

OUTPATIENT DOCUMENTATION MANUAL

SEPT 2019

QUALITY IMPROVEMENT
HUMBOLDT COUNTY MENTAL HEALTH

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Introduction

Welcome to the Department of Health and Human Services - Mental Health's Documentation Manual. The information contained in this manual provides guidelines and standards for documenting Specialty Mental Health Services for Medi-Cal billing according to Title 9 as well as other contractual and regulatory requirements. Referring to this manual will assist you with answering questions about documentation and claiming.

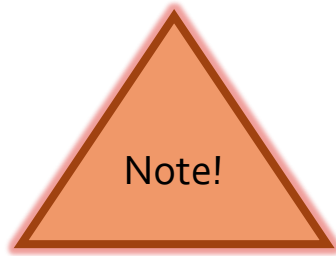
When questions or concerns emerge that are not addressed in this manual please consult your subject matter expert (SME) first, then your supervisor ([see appendix H for a list of SMEs](#)). It is important that SMEs are aware of questions or concerns in order to assist with providing the best orientation and training possible. If your supervisor has questions, they can contact the [Quality Improvement Unit \(MHB-QI QA@co.humboldt.ca.us\)](#) or [Medical Records \(MedicalRecordsMH@co.humboldt.ca.us\)](#) for answers. This process allows all programs to benefit from the question and answer dialogue.

The Quality Improvement Training Unit provides documentation training monthly, and all staff are welcome. This training is required annually. Your supervisor will be notified of the trainings a month in advance. Training schedules can also found by browsing courses in [Relias](#), our e-learning platform, referenced to throughout this manual.

Helpful Hints and Shortcuts



The Quick Tip symbol indicates suggestions to make this manual easier to understand.



The Note! Symbol indicates warnings that must be paid attention to within this manual.



The Examples symbol indicates good examples for your review.

“CTRL F” = Find

To find a specific word or phrase, press CTRL + F (or click Find in the upper right hand corner of the Home ribbon), type what you want to search for in Find What, and click Find Next. After a successful Find, to find each successive occurrence, you can click Find Next. If the dialog box hides what you are re looking for, once you have specified the desired options, you can click Less to hide the rest of the dialog box. On the other hand, if the dialog box is really in the way and you have a large enough screen, you can move the dialog box completely off the window.

“CTRL +” = Zoom In

If you need to enlarge the screen you are viewing, press CTRL and + (or click the Zoom + symbol in the ribbon). This function is especially helpful in the Example section when you are viewing the Avatar screens.

“CTRL -” = Zoom Out

If you need to shrink the screen you are viewing, press CTRL and - (or click the Zoom - symbol in the ribbon).

1. Scope of Practice

How to determine who provides services

Staff will only provide services based on their credential (e.g., license, education, training, and experience). **However, the job classification determines what service activity is permissible.** Further limitations may be due to insufficient scope of competence. (Updated 6/19/19).

Staff Eligible	Service Activities
<p style="text-align: center;"> Psychiatric Prescribers and Nurse Practitioners with specialty Behavioral Certification (01) MD (02) NP (03) Physician’s Assistant (PA) (12) FNP (27) Tele-Psychiatrist (23) DO </p>	<ul style="list-style-type: none"> ▪ Assessment (3331, 3331P, 3331T) ▪ Plan Development (3391, 3391P, 3391T) ▪ Crisis Intervention (3371, 3371P) ▪ Family Therapy (3311, 3311P, 3311T) ▪ Collateral (3313, 3313P, 3313T) ▪ Individual Therapy (3341, 3341P, 3341T) ▪ Group Therapy (3351) ▪ Rehabilitation (individual, group)/Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management/Intensive Care Coordination (3303, 3303P, 3304, 3309) ▪ Medication Support * (3361, 3361P, 3361T) <p>* Including evaluation and prescribing</p>

Staff Eligible	Service Activities
<p>Registered Nurses with ADN or BSN (Interim Permitees require RN co-signatures on all services provided) (10) RN</p>	<ul style="list-style-type: none"> ▪ Nursing Assessment Only (3331, 3331P, 3331T) ▪ Plan Development * (3391, 3391P, 3391T) ▪ Crisis Intervention (3371, 3371P) ▪ Collateral (3313, 3313P, 3313T) ▪ Rehabilitation (individual, group) (3301, 3301P, 3302) / Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination (3303, 3303P, 3304, 3309) ▪ Medication Support ** (3363, 3363P, 3363T, 3364, 3365) <p>*Excluding developing the plan and approval ** Excluding evaluation and prescribing</p>
<p>Licensed Vocational Nurses and Licensed Psychiatric Technicians (13) LVN (11) LPT</p>	<ul style="list-style-type: none"> ▪ Plan Development * (3391, 3391P, 3391T) ▪ Crisis Intervention (3371, 3371P) ▪ Collateral (3313, 3313P, 3313T) ▪ Rehabilitation (individual, group) (3301, 3301P, 3302) / Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination (3303, 3303P, 3304, 3309) ▪ Medication Support ** (3363, 3363P, 3363T, 3364, 3365) <p>* Excluding developing the plan and approval **Excluding evaluation and prescribing</p>

Staff Eligible	Service Activities
<p>Behavioral Health Clinicians (BBSE Registered Associates and Licensed) (04) Licensed Clinical Psychologist (05) LCSW (06) LMFT (07) AMFT (08) ASW (23) LPCC (24) APCC</p>	<ul style="list-style-type: none"> ▪ Assessment (3331, 3331P, 3331T) ▪ Plan Development (3391, 3391P, 3391T) ▪ Crisis Intervention (3371, 3371P) ▪ Family Therapy (3311, 3311P, 3311T) ▪ Collateral (3313, 3313P, 3313T) ▪ Individual Therapy (3341, 3341P, 3341T) ▪ Group Therapy (3351) ▪ Rehabilitation (individual, group) (3301, 3301P, 3302) / Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination (3303, 3303P, 3304, 3309)
<p>Staff <i>with</i> BA/BS in Mental Health related field <i>or</i> <i>with</i> Two (2) years' experience in Mental Health (16) SAC (20) Case Manager (21) Activities Therapist (29) Occupational Therapist (OT)*</p>	<ul style="list-style-type: none"> ▪ Plan Development †, * (3391, 3391P, 3391T) ▪ Crisis Intervention (3371, 3371P) ▪ Collateral (3313, 3313P, 3313T) ▪ Rehabilitation (individual, group) (3301, 3301P, 3302) // Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination (3303, 3303P, 3304, 3309) <p>† Excluding the development and approval of the Client Treatment Plan.</p> <p>* OTs can develop goals and interventions as part of the treatment team on the 2056 MTP on SV only</p>

