and co-signed by) an LPHA who is providing DTI services or directing the program. (Depending on the writer, daily notes may need co-signature.)

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Day Treatment Intensive Interdisciplinary Notes, Continued

Form Completion Procedure (continued)

Step	Section	Action
6 cont'd	Weekly Summary Notes (continued)	• It is advisable occasionally to give an update as to where the client stands in the overall course of treatment, and to describe the client's reported medication reactions. (If a client is receiving meds from a physician outside the Department, make note of this and of the medicines received.) • Changes in Service Plan or Diagnosis: o If changes are made in the Client Recovery Plan or diagnosis, the reasons for these changes should be clear or should be explained in an ID note dated on or about the same date as the change in the plan or diagnosis.

Billing

For instructions on billing unique to day treatment can be found in the "Billing" section of this manual.

Guidelines/ Instructions from Information Notice 14-10 (continued)

Client Recovery Plan/Treatment Plan

- All Client Plans [Mental Health Services (MHS) and Medication Support Services (MSS)] for providers of Day Treatment Intensive and Day Treatment Rehabilitation services must contain the dated signatures of the client and/or caregiver, in addition to the provider's signature. This must be signed and dated at, or prior to, the time the planned service is provided. If there is no client signature, or it is dated late, there must be an indication on the Client Plan as to the reason for this, and a progress note referenced which explains the reason for it not being present or being dated late. In this latter event, the plan must still be signed at the earliest possible time.
- Goals and objectives on client plans ('MHS' and 'MSS') must be able to contrast the baseline measurements with the goal objectives.
- All Client Plans ('MHS' and 'MSS') must specify a fixed "Plan Start Date" and "Plan End Date".

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Day Treatment Intensive Interdisciplinary Notes, Continued

Guidelines/ Instructions from Information Notice 14-10 (continued)

Progress Notes

- Documentation must clearly delineate the amount of time spent by the client in each group (e.g. - 1 hr., 2 hrs. etc.). The group and Progress Note must match the program schedule.
- Note content must focus on the mental health condition and staff interventions. Daily activity logs are not Progress Notes and are not acceptable forms of documentation for any Medi-Cal billing purpose. Content that does not focus on alleviating targeted impairments (i.e. helping the client achieve treatment plan goals) related to the mental health condition does not support medical necessity for the service and the service will be disallowed.
- Progress notes must include enough information to give a clear picture of the client's responses to interventions.
- Exact hours of attendance must be documented, and present, within the client chart. It is not adequate to document as "Present at least 50% of the Day" or "Present for more than 51% of the Day". All Day Treatment notes should include exact hours and minutes of service.
- Any period of time in which a client is not present during a session must be documented. Unavoidable absent times must be properly documented. Attending another scheduled appointment, does not qualify as unavoidable. Generally, only unforeseen crisis or emergency types of events are considered unavoidable.
- It is critical to ensure documentation supports more than 4 hours of service when billing for Day Treatment Full Day.
- Documentation must illustrate which staff was directly involved with each of the services provided.
- Day Treatment notes should include clear notations of the exact time allotted for breaks and lunch, and make clear, that these times are not part of the billing for the day.
- All entries shall contain the dated signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable.

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Day Treatment Intensive Interdisciplinary Notes, Continued

Guidelines/ Instructions from Information Notice 14-10 (continued)

Administrative

- Day Treatment program schedules must include clear break out of the time allotted for breaks and lunch. It should be clear that these blocks of time are not included in the billing for the day.
- It is required that there be daily sign in/sign out sheets for each client to support client attendance in the program.
- Daily schedules will include all categories of groups required of the Programs' daily service, as well as a definition of the group (i.e-Skills Building group, Process group, Adjunctive therapies, etc.). Service providers scheduled to provide those groups must appear on daily schedules. Each group must have a sign-in and sign-out log.
- Community meetings are to be identified on the schedule and in the program description with a description of the meeting.
- Staffing requirements for the Program (i.e.- Day Treatment Intensive, Day Treatment Rehabilitation), must be evidenced by Staff Attendance sign-in Logs (or other means) which clearly identify which Staff were present on a given day. It is not adequate to merely have a staffing schedule. For any unforeseen absences, there must be a clear and documented audit trail as to what staff provided coverage, and that the service coverage was provided within their Scope of Practice.
- Persons providing Day Treatment Intensive services who do not participate in the entire Day Treatment Intensive session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. There must be a clear audit trail of the number and identity of the staff that provide Day Treatment Intensive services and function in other capacities.
- Staff providing Day Treatment Intensive services must document any period of time in which a client is not present during a session. Unavoidable absent times must be properly documented. Clients attending another scheduled appointment, does not qualify as unavoidable. Generally, only unforeseen crisis or emergency types of events are considered unavoidable.

Note: The guidelines and instructions above are in addition to the requirements cited in DMH Information Notice 02-06 and DMH Information Notice 03-03. Please refer to the above referenced notices for further details.

Reference

Information notice 14-10: County of San Bernardino Chart Documentation Requirements and Guidelines for Day Treatment Intensive and Day Treatment Rehabilitation Programs.

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Documentation in the Chart of Client Complaints

Reporting Options	The following are options for reporting client complaints and incidents: • Client complaints, including complaints about staff misconduct may be documented in the client's chart, to the extent that such documentation is necessary for follow-up client care. • The client may make his/her own report of the incident to the Quality Assurance system via the grievance forms available in the lobby of each clinic. • Information regarding an alleged incident that is necessary for Departmental investigation and follow-up will be included in a DBH incident report.
Charting	Charting related to alleged incidents of staff misconduct will be handled as follows: • When the complaint is about staff misconduct, it is recommended that initials (and not Names) be used in the chart if it is necessary to identify the staff person at all. • The exact source of information should be identified if information regarding an alleged incident is reported in the chart in the following manner: o "The client reported that..." the clinic supervisor, John Doe, reported that...,"etc. • It is charted in this way because if the provider did not observe the alleged incident, the provider does not know what actually happened.
Should Information be Included?	If it is uncertain about whether or not to include certain information about an alleged incident in the chart, a provider may consult his/her clinic supervisor.
Clinic Supervisor Action	The Clinic Supervisor will notify the staff person about whom the complaint is made regarding what information was entered in the client's chart. Clinic Supervisor will provide appropriate follow-up investigation of the clients' concern up to and including the initiation of a quality of care concern referral to Quality Management for further review.
Staff Action	The staff person may request that this chart be treated as a chart containing "sensitive information" as defined for medical records in the Medical Records Requiring Special Handling Policy and the Medical Records Requiring Special Handling Procedure.

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General Instructions for All Interdisciplinary Notes

Names

DBH chart notes are referred to in the following ways:
- Progress note
- Chart note
- Interdisciplinary note
- ID note
- "Pink note"

It is a chronological record of the course of the client's care in the Department and should contain entries whenever the client does not keep or reschedule an appointment as well as notations of provider attempts to contact the client.

Definition

These Interdisciplinary (ID) Notes are the narrative record in the chart of each client. An ID note is written for each of the following events in the course of treatment needing to be recorded for clinical or for legal purposes:
- Face-to-face contact
- Phone calls
- Collateral contacts
- Other events relevant to treatment

Time Deadline

The following guidelines apply to the writing of case ID notes:
- Every ID note must be written not later than the day after the service occurs.
    - Ideally each ID note would be written the day the services was delivered.
- Every ID note must be filed in the client's chart no later than 72 hours after the service occurs.

Purpose

ID notes:
- Communicate with others who may need to take care of the client.
- Document events and actions which indicate compliance with the required standard of care.
- Document what every provider has done so that those paying for the services will be convinced that appropriate and needed services were delivered.

Continued on next page

General Instructions for All Interdisciplinary Notes, Continued

Placement in Chart

The following policies apply to ID notes:

- ID notes are placed in the ID notes section of the chart.
- ID notes for various services in the same clinic location will be entered chronologically without being separated by service mode. These services include:
    - Mental Health Services
    - Day Rehabilitation
    - Case Management, etc.
- When an MSS note page is placed on top of a partially filled MHS note page, MHS and other services dated after the date of the meds visit must be written on a new MHS ID page and not on the previous page.
- All unused lines on the general ID note page are then diagonally lined out.

General Instructions and Billing

The following are required headings for all notes:

- DATE
- SERVICE DELIVERY TIME
    - Together with charting time and any associated plan development time.
- LOCATION
    - See codes at top of the ID note page.
- SERVICE MODE AND TYPE
- EXAMPLES would be MHS – IND., DTR-Group, CM-Place., etc.
    - See list of service headings and abbreviations below and on the CDI.
    - Example – 4-31-95 1:05 1 MHS-IND.
    - See Billing Section for specific group billing instructions.

Location

- The first number of the location code indicates the location of the provider of the service when the service was provided.
- These codes are printed at the top of the ID note page and on the CDI. "-3" is added if the service was not provided to a client face-to-face.
    - For example, individual therapy in the provider's office with the client would have a location code of "1".
    - Individual therapy provided over the phone to a client when the provider is located in a phone booth in the community would have a location code "2-3".
    - Plan Development done in the office by the provider alone would be "1-3".

Continued on next page

General Instructions for All Interdisciplinary Notes, Continued

Time Entry

Enter service time (plus charting and associated Plan Development time) in hours and minutes (one hour and 15 minutes is 1:15).

Specific Situations

The following chart applies to specific situations in writing ID notes:

If there are...	Then...
Multiple services where significant amounts of more than one service are provided in one session (e.g. individual therapy and collateral),	• Write separate notes and • Bill separately.
Multiple staff where more than one staff member is involved in providing a service,	• The initials and billing time of each staff member are listed in the "hrs.-min." column of the ID page. • Each staff member is identified by name and discipline in the ID note. • Adequate justification must be included in the note telling why more than one provider was needed.
Service(s) provided by phone,	• Head that note with the activity done followed by "phone." • Individual therapy done in the office over the phone would be headed "MHS-Ind.- phone", with a location code of "1-3."

Content

ID note contents should be as follows:

Every Note	On Occasion	As Needed
• A description of the client's current condition • The problem or dysfunction being addressed in the session • Provider interventions, and • The client's response to the interventions	A description of where the client stands in the overall course of treatment	Medication effects

Continued on next page

General Instructions for All Interdisciplinary Notes, Continued

Change in Plan or Diagnosis	When changes are made to the Client Recovery Plan or the client's diagnosis, an ID note dated on or near the date of the form change should be written to explain the reasons for the change.
Intensive Outpatient	ID notes for "intensive outpatient" services must describe several interventions and client response, to justify the greater length of services.
Dual-Diagnosis Services	See "Dual-Diagnosis Services in DBH Outpatient Clinics" regarding documentation of dual-diagnosis services.
Crisis Intervention	In addition to the "Content" section above, Crisis Intervention ID notes must contain a: • Description of the acute crisis or dysfunction that jeopardized the client's ability to maintain usual community functioning. • Plan for subsequent service, if applicable.
Sign Each Note	Sign each entry made. See "Signatures" section for signature formats. The date of the service is the date of the signature, unless the note is created or signed on a later date. In the latter case, the signature should be followed by the date.
Unused Lines	Draw a vertical or diagonal line through every blank line left after an ID page is finished.
Continuing a Note	If a note is continued from one page to the next write: • "Continued" at the bottom of the first page and sign it. • The date and "continued' at the top of the new page.
Client/Clinic Information	Each ID note page must include the following: • Client's name • Client's chart number • Client's date of birth • Name of clinic where the service was provided

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General Instructions for All Interdisciplinary Notes, Continued

Service Heading Abbreviations

The following are abbreviations used in the Service Heading:

Abbreviation	Description
MHS	Mental Health Services
CM	Case Management
MSS	Medication Support Services
DTI	Day Treatment Intensive
DTR	Day Rehabilitation (If written on the MHS ID note form)
CS	Crisis Stabilization
Pl. Dev.	Plan Development ***Note:*** Pl. Dev. For MHS is headed “MHS – PL. Dev.”, but Pl. Dev. for CM is headed “CM – L&C—Pl. Dev.”
Ind.	Individual
Group	Psychotherapy group only
Coll.	Collateral
Assess.	Assessment
Psych. Test.	Psychological Testing
Cr. Int.	Crisis Intervention
Fam. Ther. – Ind.	Family Therapy if only one open chart
Fam. Ther. – Grp.	Family Therapy if two or more open charts
Meds. Visit	If not using MSS structured note
Meds. Support	If not using MSS structured note
CM – L&C	Case Management – Linkage and Consultation
CM – Place.	Case Management – Placement
Rehab/ADL • Ind. • Group • Meds. Ed. • Group • Voc.	Rehabilitation/ADL
Voc.	Vocational
Drug S.	Drug Screen
Social.	Socialization
Eval. or Evaluation	Would be appropriate heading for the Community Functioning Evaluation, which is no longer used.

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General Instructions for All Interdisciplinary Notes, Continued

Additional Information	Also see the CDI for exact abbreviations to use in ID note headings.

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Medicare Charting and Interdisciplinary Notes

Policy

All charting for Medicare-billable services will be done according to the instructions in this section of the manual.

Current Billable Services

The Medicare-billable services are currently:

- Crisis intervention
- Assessment
- Individual therapy
- Group therapy
- Psychological testing
- Family therapy
- Collateral as it pertains to the above services
- Medications (Evaluation and Management)

Reports

The MHS560 and MHS 100 reports identify clients with Medicare.

Reference

See General Instructions for All Interdisciplinary Notes for general instructions for all ID notes.

Documents

There are no required Medicare differences in the use of the:

- Clinical Assessment
- Diagnosis Sheet
- Care Necessity Form
- Client Recovery Plan (Spanish)
- Consent for Treatment

Advance Beneficiary Notice

The Medicare Advance Beneficiary Notice must be given to Medicare beneficiaries before any service that is not expected to be reimbursed by Medicare.

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Medicare Charting and Interdisciplinary Notes, Continued

SIMON

SIMON translates the following from those described elsewhere in this chart manual to the formats required for Medicate billing:
- Diagnosis
- Billing time
- Service type
- Location

Acceptable Services

Medicare pays only for services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

Goal of Psychotherapy

The Medicare goal of psychotherapy is to:
- Reduce or eliminate symptoms, complaints or impairments that interfere with normal functioning.
- Stabilize (or improve) "at-risk" patients with chronic mental illness.
  - Maintenance is acceptable as an ongoing goal if justified in relation to what would happen or has happened to the patient when treatment is discontinued.

Not Billable to Medicare

The following services are not billable to Medicare:
- Psychotherapy for persons who do not have the cognitive capacity to participate in the treatment.

Note: A psychotherapy session cannot last longer than a patient's attention span.

Not Medically Necessary or Reasonable

Psychotherapy is not medically necessary or reasonable when:
- There is lack of progress toward improved functioning.
- There is deterioration by an SPMI patient being treated.
- The therapeutic goal is achieved.
- Cognitive or other organic problems, including dementia, preclude participation, and benefit.
- The patient is delirious.
- Substance use interferes with ability to benefit.
- The patient refuses to participate.
- The patient only needs social, recreational, or custodial services.