Staff Eligible	Service Activities
<p style="text-align: center;"> Staff <i>without</i> BA/BS in Mental Health related field <i>or</i> <i>without</i> Two (2) years' experience in Mental Health (16) RAS (18) Mental Health Worker (19) Mental Health Aide (17) Ed.S (28) Senior Mental Health Worker </p>	<ul style="list-style-type: none"> ▪ Plan Development †, * (3391, 3391P, 3391T) ▪ Crisis Intervention* (3371, 3371P) ▪ Collateral* (3313, 3313P, 3313T) ▪ Rehabilitation* (individual, group) (3301, 3301P, 3302) / Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination* (3303, 3303P, 3304, 3309) <p>† Excluding the development and approval of the Client Treatment Plan</p> <p>* All services require a co-signature by licensed staff</p>
<p style="text-align: center;"> 2nd Year Graduate Student Interns (ex. MSW 2nd year) <i>and</i> One-Year Program Graduate Student Interns (22) MSWI2 (26) MFT Trainee </p>	<ul style="list-style-type: none"> ▪ Assessment* (3331, 3331P, 3331T) ▪ Plan Development* (3391, 3391P, 3391T) ▪ Crisis Intervention* (3371, 3371P) ▪ Family Therapy* (3311, 3311P, 3311T) ▪ Collateral* (3313, 3313P, 3313T) ▪ Individual Therapy* (3341, 3341P, 3341T) ▪ Group Therapy* (3351) ▪ Rehabilitation (individual, group)* (3301, 3301P, 3302) / Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination* (3303, 3303P, 3304, 3309) <p>* All services require a co-signature by licensed staff</p>

Staff Eligible	Service Activities
<p>1st Year Graduate Student Interns (22) MSWI1</p>	<ul style="list-style-type: none"> ▪ Plan Development †, * (3391, 3391P, 3391T) ▪ Crisis Intervention* (3371, 3371P) ▪ Collateral* (3313, 3313P, 3313T) ▪ Rehabilitation (individual, group)* (3301, 3301P, 3302) / Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination* (3303, 3303P, 3304, 3309) <p>† Excluding the development and approval of the Client Treatment Plan</p> <p>* All services require a co-signature by licensed staff</p>
<p>Undergraduate Student Interns, RN Trainees, Parent Partners and Peer Coaches (50) Unlicensed</p>	<ul style="list-style-type: none"> ▪ Plan Development †, * (3391, 3391P, 3391T) ▪ Collateral* (3313, 3313P, 3313T) ▪ Rehabilitation* (individual, group**) (3301, 3301P, 3302) // Intensive Home-Based Services (3301, 3301P, 3302) ▪ Brokerage / Targeted Case Management / Intensive Care Coordination* (3303, 3303P, 3304, 3309) <p>† Excluding the development and approval of the Client Treatment Plan</p> <p>* All services require a co-signature by licensed staff</p> <p>** Group Rehabilitation Services can only be provided with a Humboldt County Clinical Staff co-leader</p>

Staff Eligible	Service Activities
<p style="text-align: center;">Non-Billing Specialist</p> <p>(30) Community Health Outreach Worker (CHOW)</p> <p>(31) Vocational Assistant</p>	<ul style="list-style-type: none"> ▪ Indirect Patient Care* (8303) ▪ Direct No-Bill Patient Care* (4301, 4302, 4303, 4304, 4314, 4391) <p>* All services require a co-signature by licensed staff</p>

Informed Consent

What is Informed Consent?

Give clients the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in client preferences and encourage shared decision-making.

Legal capacity to give consent

Adults 18 (eighteen) and older have the right to give or refuse consent to mental or medical diagnostics or treatment procedures. California Health and Safety Code § 7185.5(a) states,

“The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care...” California Code of Regulations, Title 22 § 70707(b) (6) provides that a patient has a right to "participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment."

In other cases, an individual such as a minor or a conserve has a guardian to represent them in legal consent.

Consent must be “informed,” meaning that they should be made aware of risks, benefits and alternatives to treatment before consenting. Consenting individuals must further have capacity to consent legally, physically and mentally.

Minor Consent Exception

Some minors possess their own legal consent if they are either emancipated, self-sufficient, if there is no available adult, or should it be an emergency.

[Health and Safety Code § 124260](#) notes that a minor “who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services” if, in the opinion of the attending professional, the minor is mature enough to participate

intelligently in the mental health or counseling services. Also see [Family Code 6924\(b\)](#)), which reiterates that a minor can consent to outpatient mental health services or counseling if they are 12 or older, mature enough to participate intelligently and also at risk (such as potentially at risk of serious harm to self or others, or is the alleged victim of incest or abuse).

While clinically it is usually very wise to involve parents or caregivers in treatment, in some cases there is sound rationale why involving them would be an obstacle to treatment. Such rationales should be discussed with the treatment team and with the collaboration with the minor client. Any such rationale needs clear documentation and the privacy of the client must be protected.

Laws are stricter for consent to medications than to non-medical clinical services.

Client Information Form (CIF) - 1012

Complete [Client Information Forms](#) (CIF) 1012 in coordination with the client at time of intake. CIFs capture names, contact information as well as demographics, financial information. This also contains two lines of consent, one for consent to evaluation and treatment, and another for billing authorization. The client or their legal representative must sign the CIF.

CIFs need to be updated annually to capture updated CSI (Client Service Information).

Informing Materials Packet Acknowledgement - 1196

Informing materials should be visible and accessible at service delivery locations. Staff should be able to explain the contents of the Informing Materials Packet when requested. The packet will be provided at the time of the client's initial assessment. For the record, the [1196 Informing Materials Packet Client Acknowledgment](#) is a paper form that captures the client's, or legal guardian's, either acceptance or refusal of offered materials. It must also be signed by a staff witness and retained for scanning into records.

Materials include:

- Voter Preference Form (adults only)
 - Advance Directive (adults only)
 - Beneficiary Handbook
 - Provider List
 - Program Resolution Guide
 - Notice of Privacy Practices
-

Informed Consent for Outpatient Services - 1195

Discuss the range of services provided prior to admission with the prospective client, or an authorized representative, (one holding legal consent to treatment), so that the program's services are clearly understood. As Mental Health practitioners, there is an obligation to inform clients of the risks and benefits of treatment.

At the initiation of outpatient services, we must ensure that clients understand the content of the [1195 - Informed Consent for Outpatient Services](#) form prior to the client agreeing to services and signing consent. This includes ensuring that minors who are able to consent for their own services without a parent are fully educated about the similarities and differences in the types of services they can receive. ([See](#) Cal Family Code § 6924 & Health and Safety Code § 124260).

Signing Consents

In addition, we need to have clients re-sign Informed Consent forms when they transfer from program-to-program. It is also important that we inform them of the specific risks and benefits of each particular services when they initially transfer.

Informed consent is needed once per open episode and must be obtained prior to providing services to a client. Informed consent is the first step between the admitting practitioner and client, and is the means that a client either grants, refuses, or withdraws consent. Informed consent presents the client with information about the proposed

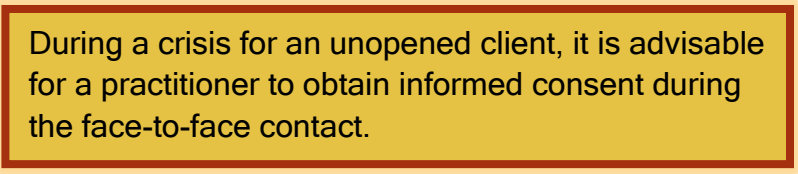
mental health services, mental health supports, or treatment, in language and manner that the client can understand.

At Department of Health and Human Services - Mental Health, we obtain written informed consent at the initial admission (first face-to-face contact) to services. This consent covers both outpatient and inpatient services and is valid for a year unless the client withdraws the consent. Document the discussion about informed consent in the client's record.

If a client is unwilling or unable to provide informed consent, document the reason, as well as attempts to obtain informed consent in the client's record.



Quick Tip



During a crisis for an unopened client, it is advisable for a practitioner to obtain informed consent during the face-to-face contact.

Outpatient Medication Advisement (Consent) - 1042

For treatment with psychotropic medications, there are additional documentation requirements for informed consent. The medical staff prescriber, the client, or the client's parent / guardian must complete the [1042 Outpatient Medication Advisement Form](#). This documentation shall include, but needs not be limited to, the reasons for taking such medications. Also include any reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to clients taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the client.

- Obtain medication consent prior to prescribing medication and whenever a new medication is prescribed.
- More than one medication may be listed on the form.
- Changes in dosage require new consent forms. A dosage range may be included on the form to reduce frequency of updating consent forms.

FAQ - Medication Consent

Q1. Do the court forms authorizing the administration of a psychotropic medication to a foster child (JV-217 - JV-224) suffice to meet the requirements for documenting informed consent to medication?

A1. Court forms do not currently include all required components for medication consents. They lack information about method of administration or side effects. In addition, the legal representative's signature is required on the medication consent form.¹

Q2. Can a child of any age be the sole signatory on a medication consent form?

A2. Children 12 years of age or older may provide legal consent to mental health treatment or counseling without parental or guardian consent.² This special authority does not extend to psychotropic medication. Parent, guardian or legal representative consent is needed. In the case of foster children, the court determines who the authorized representative on the child's behalf is. If the prescribed medication is not psychotropic and all statutory requirements are met, a child 12 years of age or older may be the sole signatory of the medication consent.³

¹ MHSUDS IN 17-040 § F6

² Family Code § 6924 / Health and Safety Code § 124260

³ WIC § 369.5(a) and 739.5(a) / MHSUDS IN 17-040 § F7

2. Request for Access to Services (RAS)

What is RAS?

RAS stands for the “Request to Access Service,” made either by telephone, in writing, or in person.

Why do we record RAS?

The California State Department of Health Care Services (DHCS) requires all county Mental Health Plans (MHPs) to maintain a log of initial requests to access services. Timely access to our services throughout our county is a required element in our contract with DHCS.

Recorded RAS calls

Humboldt County Mental Health (HCMH) staff records the contacts as well as all requests for information by clients in an electronic database called the “RAS Log.” Log all requests for information and initial requests for access of services in the RAS database.

If this is part of your role, your Supervisor will contact DHHS IS and request installation of a shortcut on your desktop in order to gain access to the RAS log.

RAS training

The RAS Training is on Relias, or located [here](#):
<http://dhhsbulletinboard/sites/Collab/programs/MHQI/Shared Documents/Training Resources/Training Material/Updated RAS Log Training July 2015.pptx>

It is required of all staff who have contact with beneficiaries seeking information or requesting services. Access Line training is located [here](#)
<http://dhhsbulletinboard/sites/enterprise/OpsDocs/DocsRef/Mental%20Health/Access%20Line%20Training.pdf>

If needing additional training, please request this from your supervisor, who will contact the QI Training Unit to schedule.

What is monitored?

1. How long clients have to wait from the initial request for services to the actual Assessment appointment. Reports from the RAS Log are generated to determine if clients have timely access to requested services. These are reported to DHCS.
2. Logging the requests for services in the RAS Log allows our department to track timely access of services to our clients as well as to track the number of calls our department receives from around the county over time.
3. Access to a statewide toll-free number 24 / 7 line. Beneficiaries can call on how to access mental health services.
4. The capacity to respond to those whose primary language is not English.
5. Provide information about crisis services regarding an urgent condition.
6. Provide information on how to use the problem resolution process.
7. Name of the identified person
8. Date of the request.
9. Initial disposition: provide the caller with location and clinic hours (or was made an appointment or referred to clinical staff on duty).

Aside from being a state requirement, the RAS Log benefits clients and staff. When logging calls, staff can refer back to the entry when following up with a client. This way, clients do not need to repeat information already relayed to HCMH staff. Staff is able to work more efficiently by having the background information when addressing a client's needs during follow-up. Other staff that coming in contact with the same client for future follow-up will have historical information to help them meet the client's needs. The RAS Log allows for time-efficient continuity of care and is a core element of HCMHs standard of care.

What happens when we cannot provide services within 10 business days of first contact?

When HCMH is unable to provide services within ten (10) business days of contact issue an NOABD ([Notice of Adverse Benefit Determination](#)). NOABD provides clients with information about their rights regarding accessing mental health services among other things (see policy no. [0704.500 Notice of Action](#)).

HCMH analysts collect data to ensure compliance with regulations for “timely access to services.” The timeliness of our services is regularly reported to the state in accordance to our contract.

What information is logged?

All requests for information and initial requests for access of mental health services (new clients) needs logging in the RAS log during, or immediately after, handling the request. The following situations are examples of requests requiring logging into the RAS log:

Examples of telephone requests are:

- Parent calling for help with child exhibiting behavioral concerns
- Client calling in emotional distress, asking how to get into counseling services
- Client who wants to be evaluated for psychotropic medications
- Client who is new to the area and wants mental health services
- Family member with concerns for their loved one wants to know the process to get them in

Examples of written requests (generally faxes) are:

- Primary care doctor referring their patient to HCMH for psychiatric evaluation
- Primary care doctor referring their patient to HCMH for counseling
- School staff requesting services for a child with behavioral issues at school

- CSU staff requesting follow up care for a stabilized client
- HCMH Intra-agency referral requesting additional services (AOD, Case Mgmt., etc.)
- Community agency (RCAA / YSB) linking their clients with mental health services
- Requests for a list of mental health providers who speak other languages

Examples of in-person requests are:

- Client with no telephone initiating the process to be seen at HCMH
- Clients seeking services through Same-Day-Services walk-in.
- Family members in distress over loved one's mental health signs and symptoms
- Referent accompanying their client to begin the process of being seen at HCMH

Pertinent information about the interaction with the client is documented in the RAS. The **client's name** (alias, John / Jane Doe is permissible), **date of birth**, **phone number**, **acuity (emergent, urgent, routine)**, use of **Language Line** (if applicable), **type of request** (information, services) and **location** being referred to are required elements of an entry.