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Medicare Charting and Interdisciplinary Notes, Continued

Dementia

Psychotherapy for dementia alone is not appropriate, whereas psychotherapy for dementia with depression may be.

Medicare Payment

Services for diagnoses not on the Medicare diagnosis list will not be paid. The following services are not separately billable to Medicare:

- Collateral
- Plan Development
- Case Management

Rehab/ADL is currently not being billed to Medicare.

Patient Education

Patient education about the illness and telephone calls, performed by the Physician, are included in service billings and are not billed separately.

Consultation with Primary Care Physician

It is required that at the beginning of care, non-Physician providers:

- Inform the patient of the desirability of the therapist conferring with the patients PCP, and unless the patient declines.
    - Document in chart if the patient declines this contact.
- Provide written notification to the PCP that services are being provided to the patient.
- Consult with the PCP in case medical conditions are contributing to the psychological conditions.

ID Notes: Stand-alone Concept

Medicare notes should give a reviewer enough information that they would not necessarily need to look at the Client Recovery Plan or Clinical Assessment. Medicare notes are more like traditional physician notes and must have more context and content than Medi-Cal notes.

Medicare Note Specifics

Use the following chart to determine what to include in the Medicare ID Notes.

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Medicare Charting and Interdisciplinary Notes, Continued

Medicare Note Specifics

Use the following chart to determine what to include in the Medicare ID Notes:

Placement	What to Include

In the first note or two	• Permission to treat: that the client signed the Consent to Treatment Form.
	• Relevant history of condition requiring treatment include in ID note even though it is in Clinical Assessment.
	• Patient's ability and willingness to resolve the mental problems present:
	   o Does the patient have both the ability to take advantage of the treatment and the motivation to do so in a manner that will make the treatment successful?
	      ▪ "Client is of average intelligence and able to participate in psychotherapy. Client is fearful of failure but expresses almost desperate desire to improve depression and return to work."
	• Primary care physicians contact or status (include date of patient's most recent contact with PCP):
	   o "I sent notice of proposed services here to Dr. Tolbert Gayton in Rialto." or
	   o "Client requested that we not contact his PCP Dr. Tolbert Gayton in Rialto whom he most recently visited 1/30/06."
	• Treatment plan including:
	   o Therapeutic interventions
	   o Planned and duration estimate
	      ▪ "Patient agrees to our recommendation of group psychotherapy lasting 16 weeks."
	• If not on meds, document reasons to refer or not to refer for meds.
	• If "interactive psychotherapy" is required, document why.

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Medicare Charting and Interdisciplinary Notes, Continued

Medicare Note Specifics (continued)

Placement	What to Include

Include in every ID Note	• Type of Service
	• Face to Face Time
	• Diagnosis, which must be consistent with official diagnosis listed on blue sheet in chart
	• Patient name (at bottom of ID note page is OK)
	• Date of service
	• Billing time
	• Patient's complaints, specific emotional or behavioral signs, or symptoms, which indicated, continued need for treatment.
	• What happened during the session in relation to the problem being treated?
	• Intervention used in that session for medication support services this would be the response to medications ordered.
	• Active participation by patient (more than just client response).
	• Progress made toward treatment goal.
	• Obstacles to treatment discovered (if any).
	• Reason for lack of improvement (if none).
	• Clinical test, exam, and lab results (if any).
	• Documentation must support or justify ICD-10-CM code/diagnosis.
	• Consultations and referrals (if any).
	• Revisions to the diagnosis, goals, or treatment plan (if any).
	    o "See updated Client Recovery Plan as of this date."
	• Immediate plan for care.
	    o "RTC for next ind. ther. 2/27/06."
	• Signature, legible name, and degree of practitioner.

Unusual Circumstances	• Long-term psychotherapy requires submitting an updated treatment summary and treatment plan when requested, with prediction of number of visits needed until end of calendar year. • Visits longer than 90 minutes require a written report submitted with the claim. • Only exceptional circumstances warrant a 75-80 minute billing.

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Medicare Charting and Interdisciplinary Notes, Continued

Medicare Payment Prompts

An ID note page with Medicare content prompts is available.

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Medication Support Services Interdisciplinary Notes

General	See "General Instructions for All Interdisciplinary Notes" section for general instructions applying to all ID notes.
Structured Note Form	The following instructions apply to MSS ID notes: • MSS ID notes will normally be written using the structured, Departmental pink form reserved for these notes only. • Any MSS notes written on the regular MHS ID note form will include the same content as required in the MSS ID note form. • The MSS ID note content is considered to be part of the MSS plan of services.
Who Can Use the Form	The following instructions apply to those who are authorized to use the MSS ID notes: • Parts A and B may be used by both physicians and R.N.'s. o R.N.'s using Part A must include all required content for Part A. • Part B may also be used by psych techs administering medications. • Co-signature is not required for nurses and psych techs using the form to document services they provide that fall within their DBH-authorized scope of practice.

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Medication Support Services Interdisciplinary Notes, Continued

Completing the Form

The following sections of the MSS ID notes must be completed as stated below:

Section	Information to be Completed
Note Content	• All sections of Part A must be filled out for visits in which meds are prescribed. • All notes (Part A and Part B) must describe staff actions (prescribing meds., etc.). • Fill in the date, billing time and service location. • All meds visit notes must include notations regarding: o Target symptoms: the problem being treated. o The client's response to medications. o Side effects noted and actions taken in response. o Presence/absence of tardive dyskinesia. o Client compliance with the medication plan. o Medication interventions. • If any part of the form is not applicable for a given visit, enter N/A. • Enter other information if relevant: o Labs o Recovery update, etc.
MSS Groups	In order for MSS – Group to be charted and billed, the note must contain description of some group process – at a minimum, a group discussion of compliance and/or side effect issues. • "Groups" that involve only separate, individual services (and no group interactions) for individuals who happen to be in the same room at the same time should not be charted or billed as group.

Termination

If it is planned to terminate medication services at a site, the provider planning the termination should notify all other providers of services to the individual at that site.

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Chapter 3 – Medication Related and Physical Assessment

Overview

Chapter 3 provides information on medication related forms and physical conditions as well as physical status forms.

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Abnormal Involuntary Movement Scale Form

Purpose

The Abnormal Involuntary Movement Scale (AIMS) Form helps the physician to stay alert regarding involuntary movement effects of medications.

- The form will be completed on all clients being prescribed medications, to establish a baseline.
- It will then be repeated annually for those clients receiving neuroleptics.

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Clozapine Side Effect Checklist

Description

The Clozapine Side Effect Checklist is used to keep a running record of side effects by the week.

Completing the Form

The following steps detail completion of this form:

Step	Action
1	• Each column represents a week. • Identify the date above and fill in the boxes for each week as indicated, by a check mark or with data regarding that item.
2	Physician initials must be entered at the bottom of each column.
3	Additional explanation of items may be written at the bottom, and any side effects should also be noted in the MSS ID note for that visit.

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Medical Codes

Codes

The following is an ICD -10-CM Codes that Support Medical Necessity (from NHIC materials). Services for other diagnoses will not be paid:

	Included Diagnoses from the Contract Between DHCS and the MHPs		**OHC Mapping as Revised by DHCS**
ICD-9-CM	Description	ICD-10-CM	Description
308.30	Acute Stress Disorder	F43.0	Acute Stress Reaction
309.90	Adjustment Disorder Unspecified	F43.20	Adjustment Disorder, Unspecified
309.24	Adjustment Disorder with Anxiety	F43.22	Adjustment Disorder with Anxiety
309.00	Adjustment Disorder with Depressed Mood	F43.21	Adjustment Disorder with Depressed Mood
309.30	Adjustment Disorder with Disturbance of Conduct	F43.24	Adjustment Disorder with Disturbance of Conduct
309.40	Adjustment Disorder with Disturbances of Emotions and Conduct	F43.25	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood	F43.23	Adjustment Disorder with Mixed Anxiety and Depressed Mood
300.22	Agoraphobia Without History of Panic Disorder	F40.00	Agoraphobia, Unspecified
300.22	Agoraphobia Without History of Panic Disorder	F40.02	Agoraphobia without Panic Disorder
307.10	Anorexia Nervosa	F50.00	Anorexia Nervosa, Unspecified
307.10	Anorexia Nervosa	F50.01	Anorexia Nervosa, Restricting Type
307.10	Anorexia Nervosa	F50.02	Anorexia Nervosa, Binge Eating/Purging Type
300.00	Anxiety Disorder Not Otherwise Specified	F41.9	Anxiety Disorder, Unspecified
299.80	Asperger's Disorder	F84.5	Asperger's Disorder
314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type	F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
314.90	Attention-Deficit/Hyperactivity Disorder, Not Otherwise Specified	F90.9	Attention-Deficit/Hyperactivity Disorder, Unspecified

Continued on next page

Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
314.02	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive Type
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
301.82	Avoidant Personality Disorder	F60.6	Avoidant Personality Disorder
296.80	Bipolar Disorder Not otherwise specified	F31.9	Bipolar Disorder, Unspecified
296.80	Bipolar Disorder Not otherwise specified	F30.8	Other Manic Episodes
296.80	Bipolar Disorder Not otherwise specified	F32.8	Other Depressive Episodes
296.04	Bipolar I Disorder , Single Manic Episode, Severe with Psychotic Features	F30.2	Manic Episode, Severe with Psychotic Symptoms
296.56	Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission	F31.76	Bipolar Disorder, Current Episode Depressed, In Full Remission
296.55	Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission	F31.75	Bipolar Disorder, Current Episode Depressed, In Partial Remission
296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe with Psychotic Features	F31.5	Bipolar Disorder, Current Episode Depressed, Severe with Psychotic Features
296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe without Psychotic Features	F31.4	Bipolar Disorder, Current Episode Depressed, Severe without Psychotic Features
296.40	Bipolar I Disorder, Most Recent Episode Hypomanic	F31.89	Other Bipolar Disorder

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Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
296.40	Bipolar I Disorder, Most Recent Episode Manic	F31.10	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Unspecified
296.46	Bipolar I Disorder, Most Recent Episode Manic, In Full Remission	F31.74	Bipolar Disorder, In Full Remission, Most Recent Episode Manic
296.45	Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission	F31.73	Bipolar Disorder, In Partial Remission, Most Recent Episode Manic
296.41	Bipolar I Disorder, Most Recent Episode Manic, Mild	F31.11	Bipolar Disorder, Current Episode manic without Psychotic Features, Mild
296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	F31.12	Bipolar Disorder, Current Episode Manic without Psychotic Features, Moderate
296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe with Psychotic Features	F31.2	Bipolar Disorder, Current Episode Manic Severe with Psychotic Features
296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe without Psychotic Features	F31.13	Bipolar Disorder, Current Episode Manic without Psychotic Features, Severe
296.50	Bipolar I Disorder, Most Recent Episode Manic, Unspecified	F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
296.66	Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission	F31.78	Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
296.65	Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission	F31.77	Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
296.61	Bipolar I Disorder, Most Recent Episode Mixed, Mild	F31.61	Bipolar I Disorder, Most Recent Episode Mixed, Mild
296.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate	F31.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate

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Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
296.63	Bipolar I Disorder, Most Recent Episode Mixed, Severe without Psychotic Features	F31.63	Bipolar I Disorder, Most Recent Episode Mixed, Severe without Psychotic Features
296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified	F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
296.70	Bipolar I Disorder, Most Recent Episode Unspecified	F31.9	Bipolar Disorder, Unspecified
296.51	Bipolar I Disorder, Most Recent Episode, Depressed, Mild	F31.31	Bipolar Disorder, Current Episode Depressed, Mild
296.06	Bipolar I Disorder, Single Manic Episode, In Full Remission	F30.4	Manic Episode in Full Remission
296.05	Bipolar I Disorder, Single Manic Episode, In Partial Remission	F30.3	Manic Episode in Partial Remission
296.01	Bipolar I Disorder, Single Manic Episode, Mild	F30.11	Manic Episode without Psychotic Symptoms, Mild
296.02	Bipolar I Disorder, Single Manic Episode, Moderate	F30.12	Manic Episode without Psychotic Symptoms, Moderate
296.03	Bipolar I Disorder, Single Manic Episode, Severe without Psychotic Features	F30.13	Manic Episode, Severe, without Psychotic Symptoms
296.00	Bipolar I Disorder, Single Manic Episode, Unspecified	F30.10	Manic Episode without Psychotic Symptoms, Unspecified
296.00	Bipolar I Disorder, Single Manic Episode, Unspecified	F30.9	Manic Episode, Unspecified
296.89	Bipolar II Disorder	F31.81	Bipolar II Disorder
300.70	Body Dysmorphic Disorder	F45.22	Body Dysmorphic Disorder
301.83	Borderline Personality Disorder	F60.3	Borderline Personality Disorder
298.80	Brief Psychotic Disorder	F23	Brief Psychotic Disorder
307.51	Bulimia Nervosa	F50.2	Bulimia Nervosa
299.10	Childhood Disintegrative Disorder	F84.3	Other Childhood Disintegrative Disorder

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Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
312.82	Conduct Disorder, Adolescent-Onset Type	F91.2	Conduct Disorder, Adolescent-Onset Type
312.81	Conduct Disorder, Childhood-Onset Type	F91.1	Conduct Disorder, Childhood-Onset Type
312.89	Conduct Disorder, Unspecified Onset	F91.9	Conduct Disorder, Unspecified
300.11	Conversion Disorder	F44.4	Conversion Disorder with Motor Symptoms or Deficit
300.11	Conversion Disorder	F44.5	Conversion Disorder with Seizures or Convulsions
300.11	Conversion Disorder	F44.6	Conversion Disorder with Sensory Symptom or Deficit
300.11	Conversion Disorder	F44.7	Conversion Disorder with Mixed Symptom Presentation
301.13	Cyclothymic Disorder	F34.0	Cyclothymic Disorder
297.10	Delusional Disorder	F22	Delusional Disorder
301.60	Dependent Personality Disorder	F60.7	Dependent Personality Disorder
300.60	Depersonalization Disorder	F48.1	Depersonalization-Derealization Syndrome
311.00	Depressive Disorder Not Otherwise Specified	F39	Unspecified Mood [Affective] Disorder
799.90	Diagnosis Deferred	R69	Illness, Unspecified
313.90	Disorder of Infancy, Childhood, or Adolescence Not Otherwise Specified	F93.9	Childhood Emotional Disorder, Unspecified
312.90	Disruptive Behavior Disorder NOS	F91.9	Conduct Disorder, Unspecified
300.12	Dissociative Amnesia	F44.0	Dissociative Amnesia
300.15	Dissociative Disorder Not Otherwise Specified	F44.9	Dissociative and Conversion Disorder, Unspecified
300.13	Dissociative Fugue	F44.1	Dissociative Fugue
300.14	Dissociative Identity Disorder	F44.81	Dissociative Identity Disorder
300.40	Dysthymic Disorder	F34.1	Dysthymic Disorder

Note: Diagnosis 799.90 (Diagnosis Deferred) above is not an included diagnosis.