Helpful information staff can enter in the "Disposition" box includes what the purpose of the contact was, what follow-up was needed, what referrals were given and how staff assisted in accessing services.

It is important that staff document the first available appointment in the RAS Log follow-up. If a client declines that first available appointment due to a scheduling conflict or other reason and chooses a later date, our data will reflect how soon HCMH was able to accommodate the client.

(See [0100.600 Request for Access to Mental Health Services](#)).

Who has to record RAS?

Enter all of the above scenarios into the RAS log by the first staff in communication with the client or receiver of a written request. During business hours, reception would often be the first point of contact that enters a RAS for follow-up by Access Team staff. Other units who will receive requests for services would be Same Day Services, Crisis Stabilization Unit and Sempervirens. In addition, calls coming into HCMH's answering service e-mails reception the next business day for entry into the RAS Log.

CSI Assessment Data

DHCS is requiring MHPs to provide data, called CSI (Client Service Information), to monitor timely access to services, and statistics related to usage rates of mental health, demographics and accessibility. Data include dates of first contact, first appointment offered, and first appointment accepted. This data should be updated annually.

CSI Data captured in the 1012 CIF is entered into a few key Avatar forms:

- Admission (admission tab and demographics tab)
 - CSI Admission Form
 - Update Client Information Form (for current contact information)
 - Discharge Form (CSI tab)
 - CSI Assessment
-

3. Medical Necessity

Medical Necessity Concept

Medicare defines medically necessary as “health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms that meet accepted standards of medicine.” This necessity aims at improving a critical, debilitating, area of life functioning.

Qualifying for medical necessity

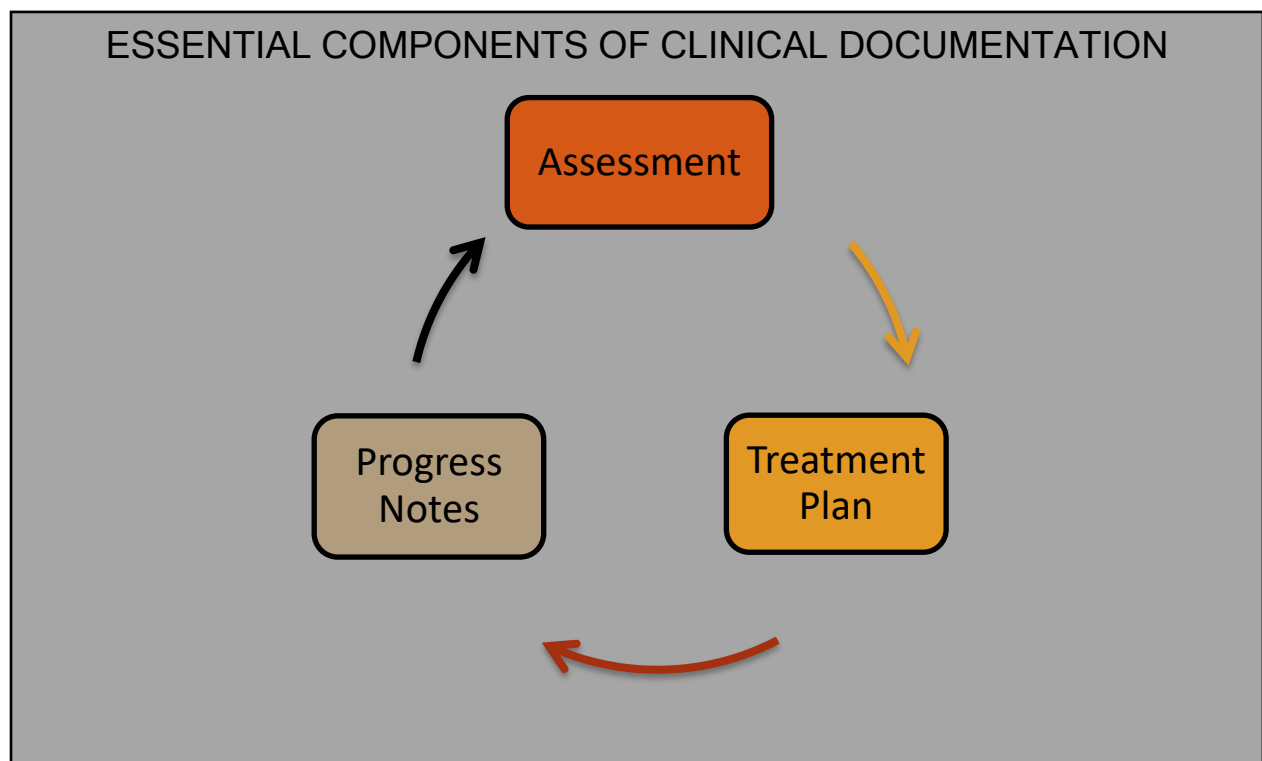
1. At the time of admission, the client must have a primary “covered” diagnosis (with a valid DSM (Diagnostic and Statistical Manual) and latest ICD (International Classification of Diseases) code), from a licensed mental health professional (LHMP) within their scope of practice. Please refer to the list on the following pages for included and excluded diagnoses. If a patient does not fit included diagnostic criteria, an appropriate referral needs to be considered.
 2. To qualify for specialty mental health services, the client must have either a **serious impairment due to a mental health disorder or the probability of significant deterioration in an important area of life functioning due to a mental disorder.** Children also qualify if there is a probability they will not progress developmentally as individually appropriate without the aid of mental health services.
 3. The proposed interventions in the subsequent treatment plan are to focus on the mental health impairment, expecting the client will benefit from treatment. *Note: The impairment describing the necessity for specialty mental health services would be non-responsive to solely physical healthcare-based treatment.*
-

Medical Necessity and “The Golden Thread”

Staff documenting services on a case should have in mind clear connections between the diagnosis, goals, and the services provided. This means that the key

elements of a chart, beginning with the Assessment, developing a Client Treatment Plan, proceeding to Progress Notes and finally to a Treatment Summary at the end, must follow a logical flow, also known as “**The Golden Thread.**” This thread underscores the continued existence of the medical necessity for treatment as well as how mental health services are contributing to recovery.