Continued on next page

Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
307.50	Eating Disorder Not Otherwise Specified	F50.9	Eating Disorder, Unspecified
787.60	Encopresis, With Constipation and Overflow Incontinence	R15.9	Full Incontinence of Feces
787.60	Encopresis, With Constipation and Overflow Incontinence	R15.0	Incomplete Defecation
307.70	Encopresis, without constipation and overflow incontinence	F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
307.60	Enuresis (Not due to a general medical condition)	F98.0	Enuresis Not Due to a Substance or Known Physiological Condition
302.40	Exhibitionism	F65.2	Exhibitionism
300.19	Factitious Disorders Not Otherwise Specified	F68.10	Factitious Disorders Unspecified
300.19	Factitious Disorders With Combined Psychological and Physical Signs and Symptoms	F68.13	Factitious Disorders with Combined Psychological and Physical Signs and Symptoms
300.19	Factitious Disorders with Predominantly Physical Signs and Symptoms	F68.12	Factitious Disorders with Predominantly Physical Signs and Symptoms
300.16	Factitious Disorders with Predominantly Psychological Signs and Symptoms	F68.11	Factitious Disorders with Predominantly Psychological Signs and Symptoms
307.59	Feeding Disorder of Infancy or Early Childhood	F98.29	Other Feeding Disorders of Infancy and Early Childhood
302.81	Fetishism	F65.0	Fetishism
302.89	Frotteurism	F65.81	Frotteurism
302.85	Gender Identity Disorder in Adolescents or Adults	F64.1	Gender Identity Disorder in Adolescence and Adulthood
302.60	Gender Identity Disorder in Children	F64.2	Gender Identity Disorder of Childhood
302.60	Gender Identity Disorder Not Otherwise Specified	F64.9	Gender Identity Disorder, Unspecified

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Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
300.02	Generalized Anxiety Disorder	F41.1	Generalized Anxiety Disorder
300.02	Generalized Anxiety Disorder	F41.3	Other Mixed Anxiety Disorders
300.02	Generalized Anxiety Disorder	F41.8	Other Specified Anxiety Disorder
301.50	Histrionic Personality Disorder	F60.4	Histrionic Personality Disorder
313.82	Identity Problem	F93.8	Other Childhood Emotional Disorder
312.30	Impulse Control Disorder Not Otherwise Specified	F63.9	Impulse Disorder, Unspecified
312.34	Intermittent Explosive Disorder	F63.81	Intermittent Explosive Disorder
312.32	Kleptomania	F63.2	Kleptomania
296.36	Major Depressive Disorder, Recurrent, in Full Remission	F33.42	Major Depressive Disorder, Recurrent, in Full Remission
296.35	Major Depressive Disorder, Recurrent, In Partial Remission	F33.41	Major Depressive Disorder, Recurrent, In Partial Remission
296.31	Major Depressive Disorder, Recurrent, Mild	F33.0	Major Depressive Disorder, Recurrent, Mild
296.32	Major Depressive Disorder, Recurrent, Moderate	F33.1	Major Depressive Disorder, Recurrent, Moderate
296.34	Major Depressive Disorder, Recurrent, Severe with Psychotic Features	F33.3	Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms
296.33	Major Depressive Disorder, Recurrent, Severe without Psychotic Features	F33.2	Major Depressive Disorder, Recurrent, Severe without Psychotic Features
296.30	Major Depressive Disorder, Recurrent, Unspecified	F33.40	Major Depressive Disorder, Recurrent, In Remission, Unspecified
296.30	Major Depressive Disorder, Recurrent, Unspecified	F33.9	Major Depressive Disorder, Recurrent, Unspecified
296.26	Major Depressive Disorder, Single Episode, In Full Remission	F32.5	Major Depressive Disorder, Single Episode, In Full Remission

Continued on next page

Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
296.25	Major Depressive Disorder, Single Episode, In Partial Remission	F32.4	Major Depressive Disorder, Single Episode, In Partial Remission
296.21	Major Depressive Disorder, Single Episode, Mild	F32.0	Major Depressive Disorder, Single Episode, Mild
296.22	Major Depressive Disorder, Single Episode, Moderate	F32.1	Major Depressive Disorder, Single Episode, Moderate
296.24	Major Depressive Disorder, Single Episode, Severe with Psychotic Features	F32.3	Major Depressive Disorder, Single Episode, Severe, with Psychotic Features.
296.23	Major Depressive Disorder, Single Episode, Severe without Psychotic Features	F32.2	Major Depressive Disorder, Single Episode, Severe, without Psychotic Features
296.20	Major Depressive Disorder, Single Episode, Unspecified	F32.9	Major Depressive Disorder, Single Episode, Unspecified
333.90	Medication-Induced Movement Disorder, Not Otherwise Specified	G25.9	Extrapyramidal and Movement Disorder, Unspecified
333.90	Medication-Induced Movement Disorder, Not Otherwise Specified	G25.70	Drug Induced Movement Disorder, Unspecified
333.10	Medication-Induced Postural Tremor	G25.1	Drug-Induced Tremor
296.90	Mood Disorder Not Otherwise Specified	F39	Unspecified Mood [Affective] Disorder
296.90	Mood Disorder Not Otherwise Specified	F33.8	Other Recurrent Depressive Disorders
296.90	Mood Disorder Not Otherwise Specified	F34.8	Other persistent Mood [Affective] Disorders
296.90	Mood Disorder Not Otherwise Specified	F34.9	Persistent Mood [Affective] Disorder, Unspecified
301.81	Narcissistic Personality Disorder	F60.81	Narcissistic Personality Disorder
333.92	Neuroleptic Malignant Syndrome	G21.0	Malignant Neuroleptic Syndrome
333.99	Neuroleptic-Induced Acute Akathisia	G25.71	Medication-Induced Acute Akathisia

Continued on next page

Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
333.70	Neuroleptic-Induced Acute Dystonia	G25.9	Extrapyramidal and Movement Disorder, Unspecified
332.10	Neuroleptic-Induced Parkinsonism	G21.11	Neuroleptic-Induced Parkinsonism
333.82	Neuroleptic-Induced Tardive Dyskinesia	G24.4	Idiopathic Orofacial Dystonia
V71.09	No Diagnosis	Z03.89	Encounter for Observation for other Suspected Diseases and Conditions Ruled out
300.30	Obsessive - Compulsive Disorder	F42	Obsessive-Compulsive Disorder
301.40	Obsessive-Compulsive Personality Disorder	F60.5	Obsessive-Compulsive Personality Disorder
313.81	Oppositional Defiant Disorder	F91.3	Oppositional Defiant Disorder
307.89	Pain Disorder Associated with Both Psychological Factors and a General Medical Condition	F45.42	Pain Disorder with Related Psychological Factors
307.80	Pain Disorder Associated with Psychological Factors	F45.41	Pain Disorder Exclusively Related to Psychological Factors
300.21	Panic Disorder with Agoraphobia	F40.01	Agoraphobia with Panic Disorder
300.01	Panic Disorder Without Agoraphobia	F41.0	Panic Disorder without Agoraphobia
301.00	Paranoid Personality Disorder	F60.0	Paranoid Personality Disorder
302.90	Paraphilia Not Otherwise Specified	F65.9	Paraphilia Unspecified
312.31	Pathological Gambling	F63.0	Pathological Gambling
302.20	Pedophilia	F65.4	Pedophilia
301.90	Personality Disorder Not Otherwise Specified	F60.9	Personality Disorder, Unspecified

Note: Diagnosis V71.09 (No Diagnosis) above is not an included diagnosis.

Continued on next page

Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
299.80	Pervasive Developmental Disorder Not Otherwise Specified	F84.8	Other Pervasive Developmental Disorder
299.80	Pervasive Developmental Disorder Not Otherwise Specified	F84.9	Pervasive Developmental Disorder, Unspecified
307.52	Pica	F98.3	Pica of infancy and Childhood
309.81	Posttraumatic Stress Disorder	F43.10	Post-Traumatic Stress Disorder, Unspecified
309.81	Posttraumatic Stress Disorder	F43.11	Post-Traumatic Stress Disorder, Acute
309.81	Posttraumatic Stress Disorder	F43.12	Post-Traumatic Stress Disorder, Chronic
298.90	Psychotic Disorder Not Otherwise Specified	F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
298.90	Psychotic Disorder Not Otherwise Specified	F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
312.33	Pyromania	F63.1	Pyromania
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	F94.1	Reactive Attachment Disorder of Childhood
299.80	Rett's Disorder	F84.2	Rett's Syndrome
307.53	Rumination Disorder	F98.21	Rumination Disorder of Infancy
295.70	Schizoaffective Disorder	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	Schizoaffective Disorder	F25.1	Schizoaffective Disorder, Depressive Type
295.70	Schizoaffective Disorder	F25.8	Other Schizoaffective Disorders
295.70	Schizoaffective Disorder	F25.9	Schizoaffective Disorder, Unspecified
301.20	Schizoid Personality Disorder	F60.1	Schizoid Personality Disorder
295.20	Schizophrenia, Catatonic Type	F20.2	Catatonic Schizophrenia
295.10	Schizophrenia, Disorganized Type	F20.1	Disorganized Schizophrenia
295.30	Schizophrenia, Paranoid Type	F20.0	Paranoid Schizophrenia

Continued on next page

Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
295.60	Schizophrenia, Residual Type	F20.5	Residual Schizophrenia
295.90	Schizophrenia, Undifferentiated Type	F20.3	Undifferentiated Schizophrenia
295.90	Schizophrenia, Undifferentiated Type	F20.9	Schizophrenia, Unspecified
295.40	Schizophreniform Disorder	F20.81	Schizophreniform Disorder
301.22	Schizotypal Personality Disorder	F21	Schizotypal Disorder
313.23	Selective Mutism	F94.0	Selective Mutism
309.21	Separation Anxiety Disorder	F93.0	Separation Anxiety Disorder of Childhood
302.83	Sexism Masochism	F65.51	Sexism Masochism
302.90	Sexual Disorder Not Otherwise Specified	F65.9	Paraphilia Unspecified
302.84	Sexual Sadism	F65.50	Sadomasochism, Unspecified
302.84	Sexual Sadism	F65.52	Sexual Sadism
297.30	Shared Psychotic Disorder	F24	Shared Psychotic Disorder
300.23	Social Phobia	F40.10	Social Phobia, Unspecified
300.23	Social Phobia	F40.11	Social Phobia, Generalized
300.81	Somatization Disorder	F45.0	Somatization Disorder
300.82	Somatization Disorder Not Otherwise Specified	F45.8	Other Somatoform Disorders
300.29	Specific Phobia	F40.210	Arachnophobia
300.29	Specific Phobia	F40.218	Other Animal Type Phobia
300.29	Specific Phobia	F40.228	Other Natural Environment Type Phobia
300.29	Specific Phobia	F40.220	Fear of Thunderstorms
300.29	Specific Phobia	F40.230	Fear of Blood
300.29	Specific Phobia	F40.231	Fear of Injections and Transfusions
300.29	Specific Phobia	F40.232	Fear of Other Medical Care
300.29	Specific Phobia	F40.233	Fear of Injury
300.29	Specific Phobia	F40.240	Claustrophobia
300.29	Specific Phobia	F40.241	Acrophobia
300.29	Specific Phobia	F40.242	Fear of Bridges
300.29	Specific Phobia	F40.243	Fear of flying

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Medical Codes, Continued

Codes (continued)

	Included Diagnoses from the Contract Between DHCS and the MHPs		OHC Mapping as Revised by DHCS
300.29	Specific Phobia	F40.248	Other Situational Type Phobia
300.29	Specific Phobia	F40.290	Androphobia
300.29	Specific Phobia	F40.291	Gynephobia
300.29	Specific Phobia	F40.298	Other Specified Phobia
300.29	Specific Phobia	F40.8	Other Phobic Anxiety Disorders
307.30	Stereotypic Movement Disorder	F98.4	Stereotyped Movement Disorders
302.30	Transvestic Fetishism	F65.1	Transvestic Fetishism
312.39	Trichotillomania	F63.3	Trichotillomania
300.82	Undifferentiated Somatoform Disorder	F45.1	Undifferentiated Somatoform Disorder
300.82	Undifferentiated Somatoform Disorder	F45.8	Other Somatoform Disorders
302.82	Voyeurism	F65.3	Voyeurism

Note: Treatment of diagnoses 332.1 – 333.99 (Medication Induced Movement Disorders) is a covered service only when the Medication Induced Movement Disorder is related to one or more included diagnoses.

Continued on next page

Medications Order Sheet

Directions

Complete all columns:

- Date/time
- Medicine
- Dosage/Strength (for example 150 mg – 1.5cc:100mg/cc)
- Frequency
- Route/site of entry
- Number of tablets on hand
- New amount prescribed
- Refills
- Signature

Medication shall be administered only when a psychiatrist/physicians order is written in the client's medical record. All medication shall be verified by the licensed nurse against the written doctor's order prior to administering medication. Nursing staff shall verify that the patient, medication, dose, frequency and route are correct.

Injectable Medications: Receipt of injectable medications shall be documented in the appropriate log book and on an interdisciplinary note if for a specific patient. All injectable medications will be documented on the OMR and appropriate log at time of administration. After any injectable medication is given, nursing staff will **immediately** record the administration on the OMR, including the site code and print/sign their name. This helps to ensure the safety of the patient and promotes accurate recordkeeping.

Oral Medications: Receipt of oral medications shall be documented on the appropriate medication log and on an interdisciplinary note if for a specific patient. Dispensing of oral meds shall be documented on the appropriate medication log and on an interdisciplinary note.

Note: For intramuscular administrations, it is critical to include the time and site of the injection.

Ability to Manage Meds

A notation regarding the client's ability to manage his/her own medications must be made at the bottom of each Medications Order Sheet.

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Clinical Laboratory

Policy and Procedure

There should be a baseline laboratory study appropriate to the medication prescribed and annual laboratory studies thereafter. Laboratory reports from an outside clinic or agency within the past year are acceptable.

Specific Meds

Appropriately-timed blood level findings should be obtained and on file for clients taking the following medications:

- Lithium
- Tegretol
- Dilantin
- Phenobarbital
- Others requiring frequent monitoring

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HIV and AIDS Charting

Policy

Since HIV testing is to remain as confidential as possible in order to encourage more people to consent to be tested, HIV/AIDS status which has been determined by testing in the ADS HIV/AIDS testing and counseling program is to be treated as confidential.

Disclosure of Information

Testing program staff will not disclose or release this test status information to anyone without the individual's written permission on the release of information form or as otherwise permitted by law, for example to:

- Employees in DMH or OADP whose work involves contact with bodily fluids of clients.

Notation of Information

The law permits notation by HIV/AIDS testing and counseling program staff of HIV results in ADS and DMH client charts, but in order to promote early detection, DBH policy allows ADS HIV/AIDS testing and counseling program staff not to place this HIV/AIDS information in ADS or DBH charts.

Reference: Health and Safety Code 199.20 et seq; 42 C.F.R., Para. 2.

DBH Medical Records

Charting by DBH or ADS clinicians or physicians of a client's HIV test results or AIDS diagnosis does not require client authorization if obtained appropriately from:

- Other medical records
- Collateral persons
- Client's disclosure

Reference: California Hospital Assoc., Consent Manual 1995 Edition, Chapter 20.

Continued on next page

HIV and AIDS Charting, Continued

Clinician/ Physician Decision

Clinicians and physicians may decide whether to chart known HIV/AIDS information regarding a client, but if such information is not charted, the risks of not charting this information to the following persons should be carefully considered:

- Client
- Clinician
- Other health care workers

Where Diagnosis is Reported

When a client's HIV positive status or AIDS status is charted, the HIV – positive status or AIDS diagnosis can also be recorded if it is relevant to the appropriate management of the case.

Disclosure by Staff

Disclosure of a client's HIV/AIDS status through:

- Oral communications
- Written communications
- Disclosure of the medical recorded

Requires that the client specifically authorize the HIV/AIDS disclosure in writing, using the release of information form, except in the following circumstances:

- To another health care practitioner or an agent or employee thereof who provides the client's direct care and treatment. Authorized disclosure under this section does not include:
    - Certain health care services plans. Disclosures to insurance companies are governed by Insurance Code 799 et. seq.
    - Non-treatment personnel of any kind (clerks, janitors, etc.).
- To the clients legal representative, conservator, or the person who gave consent to the client's HIV test.
- To a provider of health care who procures, processes, distributes, or uses a human body part donated pursuant to the Uniform Anatomical Gift Act.

Reference: California Hospital Association, Consent Manual, 1995 Edition, Chapter 20.

Continued on next page

HIV and AIDS Charting, Continued

Procedure for Release of Information

The following procedure is used when releasing information regarding the client's HIV/AIDS status:

<table>
<tr><th>Step</th><th colspan="2">Action</th></tr>
<tr><td>1</td><td colspan="2">Any DBH employee involved in obtaining client consent to the release of DBH confidential information will ask the client:
• "Is there any reason to think that HIV or AIDS information about you might be included in your medical record?"
    o The client may indicate at that point, without answering the question, that he/she wishes to compete the release process with a specific other person, such as his/her clinician or physician.</td></tr>
<tr><td rowspan="3">2</td><td>If the client answers...</td><td>Then...</td></tr>
<tr><td>"No" and the staff person involved knows of no HIV/AIDS information in the record,</td><td>The release process will proceed as usual.</td></tr>
<tr><td>"Yes" (or if the client answers "No" but the DBH staff persons involved know that such information is included in the record),</td><td>The client will be asked if he/she wishes to consent to release of both psychiatric and HIV/AIDS information in the record.</td></tr>
<tr><td rowspan="5">3</td><td>If...</td><td>Then...</td></tr>
<tr><td>The client consents to the release of both psychiatric and HIV/AIDS information,</td><td>That fact will be noted non the release form (by writing in the "SPECIFIC TYPES OF INFORMATION" blank "Client consents to the release for any HIV/AIDS information in the recorded at this time").</td></tr>
<tr><td>The client does not consent to the release of HIV/AIDS information,</td><td>That fact will <u>not</u> be noted on the release form.</td></tr>
<tr><td>The client consents to disclosure of psychiatric information but not HIV/AIDS information,</td><td>Disclosures must be so edited and HIV/AIDS information removed from the disclosure, unless otherwise permitted or required by law.</td></tr>
<tr><td>Editing of HIV/AIDS information is needed prior to a disclosure of client information,</td><td>A clinician or physician will do this editing, using the directions of Medical Records regarding how to carry out the editing.</td></tr>
</table>

Continued on next page

HIV and AIDS Charting, Continued

Disclosure to Persons in Danger of Harm

The physician who ordered the antibody test may disclose confirmed positive test results of his or her patient to:

- A person reasonably believed to be the spouse of the patient.
- A person reasonably believed to be a sexual partner.
- A person with whom the patient has shared the use of hypodermic needles
- The County Health officer.

A physician shall not be held civilly or criminally liable for doing so. Prior to disclosing the test result to a third party, a physician must first:

- Discuss the results with the patient.
- Counsel the patient.
- Attempt to obtain the patients' voluntary consent to notify the patient's contacts.

Also, when the physician discloses the information to a contact, the physician must refer that person for appropriate care.

Reference: Health and Safety Code 199.25.

Court Case

A recent California Court of Appeals decision (Reisner v. Regents of University of California [1995] 31 Cal App. 4th 11-95) indicates that in certain situations physicians may have a duty to warn those who could be harmed by a client's HIV infection. If medical staff are unsure how to proceed in these circumstances, even after carrying out the permissive disclosure in the immediately preceding instructions. See CONSULTATION SECTION below.

Permissive or Discretionary Disclosure

To date, there is not statutory authorization for permissive or discretionary disclosure of a client's AIDS/HIV status to those described in the immediately preceding instructions by a treating non-physician without a release of information by the client. See CONSULTATION SECTION below.

Mandated Reporting – General

The law imposes a duty on medical or other personnel providing services in adult correctional or juvenile detention facilities to communicate to the officer in charge information that indicates that an inmate or minor at the facility has been exposed to or infected by the HIV virus.

Continued on next page

HIV and AIDS Charting, Continued

Specific Requirements

There are currently no mandatory reporting requirements regarding HIV test results or HIV status, but there are reporting requirements regarding a diagnosis of actual AIDS.

The following criteria shall be followed:

Who Reports	Required Reporting
DBH physicians who makes a diagnosis of AIDS	Should report it immediately to the County Public Health Officer 800-782-4264.
Physicians and hospitals	Must immediately report all transfusion-associated AIDS cases confirmed by the person's physician to the County Health Officer for investigation.
Hospitals	Must report to the State Department of Health Services and the County Health Officer whenever a person is hospitalized whose physician confirms that the person has a diagnosis of AIDS.

Reference: California Hospital Association, Consent Manual, 1995 Edition, Chapter 20.

When Reports are Made

Reports must be made as soon as practicable after hospitalization. These reports must include:

- The person's name
- The person's date of birth
- The person's address
- The person's social security number
- Hospital name
- Date of the person's hospitalization

Liability

There is no liability for hospitals and physicians making these required reports.

Legal Requirement

There is no legal requirement that the client be notified regarding these reports.

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HIV and AIDS Charting, Continued

Consultation Disclosures of information regarding a person's HIV and/or AIDS status may present legal issues, including occasionally the issue of possible Tarasoff warnings. In the event that a question regarding disclosure is not covered in the material set forth hereinabove, follow the steps below:

Step	Action
1	The clinician's supervisor should be consulted concerning the propriety of releasing confidential information in that given situation.
2	County Counsel can only be contacted via Department administration, by first contacting one's Program Manager II.

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Physical Assessment

Description

The Physical Assessment:
- Verifies that the physician has discussed with the client the need for the client to have a complete physical examination.
- Allows client and physician to be fully aware of the client's physical condition and of any contraindications to the use of psychotropic medications.

Completing the Form

The Physical Assessment form is completed as follows:
- The client should be reminded of this annually and the form filled out and signed by the client every year.
- The form should be filed with the AIMS in Section 1 of the chart.
- A copy of a physical examination from another facility, such as County Medical Center, can be filed in the chart in lieu of Physical Assessment.

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Chapter 4 – Other Treatment Procedures

Overview

Chapter 4 discusses how to handle other treatment procedures for each client.

Contents

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Charting Interpretation and Service in Non-English Language

Entry Detail for Interpretation of a Service	The person writing the chart note will enter, immediately following the service name (MHS-Ind. Ther., etc.), "(Interpretation provided in [Specify language] by [name of interpreter, source of interpreter/agency])".
Example	MHS-Ind. Ther. (Interpretation provided in Spanish by Adam Articulate).
Entry Detail for Provision of Service	Charting provision of service in a non-English language involves the person writing the chart note will enter, immediately following the service name "(Provided in [specify language].)"
Example	MHS-Ind. Ther. (Provided in Vietnamese).

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Child Abuse Reporting Forms

Process	After a required child abuse report has been made, a copy of the Child Abuse reporting form will be placed in the Correspondence section of the chart.

Continued on next page

Discharge Summary

Description

The Discharge Summary describes briefly the:

- Reason for the client's treatment
- Course of treatment
- Client's condition on discharge

Which Cases must have a DS

A Discharge Summary must be completed as follows:

- On all cases open more than two months.
- For all cases, an ID note is written at least noting the discharge.
- In cases open less than two months, this ID note should explain the above items.

Timing

Discharge Summaries must be completed within the following time frames:

If...	Then...
It is unclear whether the client will return for further services,	The Discharge Summary will be completed no later than six months from the last service.
No further treatment is planned,	The Discharge Summary will be completed within one month of a clear termination.
A client has a planned absence of somewhat more than six months, but it is planned that the client will return for further treatment and if the rationale for this is explained in the ID notes,	The chart may be kept open for longer than six months.

Continued on next page

Discharge Summary, Continued

Completing the Form

The following instructions apply to completion of the Discharge Summary:

- All parts of the form must be completed.
- Indicate what services are being terminated:
  - MHS
  - DTR
  - MSS, etc.
- If the client is receiving medications upon discharge, fill in the names of those medicines.
- "Admission Date" is the date of entry or registration for the client.
- Date of Last Documented Client Contact is the date of the last clinical service involving actual contact with the client.

See Chart Closure section this manual for related information.

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General Report Form

Purpose	The General Report Form may be used as a formatted form for typing any report. All relevant information is filled in at the top of each page used.

Continued on next page

Notice of Action Forms

Requirement

The following requirements apply to the receipt of Notice of Action (NOA) forms:

When...	Then...
A Medi-Cal (or other Notice of Action) is given to a client, indicating a denial of services,	A copy of the Notice of Action form will be placed in the chart (in the Legal section). ***Note:*** Copy of NOA form must be submitted to Quality Management. If the beneficiary is being referred to his/her Managed Care Plan (MCP) for services, staff should obtain a release of information and then submit the NOA and a referral to the MCP.
The chart is closed and episode ended,	This form will be placed in the episode according to instructions from the Medical Records Office.

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Chapter 5 – Treatment Consents, Authorization, and Releases

Overview

Chapter 5 is about what forms are needed to obtain consent from clients. The chapter also discusses releases needed by DBH to release client information.

Contents

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Advance Directives

Description

Advance directives:

- Provide instruction on how a person wants his/her future healthcare to be carried out.
- Have legal standing and should be honored by all healthcare providers when properly prepared.
- May address psychiatric care as well as other healthcare areas.

Requirement to Notify

The California Department of Health Care Services (DHCS) requires:

- DBH to inform adult clients upon entry about advance directives.
- Those clients have the right to establish directives.

Note: Advance directive notification is not required for minor clients.

Where Information is Found

Reference to this is in the DBH Consumer Brochure, and detailed materials being developed on the subject are part of the information that all sites and providers are required to provide to clients in waiting rooms.

Use of Form

The DBH Advance Directives Notice form is used to advise all providers whether or not the client has established advance directives. The following information is recorded on the form:

- If the client reports that he/she has no advance directives that will be noted in the top section of the form.
- If advance directives are completed here, or if the client brings to us a copy, these will be filed with the Notice form in the chart section that contains consents for treatment.
- The client may also tell us that advance directives are at another location a physicians' office, and agency etc. and that other location will be recorded on the Notice form.
- Clients will be informed that they can bring a copy of current advance directives for inclusion in the DBH chart.
- Additional sections of the form will be completed if the client changes his/her advance directives or where they can be obtained.

Continued on next page

Advance Directives, Continued

Responsibility to Follow Advance Directives

The client's advance directives will be followed in almost all cases, however use the following table in these two situations:

If...	Then...
A provider believes that for some reason an advance directive should not be honored,	Supervisors and County Counsel should be consulted.
It is known that an advance directive exists and a critical healthcare decision(s) must be made,	That advance directive should be consulted, whether or not it is in the DBH chart.

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Authorization to Obtain Medical Care for Minor

Purpose

Medical Care Authorization for a minor enables a person with medical care rights regarding a minor (such as a parent or legal guardian) to authorize, in advance, DBH clinic staff to obtain medical care for the minor should that become necessary while the minor is in the care of the clinic and the parent is not available.

Example: A child falls or is cut while in a session and parents are not in the clinic.

Procedures

The following procedures apply to completion of this form:

- It is recommended that clinics have this form completed for each minor client at the time of registration and treatment consent.
- Any non-parent who signs this form must produce documentation to prove their custodial and/or medical rights, just as they must do in order to be allowed to sign the treatment consents.
- The form must be witnessed (with signature) by DBH staff.
- Staff must take this form with them to the medical facility if they take the minor for care.

Continued on next page

Authorization to Release Confidential Protected Health Information

Policy

The Authorization to Release Confidential Protected Health Information (PHI) is used both to request information from other sources and to release DBH information regarding a client.

Completion of Authorization

Following are procedures for completing the authorization:

- Make sure that the client understands what information will be released and any foreseeable consequences of the release
- Enter name of facility releasing information after “I AUTHORIZE:”
- Enter name of facility receiving information above “Facility Name.”
- If possible, the name of a specific person who is to receive the information is required

If DBH is releasing information, enter the specific purpose(s) for the release (e.g., SSI application, inform client’s new therapist, provide required probation reports, etc.).

Check information to be released, or describe in “Other.” Only information necessary for the purpose listed above should be released. It is very rare that an entire chart would be copied and released.

Use of Authorization

An authorization, once signed, may not be used to justify future releases of information unless these are exactly the same as described in the release, are intended by the authorizing person to occur when signing the release, and occur before the expiration of the release.

The authorizing person has a right to a copy of the release. It is good practice always to give a copy to the authorizing person.

Cancellation of Authorization

The client or client representative (conservator, person with medical consent rights for a minor) may cancel the release in writing at any time. If not cancelled specifically, an authorization terminates 90 days from the date of signature, or if so checked on the form, (1) on completion of the requested action, or (2) one year from the date of signature or the date the client’s chart is closed, whichever comes first.

Continued on next page

Authorization to Release Confidential Protected Health Information, Continued

Release of Health Information

Protected health information (PHI) received from other sources should usually not be released by DBH to another facility. Clients are informed that DBH cannot guarantee that facilities receiving PHI from DBH will not release it themselves to other facilities.

Only alcohol and drug related PHI is legally protected from such re-release, as noted on the release form.