The Assessment identifies the signs and symptoms of the client’s mental health condition, including the functional impairments that result. The Client Treatment Plan goals focus on reducing impairments and alleviating symptoms documented in the Assessment. The Progress Notes reflect interventions used to reduce impairments documented in the Client Treatment Plan as well progress toward the identified goals on the Client Treatment Plan. The Progress Notes help identify changed signs and symptoms of the client’s mental health condition when updating the Assessment.



Diagnoses

To qualify for SMHS, a patient must have, as the primary and influential mental health diagnosis, a current and qualifying covered diagnosis. An historical diagnosis or one that is in remission will not qualify. Uncovered diagnoses are only permitted for SMHS as secondary or tertiary diagnoses. DHCS publishes annual updates to the included diagnosis list.

Only staff who are licensed or waived with their scope of practice and scope of competence, to assign mental health diagnoses may do so. Diagnosing beyond the training or testing required for some diagnoses, (typically such as a medical condition, or developmental, or neurological disorder), may be considered unethical.

For the purposes of diagnosing in Avatar, a qualifying diagnosis must be included diagnoses from DHCS as well as meet the standards of ICD (International Classification of Diseases) from the World Health Organization and the DSM-5 (Diagnostic and Statistical Manual).

Entered diagnoses may include medical diagnoses as necessary considerations for treatment decisions regarding the holistic health of individual clients. If including a medical diagnosis, document who is the diagnoser and where the individual may be seeking treatment for medical conditions.

For more specifics, see [Relias](#) training “Diagnosing in Avatar.”

Covered Diagnoses

CCR regulations⁴ categorize the following DSM-IV categories qualify:

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders

⁴ See the California Code of Regulations CCR, Title 9, Sections 1830.205 and 1830.210 for additional information.

- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and Other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
- Mood Disorders, except Mood Disorders due to a General Medical Condition
- Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilic Disorders
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorder related to other included diagnoses

Translated into DSM 5 Covered Diagnoses / Categories:

- Attention-Deficit / Hyperactivity Disorder
- Stereotypic Movement Disorder
- Tic Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders* (except Catatonia and Catatonic Disorders)
- Bipolar and related Disorders*
- Depressive Disorders* (except Premenstrual Dysphoric Disorder)
- Anxiety Disorders*
- Obsessive-Compulsive and related Disorders* (except Excoriation (Skin-Picking) Disorder)
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders

- Somatic Symptom and Related Disorders (except Psychological Factors Affecting other Medical Conditions)
- Feeding and Eating Disorders
- Elimination Disorders (except Other Specified Elimination Disorder with urinary symptoms and Unspecified Elimination Disorder with urinary symptoms)
- Gender Dysphoria (except Gender Dysphoria in Adolescents and Adults)**
- Disruptive, Impulse-Control, and Conduct Disorders (except Antisocial Personality Disorder)
- Personality Disorders* (except Other Specified Personality Disorder)
- Paraphilic Disorders
- The following Medication-Induced Movement Disorders:
 - Neuroleptic Malignant Syndrome
 - Neuroleptic-Induced Parkinsonism
 - Medication-Induced Postural Tremor
 - Tardive Akathisia

*Except Substance / Medication-Induced Disorders and Disorders Due to Another Medical Condition

** Not considered an covered diagnosis in [IN-053](#)

Excluded Diagnoses

The following DSM-IV disorders do not qualify for a primary diagnosis:

- Autistic Disorder
- Learning Disorders
- Motor Skill Disorders
- Communication Disorders
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions

- Sleep Disorders
- Other conditions that may be a focus of clinical attention, except Medication-Induced Movement Disorders
- Intellectual Disability
- Antisocial Personality Disorder
- Deferred, provisional, stand alone “rule out” diagnoses, or “by history” diagnoses
- Z Codes

Translated into DSM 5 Excluded Diagnoses / Categories:

- Neurodevelopmental Disorders (except Attention-Deficit / Hyperactivity Disorder, Stereotypic Movement Disorder, Tic Disorders)
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Other Mental Disorders
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication (except those listed as covered above)
- Other Conditions That May Be a Focus of Clinical Attention



Quick Tip

Keep up-to-date with QI Bulletins, which inform you of any changes at federal and state levels regarding which diagnoses are covered and uncovered.

Levels

Purpose

This is an attempt to categorize a client's acuity or level of need. The Levels System is three tiered and completed at the same time as the Assessment and Diagnosis:

- Level 1: the most acute need; serious impairment
 - Level 2: the medium acute need; moderate impairment
 - Level 3: the least acute need; mild impairment
-

Adults

Adult Level 1

1. The client meets medical necessity criteria.
2. The client has a Serious Mental Disorder, meaning all of the following three criteria (a-c) are required:
 - a. At a minimum, one of the included diagnoses based on Medical Necessity Criteria, and most typically, a severely disabling mental disorder, such as schizophrenia and other serious psychotic disorders, or major mood and anxiety disorders.
 - b. As a result of the mental disorder, has substantial impairment in at least one of the following areas of life functioning:
 - i. Health
 - 1) Difficulty managing basic needs [Activities of Daily Living (ADLs)]
 - 2) Health is seriously at risk due to noncompliance with medication or healthcare
 - 3) Serious to moderate substance abuse
 - ii. Daily Activities
 - 1) No employment, training program, or school
 - 2) No interest in leisure activities
 - iii. Social Relationships
 - 1) No support system and / or unable to access support

Adult Level 1

2) No friends and / or significant other

iv. Living Arrangement

1) Seriously at risk of losing current living arrangement due to behavior (e.g. aggressive incidents, suicidal / self-harm behavior)

2) Homeless

3) Unable to secure alternative living arrangement

c. Likely to become so disabled as to require public assistance, services, or entitlements.

3. And / or at risk for highest levels of care (e.g. CSU, PHF, jail, IMD)

a. Dangerous / destructive behavior

b. Suicidal ideation / plan; self-injurious behavior

c. Unable to provide for basic needs

d. History of CSU / inpatient admissions

e. Clients living / placed in an Institute for Mental Disease (IMD) facility

Adult Level 2

1. The client meets medical necessity criteria and has a significant impairment in at least one of the following four areas of life functioning (or probability of significant deterioration):

a. Health

i. Requires encouragement and / or assistance for basic needs (ADLs)

ii. Has difficulty maintaining compliance with medication or healthcare

iii. Moderate to severe substance abuse

b. Daily Activities

i. Unable to initiate and / or maintain daily activities on a regular basis

c. Social Relationships

i. Lack of a support system and / or difficulty accessing support

ii. Lack of friends and / or significant other

d. Living Arrangement

Adult Level 2

- i. Has difficulty managing money
- ii. Some risk of losing current living arrangement due to behavior (e.g. aggressive incidents, suicidal / self-harm behavior)
- iii. Homeless
- iv. Difficulty securing alternative living arrangement

Adult Level 3

1. The client meets medical necessity criteria.
2. Without mental health treatment, there is a reasonable probability of deterioration in at least one important area of life functioning.