Signatures on Release Forms

The person signing the release must be the client or a person having medical consent rights for the client, such as a DCS worker or conservator. All persons besides those reasonably believed to be the parents of a minor client must provide written proof of their right to make medical decisions for the client.

Requests for PHI, once completed, will be forwarded to the current provider(s) treating the client. The provider will sign the form (or not sign the form, if he/she wishes to deny the release based on client welfare).

Release Information Rules

When the protections afforded confidential/PHI information are different in California law and in HIPAA, the rule affording greater protection will be used. Thus, if HIPAA permits release but state law, as embodied in Welfare and Institutions Code 5328, does not allow it, the information will not be released. In problem situations, supervisors should be consulted.

Note: See the Department's Standard Practice Manual for rules relating to a client's request for information from his/her own chart that DBH providers do not believe is in the client's best interest.

Continued on next page

Consent of Outpatient Treatment Form

Description

The Consent of Outpatient Treatment Form explains certain conditions of treatment, including circumstances under which confidential information may be disclosed without the client's consent.

When Form is Signed

The form should be signed by the client or responsible guardian, conservator, etc. before the client receives professional services, if at all possible, or as soon as possible thereafter.

Services in the Field

When initial services are provided in the field (no clinic visit), if face-to-face contact with the person being helped occurs, then a Consent of Outpatient Treatment Form will be signed by the person (or other person with legal consent rights).

Minors

Consent forms are accessible in English and Spanish. Note that the following persons do not automatically have the right to consent to this treatment:

- DPSS workers
- CPS workers
- Foster parents
- Legal guardians

These persons will not be allowed to consent to treatment for minors unless they have the authorization to do so in writing.

See Consent for Treatment of Minors Policy for details regarding who can consent to treatment for minors.

Filing Written Authorizations

If any person other than a parent signs for consent, his/her written authorization to do so will be placed in the chart. This includes copies of:

- Guardianship
- Conservatorship orders
- DPSS court authorizations to consent to treatment

Continued on next page

Consent of Outpatient Treatment Form, Continued

Therapy vs. Medications	Consent for psychotherapy or counseling, for adults or for minors, does not imply consent for the use of psychotropic medications (which must have separate consent).
Conservatees	In the case of a client who is under conservatorship, the conservator must authorize all non-emergency outpatient care.
Medi-Cal	All Medi-Cal eligible clients must have their attention drawn to item 10 of the consent form, which indicates that receiving mental health services is not a prerequisite for access to other community services, and that the client may seek other providers and services when they are desired.
Witness	A Departmental representative (clerk or professional) must sign the form also, as a "witness."
Filing	The form is filed in the center (middle) section of the chart, on the right hand side.
Copy for Client	The client is given a copy of the signed consent form.
Consent Form in Another Language	See Forms in other Languages section for procedures for the use of a consent form issued by Quality Management in a language other than English.

Continued on next page

Consent to Sound or Video Record

Usage	The Consent to Sound or Video Record form will be used to document client consent for recordings of client sessions.
Purpose of Recording	The specific purposes for which the recording will be used must be specified, and the date of consent expiration must be listed.
Decision to Consent Changes	If the client changes his or her mind and wishes to cancel the consent, this is documented on the same form.
Filing Form	The form is filed along with the other treatment consents in the chart.

Continued on next page

Medicare Advance Beneficiary Notice

Purpose

The Medicare Advance Beneficiary Notice is used to notify Medicare clients that a certain service may not or will not be reimbursable by Medicare.

Frequency

The Medicare ABN is filled out and signed by the client in advance of every service that may not or will not be reimbursable by Medicare (except that only annual notice is necessary regarding a service that is never covered by Medicare).

Procedure

The following procedure is followed when completing the Medicare Advance Beneficiary Notice:

<table>
<tr><th>Step</th><th colspan="2">Action</th></tr>
<tr><td>1</td><td colspan="2">The client's name and Medicare number (if available) are entered at the top of the form.</td></tr>
<tr><td>2</td><td colspan="2">The client is told that the service in question may not or will not be reimbursable by Medicare.
• The form is pre-printed with information about services that are not covered and the reasons why this might be so.</td></tr>
<tr><td>3</td><td colspan="2">In the "Items or Services" box, write the name(s) of the service(s) in question. The reason(s) each service in question may not or will not be reimbursable is (are) indicated in the "Because" box by checking the appropriate box or writing in the reason.</td></tr>
<tr><td rowspan="4">4</td><td colspan="2">The following actions will be taken should the client ask questions at this point:</td></tr>
<tr><td>If the client...</td><td>Then the...</td></tr>
<tr><td>Asks the potential cost of the service to himself/herself,</td><td>Estimated cost is entered in the appropriate space on the form.</td></tr>
<tr><td>Does not ask the cost,</td><td>Enter "did not ask."</td></tr>
<tr><td>5</td><td colspan="2">The client checks option 1 or 2, indicating that he/she wants or does not want to proceed with the service, and signs the form.</td></tr>
<tr><td>6</td><td colspan="2">Retain the original signed form, and give a copy to the beneficiary. If the client refuses to sign but demands the service, note on the form that the client refused to sign but demanded the service.</td></tr>
</table>

Filing

The originals of the form are filed as the top paper in the "Identification" section in the back of the chart.

Continued on next page

Medication Consent Form

When Completed

The Medication Consent Form (Spanish; Vietnamese) should be completed the first time the physician prescribes medication for a client.

Completing Form

The following steps in completing the Medication Consent Form:

Step	Completed by	Action
1	Physician	Gives the client the information explanations called for in the top section.
2	Physician	Signs and dates the top portion.
3	Physician	Writes in the medication name in the bottom section.
4	Client	Dates and signs that line in the bottom section.

Each time another medication is started, the physician gives the appropriate information (at the top) and then initials and dates on the blank line in the middle of the page, affirming that such information has been given. The client signs and dates for each new medication.

New Form Necessary?

Use the following table to determine if a new form is necessary:

Situation	New Form Needed?
Another physician fills in for the client's regular physician.	No
A new physician takes over the case.	No
If form cannot be added to (out of lines).	Yes
A new episode is opened for the client.	Yes

Re-Continuance of Discontinued Meds

If a previously used but discontinued medication is started again, a new line on the form need not be completed.

Continued on next page

Medication Consent Form, Continued

Re-writing the Form

There is no requirement for re-writing the form based solely on how long a form has been used.

Form in another Language

See Forms in Another Language section for procedures for use of a Medication Consent Form issued by Quality Management in a language other than English.

Continued on next page

Telepsychiatry Consent Form

Purpose

The DBH Telepsychiatry Consent Form will be used, in addition to the regular Consent of Outpatient Treatment Form, whenever telehealth/telemedicine services are provided.

Continued on next page

Treatment Consent Delegation

Purpose

In some cases, parents or other persons with medical consent rights for a child may be unable to come to a clinic to consent to treatment for the child. Also see Consent for Treatment of Minors Policy for other parameters regarding consent in cases of minors.

Procedure

The following rules apply to completion of the Delegation of Treatment Consent:

- This form may only be used if the parent is physically unable to be present, because of being:
  - Housebound,
  - Incarcerated, etc.
- It may not be used to gain consent in case in which parents are simply uninterested or unwilling to come.
- The signature of a witness who observes the parent or other delegating person sign the form must be included.
- The person receiving treatment consent delegation must show, in addition to the delegation form, a copy of an ID showing the delegating person's signature so that we may affirm that the signature on the delegation form is genuine.
  - This ID copy is filled in the chart with the delegation form, in the place where other consent forms are filed.
- The back (or second page) of the form should be used by the delegating parent or other person to give information about the child's recent medical care.

Continued on next page

Confidential Record Release within County without Client Authorization

When the Client Files a Lawsuit

When a client files a lawsuit against the Department or the County for personal injuries, the State's Evidence Code and Civil Code provide that those accused have access to the client's record of care.

Client Consent to Access

This access to client records may be without client consent or knowledge. When there is no client consent:

If the chart is...	Then the form will be filled out and filed in the chart by the...
Open	Clinic Clerk
Closed	Medical Records

Continued on next page

Request for Release of Confidential Information to the Patients' Rights Advocate Office

Patients' Rights Advocates Access

In the appropriate discharge of their duties, patient's rights advocates need access from time to time to client charts, either for:

- Investigation of possible rights violations, or
- Required monitoring of client's rights in facilities.

Client Signature

When the client is available to sign a Release of Information: Patient's Right of Access to His/Her Own Medical Record (Spanish), this will be accomplished. However, access to client records may be without client knowledge or overt consent in some instances, and in those instances the self-explanatory form (title above) will be filled out by the advocate and filed as follows:

If there is...	Then the form will be entered in the chart by...
An open chart	The record clerk of the clinic
A closed chart	Medical Records

Continued on next page

Chapter 6 – Correspondence

Overview

Chapter 6 discusses the approval steps to provide a To Whom It May Concern letter to clients.

Contents

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To Whom It May Concern Letters Requested by Clients

Purpose

From time to time clients may request that staff provide them with To Whom It May Concern letters which the clients can take with them and show to whomever they wish.

Use by Clients

Clients may wish to use such letters as:

- Introductions to future treatment personnel
- Proof to an agency that they have received services
- Confirmation of a certain diagnosis, etc.

General Policy

In general, in accordance with the regulations of Title 22, such letter **should not be provided**. The reason for this is the concern that the client may give the information to someone who:

- Will use it to harm the client or
- Is not bound by the regulations which prohibit re-release of the information to another party.

Requests from Future Treatment Personnel

Any need of future treatment personnel for records should be met by a request from those personnel to DBH for the records, with a proper release from the client.

Justifiable Exception

If there seems to be a justifiable exception to the above prohibition, then the purposes for which the client anticipates using the letter should be carefully discussed with the client, to make sure that such use:

- Would be in the client's best interest and
- That the client is not intending to use the information in a deceptive or inappropriate way.

Exception Procedure

If it is decided that such an exception exists and that a letter is to be provided then the following procedure applies:

Step	Action
1	Release of information form should be signed by the client.
2	Details of the anticipated uses of the letter must be provided.
3	Release of information form is given to the client.

Continued on next page

To Whom It May Concern Letters Requested by Clients, Continued

Facts vs. Opinions

In general, such letters should confine themselves to the facts of a client's care in this department. The more the letters depart from the facts and go into areas of opinion or speculation, the more likely it is that the information could be misused.

Approval

All To Whom it May Concern letters must be reviewed by the Clinic Supervisor for appropriateness.

If the Clinic Supervisor...	Then he/she will...
Approves,	Initial the letter.
Does not approve,	Not release the letter.

Required Paragraph

All To Whom it May Concern Letters will contain the following paragraph:

Any person receiving this letter should note that California Title 22 regulations prohibit him/her from giving this letter or a copy of this letter to anyone else, or informing anyone else of any of the information contained in this letter, without the client's specific written permission. Furthermore, the person about whom this letter is written (or his/her legal guardian or parent) has been informed that in giving this letter to anyone, he/she assumes a certain risk regarding the future safeguarding of the information.

Release at a Later Date

To Whom it May Concern letters should never be released at later times to any other parties, without the client's specific consent.

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Chapter 7 – General Chart Procedures

Overview

Chapter 7 is about standard chart requirements such as approved abbreviations, how to make chart corrections, and the need for legible handwriting to avoid disallowed payments.

Contents

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Abbreviations List

Policy

Only abbreviations in the Department's officially approved list of abbreviations may be used in DBH charts.

Programs or individuals wishing to add abbreviations to the list may submit them to the Quality Management for consideration. Consideration will be made on the basis of clarity and non-ambiguity.

Abbreviations

The following list shows common abbreviations used in this handbook as revised on April 1, 2016:

Abbreviation	Description
AA	Alcoholics Anonymous
ABC	Augmented Board and Care Homes
ABPP	American Board of Professional Psychology
ACOA	Adult Child(ren) of Alcoholics
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
admin.	Administration/administrative
Adol.	Adolescent
ad.-bro.	adoptive brother
ad.-dau.	adoptive daughter
ad-A / ad.-fa.	adoptive father
ad.-M / ad.-mo.	adoptive mother
ad.-sis.	adoptive sister
ad.-son	adoptive son
A /fa.	father
ADS	DBH Div. of Alcohol and Drug Services
A/H	Auditory hallucinations
AIDS	Acquired Immune Deficiency Syndrome
AKA	Also known as
A.M.	Ante Meridiem = morning
AMA	Against Medical Advice
AMAC	Adults Molested as Children

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
ANSA	Adult Needs and Strengths Assessment
approx.	approximately
appt.	appointment
APS	Adult Protective Services
ARMC	Arrowhead Regional Medical Center
ARMC-BH	Arrowhead Regional Medical Center – Behavioral Health
ARTS	Adult Residential Treatment System
ASAP	As soon as possible
ASI	Addiction Severity Index
assess.	assessment
assoc.	association
asst.	Assistant/assist
A/V/H	Auditory and Visual hallucinations
AWOL	Absent without leave
$\bar{a}$	Before
B.A.	Bachelor of Arts
BAL	Blood Alcohol Level
Basis-32	Behavior and Symptom Identification Scale
B&C	Board & Care
BCD	Board Certified Diplomate (Social Work)
B/F	Boyfriend
BFCS	Bilingual Family Counseling Services
BHRC	Behavioral Health Resource Center
BIB	Brought in by
B.I.D.	Twice a day (Latin - bis in die)
BM	Bowel movement
BP	Blood Pressure
bro.	brother
B.S.	Bachelor of Science
BUN	Blood Urea Nitrogen
CalWORKs	CalWORKs

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
CAFAS	Child and Adolescent Functional Assessment Scale
CA-QOL	California Quality of Life Scale
CANS	Child and Adolescent Needs and Strengths
canc.	cancelled
cap	capsules
CARF	Committee on Accreditation of Rehabilitation Facilities
CARS	Child Assessment Referral Services
CDSB	Casa de San Bernardino
CBC	Complete Blood Count
CBCL	Child Behavior Checklist
CCC	Community Client Contact
CCICMS	Centralized Children's Intensive Case Management Services
△	Change
CD	Chemically dependent
CERT	Fourteen day certification
CFE	Community Functioning Evaluation
CHF	Congestive heart failure
CID	Center for Individuals w/Disabilities
Cl., cl.	Client
Cl. Pl.	Client Plan
CLEP	Client Living Environmental Profile
clin.	clinician
Clin.Th.	Clinical Therapist
C&L	Consultation and Liaison
CM	Case Management
C.Mgr	Case Manager
CMDC	Chino Multiple Diagnosis Clinic
CNS	Central Nervous System
CODA	Codependents Anonymous
coll.	Collateral
conj.	Conjoint

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
CONS	Conservatorship
Consult	Consultation
cont.	continued
COTA	Certified Occupational Therapy Assistant
CPS	Child Protective Services
CSQ-8	Client Satisfaction Questionnaire
CSOC	Children's System of Care
CSOC-TAT	CSOC Technical Assistance Team
CSW Int.	Clinical Social Worker Intern
CT Scan	Computerized Tomography Scan
CYA	California Youth Authority
CWIC	Crisis Walk-In Clinic
dau.	daughter
day tx	day treatment
DAAS	Department of Aging and Adult Services
DBH	Department of Behavioral Health (San Bernardino)
D/C	Discharge, discontinue
DCS	Department of Children's Services
DD	Developmentally Disabled
DDX	Differential diagnosis
dept.	department
Des/Mtn	Desert/mountain region
DHCS	Department of Health Care Services
DPG	Deputy Public Guardian
Dr.	Doctor
DR	Department of Vocational Rehabilitation
DIP	Drunk in Public
DSM-5	Diagnostic & Statistical Manual (5th Edition)
DTI	Day Treatment Intensive
DTO	Danger to Others
DTR	Day Treatment Rehabilitative

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
dtr	Daughter
DT's	Delirium Tremens
DTS	Danger to self
DUI	Driving under the Influence
DWI	Driving While Intoxicated
DX	Diagnosis
ECT	Electroconvulsive therapy
EEG	Electroencephalogram
e.g.	exempli gratia = for example
EKG	Electrocardiogram
empl.	employment
EPS	Extra Pyramidal Symptoms
ESPDT	Early Periodic Screening Diagnosis & Treatment
E.D.	Emergency Department
E.R.	Emergency Room
esp.	especially
etc.	et cetera
ETOH	alcohol
eval.	evaluation
EVRC	East Valley Recovery Center (previously Phoenix)
ex-hus.	ex-husband
EYH	Enriched Youth Home
ex-wife	ex-wife
fam.	family
F.I.	Financial Interviewers
fos.-bro.	foster brother
fos.-dau.	foster daughter
fos.-hm.	foster home
fos.-A /fos.-fa.	foster father
fos.-M /fos.-mo.	foster mother
fos.-sis	foster sister

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
fos.-son	foster son
ft	feet
FYI	For your information
GA	Gamblers Anonymous
GAF	Global Assessment of Functioning Scale
GD	Gravely disabled
G/F	Girlfriend
G.I.	Gastrointestinal
gr.-dau.	granddaughter
gr.-A / gr.-fa. M	grandfather
gr.- / gr.-mo	grandmother
gr.-son	grandson
grp	group
grp. hm./GRH	group home
HCG	Human Chorionic Gonadotropin test
H.F.	Healthy Families Program
H/I	Homicidal Ideation
HIV	Human Immunodeficiency Virus
Hom. Id.	Homicidal Ideation
hosp.	hospital
hr	hour
H.S.	Bedtime, hour of sleep
ht.	height
hus.	husband
hx	history
IA	Interim Assistance
IBHS	Inland Behavioral Health Services
ICD-9-CM	Int'l Class. of Diseases-9-Clinical Modification
ICD-10-CM	Int'l Class. Of Diseases-10-Clinical Modification
ID Notes	Interdisciplinary notes
IDU	Injecting drug user

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Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
i.e.	That is
IEHP	Inland Empire Health Plan
IFP	Intensive Family Preservation Program
IM	Intramuscularly
IMD	Institute for Mental Disease
in	inch
incl.	including
ind	individual
IQ	Intelligence Quotient
IRC	Inland Regional Center
IV	Intravenous
IVDA	Intravenous drug abuse
IVDU	Intravenous drug user
JCAHO	Joint Commission on Accreditation of Hospital Orgs.
JESD	Jobs and Employment Services Department
JETS	Juvenile Evaluation and Treatment Services (W.V. Juv. Hall)
JJOP	Juvenile Justice Outpatient Program (E.V. Juvenile Hall)
JMHS	Jail Mental Health Services
L&C	Linkage & Consultation
LCSW	Licensed Clinical Social Worker
LFT	Liver function test
lg	large
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LLBMC	Loma Linda Behavioral Medicine Center
LLUMC	Loma Linda University Medical Center
LMFT	Licensed MFT
LMP	Last menstrual period
LNMP	Last normal menstrual period
LOC	Location
LPS	Lanterman-Petris-Short Act
LPT	Licensed Psychiatric Technician

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Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
LT	Long term
LTO	Locked Time Out
LVN	Licensed Vocational Nurse
M.A.	Master of Arts
mat.-gr. A /mat.- gr.-fa.	maternal grandfather
mat.-gr. M /mat.-gr.-mo.	maternal grandmother
max.	maximum or maximize
mcg	Microgram
M/Cal	Medi-Cal
M/Care	Medicare
M.D.	Medical Doctor
MDT	Multi-Disciplinary Treatment Team
meds	medication
METRO	Metropolitan State Hospital (Norwalk)
MFT	Marriage & Family Therapist
mg	milligrams
mgr	manager
MHCI,II,III,IV	Mental Health Clinician I, II, III, IV
M.H.S	Mental Health Specialist
MHS	Mental Health Services
MHSIP	Mental Health Statistics Improvement Program Consumer Survey
mins.	minutes
MJ	Marijuana
M /mo	Mother
MR	Mental Retardation
MRI	Magnetic Resonance Imaging
M.S.	Master of Science
M.S.W.	Master of Social Work
mtg.	meeting

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
NA	Narcotics Anonymous
N/A	Not Applicable
NAPA	Napa State Hospital
N/B	Non-Billable
neg.	Negative
NHIC	National Heritage Insurance Company (Medicare)
NKA	No Known Allergy
no.	Numero = Number
noc	Night
NPS	Non-Public school
NVS	North Valley School
OA	Overeaters Anonymous
occas.	occasional(ly)
1:1	Individual therapy/One to one observation
OT	Occupational Therapist
OTR	Registered Occupational Therapist
outpt.	outpatient
O/V	Office Visit
$\bar{p}$	After
pat.-gr.A /pat.- gr.fa.	paternal grandfather
pat.-grM /pat.- gr.-mo.	paternal grandmother
P.C.	Penal Code
P.D.	Police Department
PDD	Pervasive Developmental Disorder
PET	Psychiatric Evaluation Team
PET SCAN	Positron Emission Tomography Scan
Ph.D.	Doctor of Philosophy (psychology)
PHF	Psychiatric Health Facility
PL	Placement

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Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
Pl.Dev.	Plan Development
pl. ther.	Play therapy
P.M.	Post Meridiem = after noon
PMS	Premenstrual Syndrome
po	Oral/by mouth
POE	Proof of Eligibility
POR	Problem Oriented Record
pos.	positive
PP	parent partner
prn	Pro re nata = whenever necessary, as needed
prob.	problem
PSH	Patton State Hospital
Psych Triage	Psychiatric Triage (ARMC)
Psy.D.	Doctor of Psychology
P.T.	Psychiatric Technician
pt.	patient
pta	prior to admission/arrival
PTSD	Post-Traumatic Stress Disorder
Pub. cons	Public Conservator
PG	Public Guardian
Pvt. cons	Private Conservator
Pvt. M.D.	Private Medical Doctor
Px	Prognosis
q	every
QID	Four times a day
R&B	Room and board
RCC	Redlands Counseling Center
RCCS	Rancho Cucamonga Counseling Services
RCH	Redlands Community Hospital
RCL	Rate Classification Level
re	regarding

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
rec'd.	received
reg. Ed.	regular education
rel-shp.	relationship
ret.	return
RFT	Renal Function Test
RGH	Riverside General Hospital
RN	Registered Nurse
R/O	Rule Out
ROWE	Reach Out West End
Rpt.	Reports/Repeat
RSP	Resource Specialist Educational Program
RTC	Return to clinic
RWD	Recovery, Wellness, and Discovery
Rx	Prescription
2nd CERT	Second 14 day certification
St. B's	St. Bernardine's Hospital
SACH	San Antonio Community Hospital
SARB	School Attendance Review Board
SART	Screening, Assessment, Referral, and Treatment
SBCDPH	San Bernardino County Department of Public Health
SBCH	San Bernardino Community Hospital
sc	Subcutaneous
schiz.	Schizophrenia or schizophrenic
SDC	Special Day Class
SDI	State Disability Income
SED	Seriously Emotionally Disturbed
SELPA	Special Education Local Plan Area
SHAC	Shandin Hills Adolescent Center
S/I	Suicidal Ideation
sib.	sibling
SIR	Special Incident Report (Children in placement only)

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
sis.	sister
sm.	small
SMA	Serum Metabolic Analysis
SMI	Seriously Mentally Ill
SNF	Skilled Nursing Facility
S.O.	Significant Other
SP	Suicide precautions
Sp.	Spanish
SPAN	San Bernardino Partners Aftercare Network Program
SPMI	Seriously and persistently mentally ill
S&R	Seclusion & restraint
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSRI	Selective Serotonin Re-uptake Inhibitor
ST	Short term
STAR	Supervised Treatment After Release
STAR-LITE	STAR - Less Intensive Treatment Environment
STAT	Immediately
STEP	Systematic Training for Effective Parenting
st.-bro.	step-brother
st.-dau.	step-daughter
st.-A /st.-fa.	step-father
st.-grM /st.-gr.- mo.	step-grandmother
st.-M /st.-mo	step-mother
st.-sis.	step-sister
st.-son	step-son
Svc.	service
Sx	symptoms
tab.	Tablet

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
TAD-ESP	Transitional Assistance Department--Employment Services Program
TANF	Temporary Assistance for Needy Families
T.B.	Tuberculosis; tubercle bacilli
TBS	Therapeutic Behavioral Services
T/C	Telephone Call
TCON	Temporary Conservatorship
TD	Tardive Dyskinesia
TFT	Thyroid function test
THC	Marijuana/Tetrahydrocannabinol
ther.	therapy
thru.	through
T.I.D.	Three times a day
trng.	training
tx	treatment
tx. pl.	treatment plan
tx. pl. conf.	treatment plan conference
tx. tm.	treatment team
UBH	United Behavioral Health
UCCC	Upland Community Counseling Center
UDS	Urine drug screen
unk.	unknown
UR	Utilization Review
U/A	Urinalysis
V.A.	Veterans Administration
VDRL	Venereal Disease Research Laboratory
V/H	Visual hallucinations
Voc. Rehab.	Department of Vocational Rehabilitation (see DR)
VOL	Voluntary
w/ or $\bar{c}$	with
WBC	White blood cells (white blood cell count)
W&I	Welfare and Institutions

Continued on next page

Abbreviations List, Continued

Abbreviations (continued)

Abbreviation	Description
w/in	Within
wk	week
W/o or $\bar{s}$	Without
WNL	Within Normal Limits
WRIT	Writ of Habeas Corpus
Wt.	Weight
WVDC	West Valley Detention Center
y/o	year old
yr.	year
YSR	Youth Self Report
½ bro.	Half-brother
½ sis.	Half-sister
1N/1˚	Primary
2N/2˚	Secondary
5150	72-hour evaluation for adults (mental illness)
5170	72-hour evaluation for persons inebriated
5250	14-day certification hold
5585.5	72-hour detention-section 5150 of W&I for minors
L/Lt	Left
R/Rt	Right
i	One tablet
ii	Two tablets
↑	Increase
↓	Decrease
ø	None
#	Number
+	Plus or positive
-	Negative
&	And
@	At
♀	Female
♂	Male

Continued on next page

Co-Signatures

Co-Signatures Required	All of the following non-regular employee interns will have all billable chart entries co-signed by an appropriate supervisor: • Volunteers • Community Service Aides **Note:** In the case of interns, this supervisor must be licensed.
Not Included	This is not required for MFT post-degree "interns" who are DBH employees.
Other Entries	Other types of entries may be signed as well, if desired.
Non-Licensed OT's	Non-licensed OT's will have all billable chart entries co-signed until licensure is achieved, and COTA's will have all billable chart entries co-signed by an appropriate supervisor during the first year of DBH employment.
ID Notes Written by Clerks	Clinic Supervisors (or designees) will co-sign administrative chart closure ID notes written by clerks.

Continued on next page

Corrections

Making Chart Corrections	Correcting items written or typed in the chart is done by: • Drawing a single line through the material deleted • Writing the replacement material next to it, with the word “error” • Initialing the change
Example of Correction	An example of appropriate correction is: • ~~touched~~ fondled error cee
White Out	White out or other means of correction should never be used in the chart.

Continued on next page

Legibility

Policy

Everything handwritten in the chart must be legible because it:
- Is useful for other clinical staff
- Can be read by auditors

Auditors

Auditors may disallow payment for services for which documentation is illegible.

Continued on next page

Medication Support Services Interdisciplinary Notes – Ink Usage

Type of Ink Used	Only black and blue ball-point ink will be used in the chart in order to: • Minimize potential water damage. • Maximize copy quality for copying and microfilming.

Continued on next page

Persons Allowed to Chart

Restricted Charting

Charting of the following items in outpatient charts may only be done by the assigned provider for the service or chart at issue:

- Services
- No-Shows
- Rescheduling
- Chart Closure

Assigned Providers

The following persons are considered assigned providers:

- Clinical therapist
- Non-staff intern
- Physician
- Clinical volunteer
- Mental Health Specialist
- Nurse
- Psych Tech
- Licensed Vocational Nurse
- Social Worker II
- Occupational Therapist
- Alcohol and Drug Counselor
- Pre-degree Interns
- Parent Partners

Day Treatment Intensive Charts

In day treatment intensive charts, only persons assigned to do so by the Clinic Supervisor or day treatment coordinator may write DTI daily or weekly summaries.

Day Treatment Intensive Weekly Summaries

Weekly summaries must be written by or co-signed by an LPHA who is an:

- Physician
- RN
- Licensed registered, or waivered clinician
- And who is DTI staff or director of the program

Other Staff

Other staff who might write notes for co-signature would include:

- O.T.'s
- Non-staff interns
- Mental Health Specialists
- Psych Techs

Continued on next page

Signatures

General Requirements

All entries in the client's chart must be legible and contain the following mandatory criteria:

1. Date of Service
2. The signature of the person providing the service (or electronic equivalent)
3. The person's type of professional degree, licensure or job title (job title is only applicable to non-licensed staff)
4. The date the documentation was entered in the chart

To ensure compliance, the signer will print (or stamp) their name and title as shown in the table below and signatures will follow the approved formats as illustrated:

Staff	Signature
Physicians	John Smith, M.D. or D.O.
Psychologists	John Smith, Ph.D. or PsyD
Licensed Clinical Social Workers,	John Smith, M.S.W, LCSW or John Smith, LCSW
Licensed Professional Clinical Counselors	John Smith, M.A., LPCC or John Smith, LPCC
Licensed Occupational Therapists	John Smith, O.T.L
Licensed Psychiatric Technicians	John Smith, P.T.
Interns	John Smith, M.A., Psychology Intern John Smith, B.S.W., Social Work Intern John Smith, B.A. MFT Trainee
Non-Licensed/Non-Registered Providers	John Smith (degree if any), job title

The above table provides examples of some of the DBH providers and does not represent all disciplines.