Minors

Minor Level 1

Severely Emotionally Disturbed (SED) Child / Adolescent (under age 18), or SED Transition Age Youth (age 18-20)

1. The client has a primary DSM Mental Health Disorder which meets Specialty Mental Health criteria, and
2. Displays a significant and substantial impairment in at least two of the following areas:
 - a. Self-care
 - b. Ability to function in the community
 - c. School Functioning
 - d. Family relationships
 - e. Another important area of life functioning, which must be specified.
3. Has at least one of the following risk factors:
 - a. The child is at risk of removal from the home or has been removed from the home
 - b. The mental disorder and impairments have been present for more than one year or are likely to continue without treatment

Minor Level 1

c. The child / adolescent displays one of the following:

i. Psychotic features

ii. Risk of suicide

iii. Risk of violence due to a mental disorder

d. The child / youth meets Special Education eligibility requirements under Education Related Mental Health Services (ERMHS).

Minor Level 2

SED Child / Adolescent (under age 21)

1. The client has a primary DSM Mental Health Disorder that meets Specialty Mental Health criteria.

2. And displays at least one of the following impairment criteria:

a. A specific significant impairment in an important area of life functioning.

b. A probability of significant deterioration in a specified and important area of life functioning without treatment.

Minor Level 3

Child / Adolescent (under age 21)

1. The client has a primary DSM Mental Health Disorder that meets Specialty Mental Health criteria.

2. The client displays the following impairment criteria: There is a probability that the child / adolescent will not progress developmentally as individually appropriate because of a mental health disorder, which can be corrected or ameliorated with mental health treatment.

Q1. How does 'Medical Necessity' tie into 'Specialty Mental Health Services,' and why is it important?

A1. 'Specialty Mental Health Services' is a Medi-Cal term for specific types of services that are reimbursable. In order for a client to receive such services, they must meet 'Medical Necessity', which establishes the reason why the client is being seen, and how their mental health issues affects their life. 'Medical Necessity' justifies the need the client has for services and why it should be covered by Medi-Cal. If a client no longer meets 'Medical Necessity' then services would be discontinued.

Q2. How do I document 'Medical Necessity' on clients who have an excluded diagnosis?

A2. A client must have an included diagnosis in order to qualify for Specialty Mental Health Services. Give clients who are determined to have an excluded diagnosis as their primary diagnosis a NOABD Denial Notice. The notice explains why they did not meet criteria. The client's excluded diagnosis can be a secondary diagnosis and still meet Medical Necessity if the primary is an included diagnosis. The DSM describes a Primary diagnosis as the 'reason for the visit' or 'the main focus of attention or treatment.' The assessor will include diagnostic criteria for the secondary diagnosis in the Assessment and the assigned Clinician will address the related impairments on the Client Plan. However, the focus of the interventions should not constitute more than 50% of the overall service provision.

Q3. If Levels 1, 2 and 3 all meet Medical Necessity, what is the purpose of rating them?

A3. The Levels are used to categorize a client's acuity or level of need. By categorizing, assessors and Access staff can determine if urgent, in-house services (Level 1) or referrals to Org Providers or Beacon (Levels 2, 3) are appropriate to meet the client's needs. The information is useful in planning treatment and measuring its impact. If a client entered treatment as a Level 1 and moved down to a Level 2 or 3 that's a good indicator of improved functioning. If a client who is a Level 3 moved to a

Level 1, the treatment team would consider adding services, increasing frequency of services or updating the Client Plan to address crisis intervention or high-risk behaviors.

Q4. How do Mental Health providers determine that the client’s condition ‘would not be responsive to physical healthcare based on treatment?’

A4. A thorough Assessment includes a discussion with the client about their medical history and current physical symptoms, so this determination is made with the client’s input and the assessor’s clinical judgment. A mental disorder caused by a general medical condition would require “evidence from the history, physical examination or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition” per the DSM. If the client reports physical medical symptoms that have gone unchecked by their medical provider, the assessor will note a recommendation of “follow up with primary care provider.”

Q5. Why do we have to authorize services internally within Mental Health?

A5. Since the Medical Necessity / Levels / Authorization form is a component of the Assessment, only licensed staff operating within their scope of practice can authorize services internally or through an Org Provider. Authorization is signed by the assessor, which indicates client has met Medical Necessity and is recommending indicated services. All staff can refer to the authorization expiration date as an indicator of annual updates needed.

Q6. If the original level has all services authorized, is a new levels assessment required for added services?

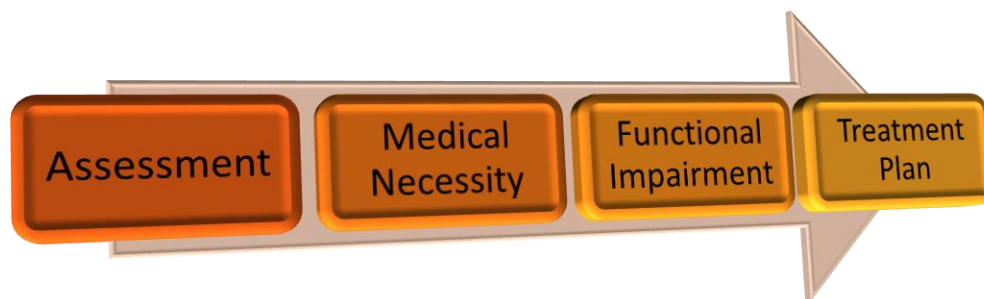
A6. No. If the assessor authorized all available Specialty Mental Health Services, providers are free to begin any of these upon receipt of an Intra-agency Referral. Keep in mind that added services require a Client Plan within 60 days of opening them to that particular service. ([1030 Adult Referral](#) / [1020 CFS Referral](#))