For chart documentation, the Board of Behavioral Sciences has additional requirements for pre-licensed staff regarding the use of abbreviations. The table below illustrates the only approved and accepted printed and signed name and titles for the following disciplines:

Discipline	Printed Name and Title	Signature
Registered Associate Clinical Social Worker	Jane Smith, Registered Associate Clinical Social Worker	Jane Smith, Registered Associate Clinical Social Worker, or Jane Smith, ASW
Registered Associate Marriage and Family Therapist	Jane Smith, Registered Associate Marriage and Family Therapist	Jane Smith, Registered Associate Marriage and Family Therapist, or Jane Smith, AMFT
Registered Associate Professional Clinical Counselor	Jane Smith, Registered Associate Professional Clinical Counselor	Jane Smith, Registered Associate Professional Clinical Counselor, or Jane Smith, APCC

Chapter 8 – Financial Agreements and Billing

Overview Chapter 8 discusses standard billing requirements to help ensure reimbursement.

Contents

Continued on next page

Time Units

How Billing is Done	Some services are billed by the minute and others are by the hour depending on the service type provided.

Continued on next page

Activities of Clerks

Not Billable	Interactions of clerical staff with clients are never billable as Medi-Cal services.

Continued on next page

Assessment

No Limit	There is no longer a limit on the number of assessment billings per episode.

Continued on next page

Auditing

Requirements

Time for supervision on a case or for audits is not billable as a client service or as Plan Development. If auditing results in a chart note indicating a change in the services plan or direction of treatment, then the time is billable.

Continued on next page

Long Term Client

Requirements A DBH client is considered a long term client if planned services are expected to be rendered beyond the 60 day intake period.

Continued on next page

Case Management Plan Development

Coding

The State Rehab manual lists Case Management Plan development as part of Linkage and Consultations. CM Plan Development notes are therefore headed "CM-L&C-Pl.Dev." and "CM-L&C-Pl. Dev. is billed using the CDI code for L&C (561). CDI code 521 is for MHS Plan Development only.

Continued on next page

Chart Closure

Billing Chart Closure

The billable service involved in chart closure is Plan Development, in the form of:

- Treatment planning.
- Monitoring of client progress.
- The following service can therefore be billed as Plan Development by clinical staff:
  - Discussions regarding the decision to terminate a service.
  - Charting the final ID note.
  - Filling out the discharge summary, as long as the summary contains some legitimate Plan Development.

Follow-Up Care

The following applies to billing for follow-up care:

If...	Then...
You have planned some follow-up care with the client or are making a referral upon termination, and you record this in the discharge summary,	It is billable.
You are doing a "true" termination with a client, and you decide with the client that no further treatment is needed, and you record that on the discharge summary,	It is billable.
If the client "disappears" and you try to contact him/her, but fail, and you fill out the discharge summary, since there is not planning or monitoring that can be done,	Filling out the discharge summary is not billable.

Last Session and Discharge Summary

It is preferable that the time for filling out the discharge summary be lumped together with the last client session. Just as other charting is combined with session time for billing purposes. If this is not possible, and a discharge summary is filled out later, a separate plan development billing can be made.

Continued on next page

Combing Service, Charting, and Plan Development Time

Example

Charting time and minor plan development time occurring before, after, or during the service can be lumped in with the service as one charge.

An example of charting minor plan development time after the service is as follows:

If the...	Then the...
Service was 50 minutes, the charting time for that session was10 minutes, and you spent 5 minutes altering a milestone at the same time,	Billing should be for 1:05 (one hour and five minutes).

Minor and Major Plan Development

The following chart contains information about minor and major plan development:

If...	Then...
Minor activities might involve minor revision of a Client Plan or planning with co-staff a particular or changed treatment approach to be used in the upcoming session ID note,	Can be combined with a treatment billing.

Note: There is no billing for Plan Development allowed for Day Treatment services.

Continued on next page

Crisis Intervention

Billable Time Consecutive crisis interventions can be billed (for up to an eight-hour total per day), as long as each note reflects that the crisis intervention was necessary and appropriate.

Continued on next page

Crisis Stabilization Unit

General

Crisis Stabilization shall be provided on site at a licensed 24-hour health care facility or hospital based outpatient program or a provider site certified by DHCS or an MHP to perform crisis stabilization.

Claiming Unit

Crisis Stabilization shall be based on hours of time. Partial blocks of time shall be rounded up or down to the nearest one hour increment except that services provided during the first hour shall always be rounded up. A maximum number of hours claimable in a 24-hour period shall be 20 hours.

Note: "Crisis Stabilization" means a service lasting less than 24 hours. Documentation of services, which indicate a service lasting 24 hours or more, does not meet the service definition of "Crisis Stabilization".

Staffing

If Crisis Stabilization services are co-located with other specialty mental health services, persons providing Crisis Stabilization must be separate and distinct from persons providing other services. Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services.

Note: Staff included in required Psychiatric Inpatient, PHF, or Nursing Facility ratios or minimums shall not be counted toward meeting Crisis Stabilization staffing as evidenced by a clear staffing/schedule of assignments as an audit trail.

Lockouts

Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission. No other Specialty Mental Health Services are reimbursable during the same time period this service is reimbursed.

Note: Necessary Case Management Services delivered to a patient within a CSU must be delivered by separate and distinct staff not involved with delivering the "Crisis Stabilization" services, or serving to meet Crisis Stabilization staffing ratios and minimums.

Continued on next page

Daily Limits

Limit for Billing	A clinician cannot bill for more minutes in one day than he/she works.

Continued on next page

Day Treatment

General

Day treatment is an all-inclusive service, meaning that:

- Staff cannot bill any day treatment time separately from the day treatment daily charge, including Plan Development.
- Similarly, one cannot bill any time to day treatment for an activity, which occurs outside the scheduled day treatment day.

Plan Development

Staff doing necessary Plan Development regarding day treatment services cannot bill those specific minutes separately from the daily day treatment charge.

Field Trips

Field trips occurring outside the normal day treatment half-day cannot be billed to day treatment. If during that outing time a necessary service occurred for a specific client, like crisis intervention, that service could be billed. (Also see outings below).

Assessment

Assessment performed with regards to day treatment can be billed as follows:

If Assessment performed...	Then...
After the individual becomes a day treatment client it is considered part of the daily charge for day treatment,	It cannot be separately billed.
Before the person is a day treatment client,	It can be billed.

Continued on next page

Evaluation

Term no longer Required	This term refers only to the Community Functioning Evaluation, which is no longer required.

Continued on next page

Groups

General

This section covers psychotherapy, Rehab/ADL, and Medication. The basic procedure is as follows:

Note: Adequate justification must be included in the note telling why more than one provider was needed.

<table>
<tr><th>Step</th><th colspan="3">Action</th></tr>
<tr><td>1</td><td colspan="3">Billed time for groups is the sum of the:
• Group time.
• Charting time for all charting done by that person on group clients.
• Associated, minor plan development time spent by that person on all group clients.</td></tr>
<tr><td rowspan="4">2</td><td colspan="3">Group size is also indicated. For a group of six clients seen for 90 minutes by two staff time would be billed as follows:</td></tr>
<tr><th>Therapist</th><th>Work</th><th>Time Billed</th></tr>
<tr><td>A</td><td>Assuming that Therapist A spent a total of 30 minutes in charting and 10 minutes in plan development,</td><td>Therapist A’s time would be 2:10 (90 + 30 + 10 = 130 minutes = 2 hours and 10 minutes or 2:10).</td></tr>
<tr><td>B</td><td>In group 90 minutes and spent a total of 20 minutes charting and 5 minutes in plan development,</td><td>Therapist B’s time would be 1:55 (90 + 30 + 5 = 115) 115 or 1:55.</td></tr>
<tr><td>3</td><td colspan="3">In the column for “Hrs.: Min.” on the ID note form, the times for all staff are listed, using their initials, plus (C=) the total number of clients that were in the group in the above example, the “Hrs.: Min.” column would contain:
• CE = 2.10
• BB = 1:55
• C = 6</td></tr>
<tr><td>4</td><td colspan="3">The same numbers are listed on all of the chart notes therapist A writes, regardless of how much attention any given client received in group or how much time was spent on that individual chart. Significant amounts of time that a client was out for any of the following reasons would be subtracted from that client’s time only:
• Late
• Left early
• Was taken out of group for some other purpose</td></tr>
<tr><td>5</td><td colspan="3">If there was only one therapist in this example his initials can be omitted (i.e. 2:10).
• C = 6</td></tr>
</table>

Continued on next page

Groups, Continued

General (continued)

Step	Action	
6	Do not add the times of therapist A and B together and enter that total anywhere.	
7	CDI. Continuing our example, on one CDI, all six clients for the group are listed. For billing purposes, it does not matter who is primary staff and who is co-staff.	
	Therapist A	Therapist B
	Enters the same 2:10 for all of the group clients, in the Duration or Primary Staff Time column.	Enters 1:55 for all of the group clients, in the Co-staff column. (See example CDI below.)

CDI's for more than three Staff

The following considerations are made when there are three or more staff:

- Since SIMON can only register two therapists per service, a third therapist would follow the same time reporting method, but would submit his/her time on a separate CDI, listing his/her total time for all group clients, with the same total group count that is on the first CDI.
- A third and fourth therapist could submit their time together on the additional CDI as staff and co-staff, etc.

Late Clients

If a client is not present for a significant portion of the group, the time missed is subtracted from the billing for that one client. Time missed can be attributed to:

- Being late
- Being taken out of the group to see the Physician, etc.

Example for Late Clients

In the example above, if one client was 30 minutes late, then his chart note and CDI line would have:

- 1:40 (instead of 2:10) for primary staff.
- 1:25 (instead of 1:55) for co-staff.
- All other client's chart notes and CDI lines would still be as described above.

Clients out of Group for Meds Visit

In this situation, subtract the time the client is out of the group from what his/her billed time would have been had he/she been in the group the whole time (just as if the client had been late; see above).

Continued on next page

Groups, Continued

Applicability Method	This method of notating billed time for groups is applicable for all services that accept a SIMON group billing.
Contract Agencies	Contract agencies bill only Medi-Cal clients but enter the actual group count: Medi-Cal clients plus other clients.

Medications Support Groups

Only the following persons can bill for Medication Support Services provided in a group:

- Physician's
- RN's
- Psych. Tech's

The method of identifying group session time on the ID note and CDI above is applicable to ALL Groups, including MSS groups.

Medications Education Groups

Medications education can be provided either under:

- Medication Support Services
  - o Billed as MSS-Meds. Ed. Group
- Rehab ADL in MHS
  - o Billed as Rehab/ADL – Meds. Ed. Group

Who can Bill

The following factors must be considered when billing for medications education groups:

- Only Physician's, RN, and Psych Techs can bill MSS.
- Clinicians can only bill for medications education under Rehab/ADL.
- If Alternatively:

If...	Then...
A physician and a clinician do a medications education group together,	It can be billed as Rehab/ADL with one chart note and using one CDI. OR, Alternatively, the: • Physician could bill MSS and chart on all clients. • Clinician could bill Rehab/ADL (and chart on all clients). • The two of them would turn in separate CDI's billing all clients and using the total group count on both CDI's.

Continued on next page

Groups, Continued

Groups with Psychotherapy and MSS

Groups with Psychotherapy and MSS must follow the table below:

If...	Then...
A clinician and a physician are both present for the entire group time in a group involving some medications support and some psychotherapy,	The time would be divided between MHS and MSS.
Within a 60 minute group, the physician was doing Medication Support Services in the group with various clients for 50 minutes (not taking clients out of the group for MSS services),	The clinician would bill each client for: • 10 minutes of MHS group therapy plus • All charting time plus • All plan development time for that MHS service. The physician: • Can be included as co-therapist for that 10 minutes of therapy (if present). • Would bill a 50 minute MSS group as the only staff present.

Multi-Family Groups

For this type of group, follow the procedure outlined in Parenting Groups section below.

Parenting Groups

Parenting groups may sometimes consist of some parents without their own charts who have children with charts, plus some parents who have their own charts but who do not have children with charts.

If...	Then...
A parent in this group does not have a chart but has a child with a chart,	The child is billed for collateral time: • The time spent on him/her in group plus • Charting plus • Plan development for that chart only.
The remaining parents do have their own charts,	They are billed for group for the remaining time.

Continued on next page

Groups, Continued

Computing Billable Time

The sum of the actual collateral time in group (without charting or plan development) is subtracted from the group time and the remainder is used for group billing.

Example

For example, in a group of two parents without charts (but who had children with charts) and three who had their own charts

If...	Then...
The group time were 60 minutes,	• The charting and plan development time for the three with their own charts 15 minutes • The collateral time spent in group on the two without charts 6 and 7 minutes, respectively • Their charting and plan development time 5 and 8 minutes, respectively, you would make two collateral billing, for 11 minutes (6+5) and 15 minutes (7+8) and three group billings for 1:02 (60-13+15) reported with a group count of 3 • Note that the group count is only the number of parents with charts and not the total number or parents
There is only one parent with his/her own chart (who does not have a child with a chart),	He/she will be billed for : • "MHS-Ind." (rather than for group with a group count of 1), of the time spent in-group specifically on him/her • Charting and minor plan development for that chart only

Parent and Children with Charts

Parents who have their own charts and also have children with charts could be billed either way.

Continued on next page

Groups, Continued

Consultation of Groups

If more than one provider facilities a group session there are two acceptable options for the documentation of the services:

- Each facilitator writes a separate note documenting their participation to the group and billable time.
- Both facilitators sign one service note with co-billing documented.

Note: Use of co-facilitation of groups must include documentation which substantiates both the clinical need for multiple providers and the active participation of both providers for the service not to be at risk for disqualification.

Continued on next page

Interpreter Services

Who may Bill Interpreting	Interpreter services are not billable by clinical staff.

Continued on next page

Lockouts

Reference See the State Manual Lockouts Chart below for services that cannot be billed for that session on the CDI.