4. Assessment

Purpose

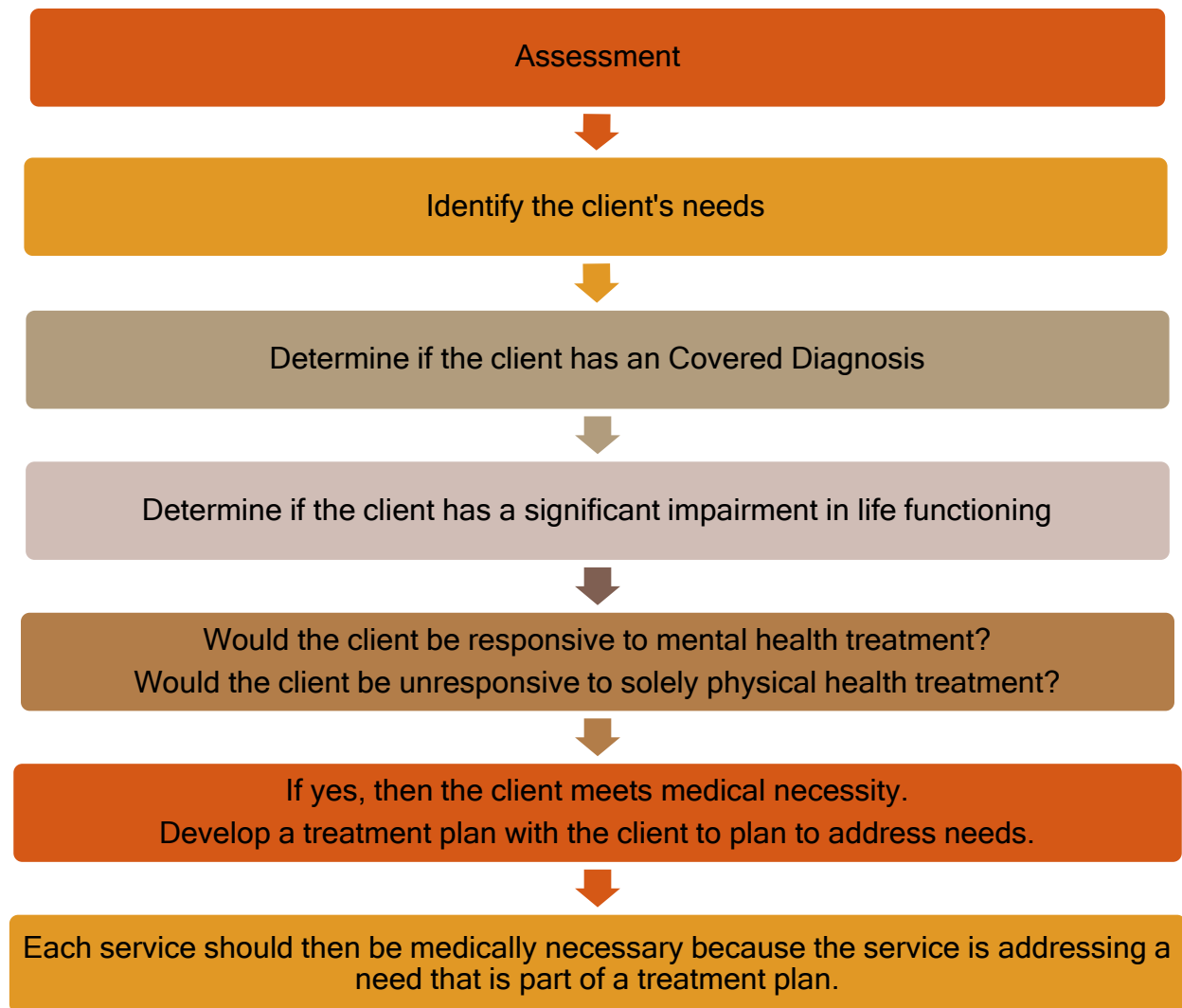
The Assessment, such as the 1096, serves as the foundation for the client's plan of care. It reinforces eligibility to receive outpatient Specialty Mental Health Services (SMHS), drives the treatment planning process, and provides the basis for ongoing changes in treatment delivery as well as discharge planning. It serves to:

1. Determine if the client meets medical necessity for SMHS,
2. Assist with formulating a clinical diagnosis, and
3. Assist with forming the foundation for the client plan.



CANS Assessment

The CANS Assessment used for minor clients may be included in a forthcoming Children's Assessment document. [For more on the CANS, see relevant section later in this document.](#)



Assessment Timelines

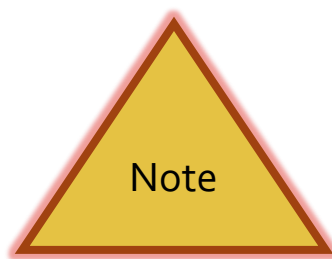
The Initial Assessment:

The initial mental health Assessment is required for all clients meeting medical necessity either who are new to the outpatient mental health system, or who are returning for services after being discharged from all outpatient services for more than thirty (30) days. **This Assessment shall be completed within sixty (60) calendar days of opening.** Assessments are valid only when signed by an LMHP, and finalized in the EHR (the date of validation appears by the LMHP staff signature). Please refer to [Appendix D - Document List and Timelines for Completion - Outpatient Services](#) for timelines and due dates for each item required in the clinical chart. Assessments should

be attached to an opened episode (not a Pre-Admit episode). [See EHR-Avatar policy and procedure 0702.02 'Pre -Admit' Epi Only Program.](#)

In general, assessments from both Out-of-County and Organizational Providers may not be used to open clients to Mental Health, but they can be used to inform the completion of a new Avatar 1096 Assessment. An exception to this is Presumptive Transfer. ([see FAQ - Assessment Q11 below](#)).

The Assessment date should match the episode opening date.



Both the Assessment (1096) and Medical Necessity / Levels (1038 / 1039) forms should be completed at the end of the first assessment interview. If you are unable to complete the assessment at that time, you must document the rationale for not completing it, include a diagnosis in your Diagnosis Form.

Updated Assessment:

- An Assessment must be updated **every year for all clients**, on or before the anniversary date of the initial assessment.
- Updated Assessments are required to be comprehensive and complete. In other words, the updated Assessment must stand alone and not simply be the same as the initial assessment
- Updated Assessments must clearly state why the client continues to require services in the presenting problem section of the Assessment (this is what establishes continued medical necessity)
- Updated Assessments must contain a summary of the treatment provided in the past years and the response to that treatment in the mental health treatment history section of the assessment
- The “pull forward” feature in Avatar may be used to start the reassessment. Key fields within the assessment will need to be completed with current

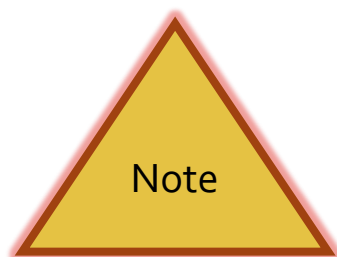
information. Be sure information is accurate currently while pulling data forward.

- If the client has an updated or changed diagnosis, if the new diagnosis changes the clinical outlook or treatment in any way, this change must be updated in a new assessment to maintain chart and care cohesion.

Assessments when client transfers to a new episode:

If a currently opened client transfers to a new episode, the Clinician may use one of the following options:

1. Complete a new Assessment within 30 calendar days of opening in the new episode, if indicated.
2. Pull forward a previous Assessment and complete all relevant fields.