MENTAL HEALTH MEDI-CAL BILLING MANUAL
Chapter 7: Edits, Lockouts and Overrides

TABLE 7-1: SD/MC TABLE OF MULTIPLE-SERVICE BILLING EDITS[131]

Mode of Service	12, 18	12, 18	12, 18	12, 18	12, 18	12, 18	12, 18	05	05	12, 18	12, 18	07-09	07-09	05
Service Function	10-19, 30-59	60-69	01-09	85-89	81-84	95-99	91-94	65-79	40-49	70-79	20-29	10-18	19	20-29
	MH/TBS Services (5)	Med Support (1)	CM / Brokerage (4)	DT Intensive Full Day	DT Intensive Half Day	DT Rehab Full Day	DT Rehab Half Day	Adult Residntl	Adult Crisis Residntl	Crisis Intvntn (2)	Crisis Stabilizn ER & UC (3)	Hospital Inpatient	Hospital Inpatient Admin Day (6)	PHF
MH/TBS Services (5)				T	T	T	T	T	A		T	A	L	A
Med Support (1)											T	A	L	A
CM/Brokerage (4)												I	I	I
DT Intensive Full Day	T			L	L	L	L		A		T	A	L	A
DT Intensive Half Day	T			L	L	L	L		A		T	A	L	A
DT Rehab Full Day	T			L	L	L	L		A		T	A	L	A
DT Rehab Half Day	T			L	L	L	L		A		T	A	L	A
Adult Residential	T							L	A		T	A	L	A
Adult Crisis Residential	A			A	A	A	A	A	L	A	A	A	L	A
Crisis Intervention (2)									A		T	A	L	A
Crisis Stabilztn ER&UC(3)	T	T		T	T	T	T	T	A	T	T	A	L	A
Hospital Inpatient	A	A	I	A	A	A	A	A	A	A	A	L	L	A
Hosp Inpatient Administrative Day (6)	L	L	I	L	L	L	L	L	L	L	L	L	L	L
PHF	A	A	I	A	A	A	A	A	A	A	A	A	L	L

- **I** Institutional Limitations - Audit
- **L** Lockout - Services that may not occur on the same day
- **A** Lockout except for day of admission
- **T** Lockout during actual time service is provided - audit, not a computer edit
- (shaded) Multiple services may be allowed on the same day, limited by the maximum time allowed.

(1) Maximum of 4 hours (240 Minutes) per day
(2) Maximum of 8 hours (480 minutes) per day
(3) Maximum of 20 hours per 24 hour period
(4) Maximum of 24 hours (1440 minutes) per day
(5) Maximum of 2878 minutes per day
(6) An Administrative Day may not be billed on the day of admission

[131] Lockout specifics are contained in Cal. Code Regs., Title 9, Division 1, Chapter 11.

Reference: DMH Mental Health Medi-Cal Billing Manual (July 17, 2008)

Continued on next page

Multiple Staff

Multiple Staff Providing Service

Service other than group may also be provided by multiple staff and billed using the staff/co-staff columns on the CDI. There would be one ID note, including the names and disciplines of all co-staff and why they were present.

Note: Use of co-facilitation of groups must include documentation which substantiates both the clinical need for multiple providers and the active participation of both providers for the service not to be at risk for disqualification.

Continued on next page

Occupational Therapy

General

OT's and non-OT's can be mixed as staff and co-staff on any of the CDI's, but see the Department's Billing and Scope of Services document for the scope of practice all persons billing.

Continued on next page

Outings

General

Field trips, camping trips, and other outings may include billable time if they provide:

- Life skills training (rehab/ADL individual or group).
- A milieu in which therapeutic issued are addressed directly with an individual client (individual therapy) or with groups of clients (group therapy).

Services

In order to bill for Mental Health Services for outing with outpatient clients or for outings with day treatment clients taking place outside the normal day treatment day, there must be an approved Mental Health Services service plan in place for each client billed, with objectives to which the outing relevant.

Charting

The following elements are essential in charting outings:

- An outing may not be charted as if it were one long group for all clients present.
- Only the time spent in an actual, defined billable activity is billable.
- Clients participating in an activity group who are doing separate projects (leather, art, etc.) must be billed as rehab/ADL ind. and not group, because there was no group activity.
- Clients on an outing what are each doing their separate “thing” are not participating in a group for those minutes.
- Each separate service and billing (individual therapy, rehab/ADL group etc.) for each separate client must have its’ own separate chart note explaining what was done during the service in attempting to further the client’s progress toward the objectives.

Audit Considerations

Auditors will be looking especially closely at the need for day treatment clients to receive additional Mental Health Services. In charting, to the extent possible, staff should indicate separately therapeutic activities or issues that occurred during the transportation.

Billing

Outings with day treatment clients conducted within the day treatment day are not separately billed. Outing billing will usually be for:

- Rehab/ADL group.
- In some cases, rehab ADL Ind.
- Although psychotherapy services may also be provided during outings if done by qualified staff.
- If multiple services are billed for any given client, care must be taken that the billing times do not overlap (“double-billing”).

Continued on next page

Outings, Continued

How Much Time May be Billed

The total outing time may be billed, although times during which staff was not engaged in therapeutic activities should be subtracted from the total time before billing. These activities include:

- Meal times
- Break time
- Sleeping
- Time just watching or not interacting with clients.
- Non-therapeutic portions of the transportation time.

Times Billed by Each Staff

The times billed by each staff member for the outing may be different. Since eight hours are assumed for sleep, each staff can bill for a maximum of 16 hours per day. Additionally, any time on an outing for which staff is not being compensated cannot be billed to Medi-Cal.

Staff per Group

Because SIMON still not accept more than two staff per group billing, outing groups may be broken up into smaller units, each in the charge of two staff, multiple CDI's may be used as in a previous section.

If...	Then...
Clients from different programs are mixed together for an outing,	They are separated by program for billing, but the total group size of the group (or sub-group) of which they were a part is used as the group count (including all clients from all programs who were in that group or subgroup), even if that is larger than the number of clients billed on that particular CDI.

Continued on next page

Preparation for Treatment

Non-Billable Time

Time spent in the following activities are not billable as client services or as plan development:

- Finding a treatment space.
- Procuring or preparing materials to be used in treatment.
- Arranging for co-staff participation in treatment, etc.

Continued on next page

Psychological Testing

Process

All of the following activities are billed to the code for psychological testing:

- Test administration
- Scoring
- Test interpretation
- Report writing time

Limits

There is no limit on the number of:

- Assessments for a client
- Separate billing for a given testing episode

Chart Notes

Each separate billing (one for the administration, the next day for the scoring, etc.) must have a separate chart note indicating what was done.

Continued on next page

Reports Outside the Department

Billing when Other Agencies Involved

The following provisions apply to billing when other agencies are involved:

- Linkage and Consultation may be used to link clients with needed services, including mental health and other social services.
- Plan Development covers only activities relating to the planning and coordination of the mental health services themselves.

Non-Billable Reports

Reports that are filled out or written for the benefit of a third party (not the Medi-Cal beneficiary) are not billable to Medi-Cal and a non-billable code should be used. Examples of such reports would include but are not limited to:

- Social Security Insurance Evaluation Forms
- Jury Duty Excuses
- Letters requested by School Programs in order to determine eligibility
- CPS Report Forms

In general terms, if the service being provided is to aid another agency in determining client eligibility, it is not billable to Medi-Cal.

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Service Location

Service Location Codes

The following provisions apply to service locations:

- There are no restrictions as to place, day, or time of day of service delivery (except for the residential services). Services may take place over the phone and/or on weekends
- The service locations on the CDI and the ID notes are the same, as follows:
  - Clinic (DMH Site)
  - Field/OOC/Jail (if no other codes apply)
  - OOC (out-of-clinic)
  - Phone
  - Non-Face-To-Face (preempts all other codes)
  - Home
  - Satellite (see Clinic Supervisor for definition)
  - School
- Use the following table to determine which codes to use:

If your service was...	Then...
Not performed face-to-face with a client or a collateral person,	Code your location first and the client's second as 3: • Example, 1-3. • All services delivered by phone are coded X-3. ***Note:*** The accompanying "1" or other code that represents provider location should never be entered In SIMON if no client is present. Otherwise, it translates into an "Office" or other visit.
Performed face-to-face with a client or a collateral person,	Choose from among codes: • 1, 4, 5, 6, and 2. • Using code 2 only as a last resort, if no other codes apply.
Performed as a crisis in the field,	It is preferable to code as: • 4, 5, 6, or 2, rather than 7. • If it is reasonable to do so.
If you think one of your service sites might be a satellite,	There are complex regulatory definitions, and your Clinic Supervisor should be consulted.

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Staffing or Team Meetings

Charting with Multiple Staff	This practice is seen as an audit risk when billed and should not be billed pending further information from DHCS.

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Subpayee Services

Not Billable

Doing subpayee functions is not billable (but of course helping the client work on budgeting can be billed as rehab/ADL).

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Time of Charting

Determining Charting Time

Use the following chart to determine how to bill charting time:

If...	Then...
You can do the charting before you turn in the CDI for the service itself,	Include the charting time in that service, even though you charted on a different day. Notes should be written no later than the next day and filed in the chart no later than 72 hours after the service.
You chart after you turn in the CDI with the billing for the service time itself,	Bill the charting time separately as Plan Development. Make clear on the note, however, • The minutes billed for the service itself (and the date of the service). • The minutes billed for the charting as Plan Development (and the date of the charting). • For example, head the note itself: o “7/23/06 0:06 MHS-Pl. Dev.” and in the note, “This note is for 0:54 billed for Ind. ther. 7/22/06.
More than one service occurs in one continuous session (collateral and individual, for instance),	There should be two separate ID notes and two separate billings each of its own proper amount of charting and plan development time added, if any.

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Travel

How to Bill Travel Time

The following considerations apply to billing for travel time:

- Travel time is not billed alone but always as part of a defined client service.
- The time billed for a service should be consistent with the content of the ID note.
- Travel time need not be separately identified in all cases, but if travel is a large enough proportion of the total time that the actual service described in the ID note does not seem appropriate to the time billed, then the ID note should include a statement such as:
    - "40 min. travel" or "33 min. travel"
- Reporting a location other that the clinic does not imply that travel took place. Travel not connected with a charted service of some sort is not billable.

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Treatment of Substance Problems

General

Substance diagnoses are acceptable as secondary diagnoses, but treatment services aimed primarily or substantially at the treatment of substance problems are not billable as mental health services.

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Uniformity

Time Entered on CDI	The time entered for a session on the ID note MUST be the same time that is billed for that session on the CDI.

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Use Actual Time

What Time Should be Billed

The time billed is the actual time used for billable services:

- 27 minutes (0:27), 33 minutes (0:33), etc.
- Do not use a standard session time (like 50 minutes) or a standard time for charting (like 10 minutes), but report the actual time used for that session and charting for that client.
- It is fraudulent to "pad" billing, by for example, adding 15 minutes for charting when you only spend 7 minutes charting.

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Chapter 9 – Forms

Overview

Chapter 9 is about forms in other languages and the order of the forms in a chart.

Contents

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Forms in Other Languages

Purpose

In order to promote client participation in treatment and client understanding of the care process, certain chart forms may be issued in languages other than English.

Procedures

The following table details the procedures for using forms in other languages:

Step	Action
1	Only translated forms issued by Quality Management will be placed in the chart.
2	When a translated form is placed in the chart, the corresponding English version will always be filed with it.
3	In the case of those forms requiring only signatures the: • English and translated versions may be copied back-to- back. • Translated version would be signed. • One not used would have a diagonal line drawn through it.
4	In the case of those forms which have important content filled in, such as the Coordination Plan and Service Plan, the: • Clinician will fill in the non-English version in the other language. • Signatures will go on the non-English version. • Clinician will fill out a corresponding English version which will be filed in the chart with the non-English version.

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Order of Forms in an Open Chart

Form Included

All forms that could possibly be used in an open MHS chart are listed below. To use this list as a "procedure tool" make a copy and highlight ONLY those forms that are used in your clinic charts.

Section Number	Section Name	Form Names
1	Plans-Orders-MEDS	• Out-of-County Authorization • Client Recovery Plan (Spanish) • Care Necessity Form • Diagnosis Sheet • Outpatient TX Authorization Request (Approved) (Adult; Child)
	TAB	
1		• ALERT SHEET for Allergies • Outpatient Medication Record • Medication Consent Form (Spanish; Vietnamese) • Abnormal Involuntary Movement Scale (AIMS) Form • Physical Assessment
2	ID Notes	• Interdisciplinary (ID) Notes • Medication Visit Interdisciplinary Note • Services Team Actions (File all ID Notes Chronologically) • Universal Referral Form • "This Chart Has Been Thinned" (a reminder)
	TAB	
	Evaluation-Admission **Do Not** "thin" this section.	• Adult Clinical Assessment • Client Resource Evaluation • Adult Psychiatric Evaluation • Child/Adol Psychiatric Evaluation • Child/Adol Clinical Assessment • Client Recovery Evaluation • Healthy Homes Assessment

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Order of Forms in an Open Chart, Continued

Form Included (continued)

Section Number	Section Name	Form Names
3	Miscellaneous	• All School records-Adolescents • Group Home Agreement • Social Security Letters of Ruling • Determination, Sub-payee Orders • Change in Payment Form
4	Consents/MISC	• Consent of Outpatient Treatment (Spanish; Vietnamese) • Medical Care Authorization for Minor (Spanish) • Consent to Sound or Video Record (Spanish) • Behavioral Health Tele-Service Consent • Release and Hold Harmless Agreement • Children's Interagency Authorization to Exchange Confidential Health Information (PHI) (Spanish) • Notice of Privacy Practices Acknowledgement (Spanish; Vietnamese) • Advance Directive Notice (Spanish) • Delegation of TX Consent • Advance Beneficiary Notice (ABN) • Placement Application
5	Correspondence	• Index for Confidential Info Released (Attach copies of information released) (Attach copies of claims, form, etc.) • Authorization to Release Confidential (PHI) (Spanish; Vietnamese) • Legal Papers: o Notice of Actions (NOA's) o Conservatorship, Court Orders, Guardianship o Treatment Attendance letters to patient from clinic o Subpoenas-Court Orders for records

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Order of Forms in an Open Chart, Continued

Form Included (continued)

Section Number	Section Name	Form Names
6	Divided by Tabs	• (On TOP of tab section) • Registration Form/Initial Contact Form • Client Episode Summary Form
		TAB
	Identification	• Face Sheet SIMON report 140
		TAB
	Physical	• Physical Exam (if available)
		TAB
	Psych-Testing	• Psych Testing report (if available) • General Report • Psychological Testing Referral • After Care or Discharge Sum (from Inpatient)
		TAB
	Clinical Lab	• Laboratory Reports (if available)
		TAB
	X-Ray/EKG	• X-Ray & EKG reports (if available)
		TAB
	Consults – Old Episodes	• Prior episodes received from DBH or copies from outside facilities may be kept here when space allows. • Or, previous episodes may be kept in the clinic chart room (enter "reminder" form in place of charting) o "RETURN OLD CHART WITH THIS EPISODE"

Changes to Permanent Chart Forms

All changes to permanent chart forms or their placement in the chart shall be presented for approval to Quality Management. Clinic forms used only as "worksheets" in the open chart do not need approval.

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Chapter 10 – Reference

Overview

Chapter 10 provides useful links to websites to help the user.

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Useful Links

ADP Bulletins	http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-InfoNotices.aspx
DBH Forms	http://www.sbcounty.gov/dbh/Forms.asp
DHCS Informational Notices	http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx
Risk Management Website	https://www.sbcounty.gov/riskmanagement/default.aspx
TCOM Website	http://www.sbcounty.gov/dbh/tcom/
Information Notices	http://www.sbcounty.gov/dbh/index.asp# (listed at the bottom of the webpage)