When clients who were treated at Sempervirens or another inpatient psychiatric hospital are referred to outpatient services for follow up, charts will require a new 1096 Outpatient Assessment. Because the client in inpatient services presented in crisis, that crisis assessment may not accurately reflect their baseline mental health condition. It is however permissible to utilize information gleaned from the inpatient assessment.

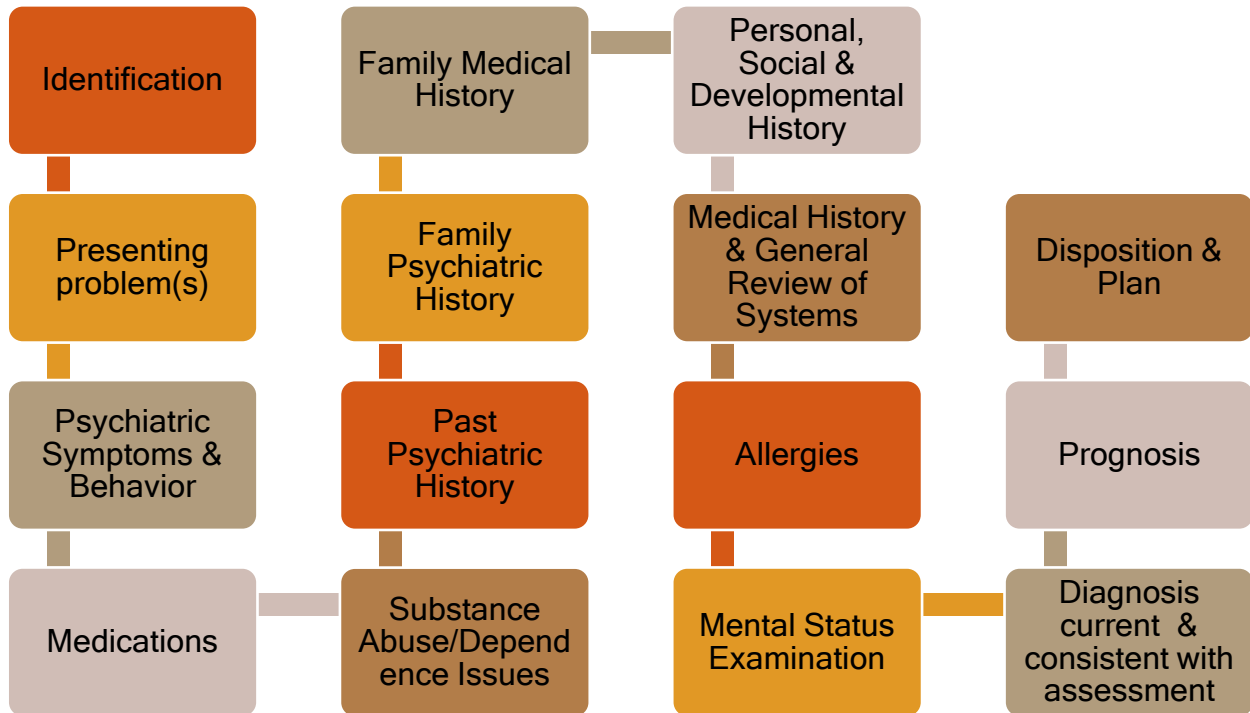
Assessment Components

Complete all sections. It is not acceptable to leave questions or sections blank. Use N/A if not applicable.

1. Presenting Problem: A description of the client's current symptoms and behaviors that supports the required DSM criteria for each diagnosis (including severity, frequency and duration of symptoms).
2. A detailed description of the client's functional impairment(s), including living situation, daily activities, social support, history of trauma, and a description of the client's cultural / spiritual / linguistic factors.

3. Medications and medication history (previous treatment, response to treatment, modalities of treatment, psychological testing)
4. Substance Exposure / Substance Use. Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications (CAM), over-the-counter (OTC), and illicit drugs.
 - a. If the client uses or has used drugs and a dual diagnosis may be present, the full Substance Use History Option must be completed; if there is no indication of a dual diagnosis, only the mandatory areas of the Substance Use History Option need to be completed. (Write n/a if not applicable.)
5. Strengths: A description of the strengths (personal assets) in achieving plan goals:
 - a. Abilities and accomplishments
 - b. Interests and aspirations
 - c. Recovery resources and assets
 - d. Unique individual attributes
6. Risks: current factors, including current or past trauma
7. Mental Status Exam
8. A Diagnosis must be completed. Both the numerical code and full description of the diagnoses. Diagnoses are based on the latest DSM / ICD.
 - a. Please note that for SMHS, substance use diagnoses shall be listed as secondary diagnoses. If the alcohol and drug use diagnosis is the client's primary diagnosis, the client does not qualify for specialty mental health services and the client should be provided a referral to SUD.
 - b. A progress note must accompany any updated diagnosis in order to document the change. If the change ushers a significantly different set up symptoms and problems which affect the course of treatment, the change must also be noted by updating the assessment client treatment plan
9. Other information as needed

Assessment Content Areas:



“One-shot” Assessment

If during the assessment interview it is clear that the client does not fit the levels criteria for SMHS, the client can be referred to another provider or lower level of care. A comprehensive assessment is preferred but not required in this case. Instead, a “one shot” can be done by opening and closing an episode in the same day with the following steps in Avatar:

1. Open a new episode
2. Complete Diagnosis
3. Complete 1173 Mental Status Exam
4. Complete 1038 Medical Necessity (*doesn't need authorization part*)
5. Complete a Humboldt Progress Note (*doesn't need FIRP elements*)
6. Close the episode

If the client does not meet medical necessity, the diagnoses of dx deferred (R69) OR no diagnosis (z03.89), may be used in Diagnosis form.

FAQ - Assessment

Q1. What is the time frame for initial assessments?

A1. Initial assessments should be completed during the first 60 days from chart opening.

Q2. When must assessments be updated?

A2. Assessment bundles (1096 Assessment, Diagnosis, 1173 Mental Status Exam, 1038 / 1039 Level Forms) must be updated annually for both adult and minor clients to continue to receive SMHS. For example: If I complete an intake and Assessment on a new client today, November 1, 2019, my “due date” would be November 1, 2020. The due date is determined by the date the Assessment was started, not the date the Assessment was signed/submitted. Assessment bundles should also be updated if symptoms or impairments change (see Q3 below).

Q3. What if the client’s symptoms or diagnoses change?

A3. Assessments may be updated earlier than the due date if symptoms or impairments change. If a diagnosis is changed or updated during the same treatment episode, the assessment, and therefore the rest of the chart and treatment plan must change accordingly. A progress note should also acknowledge a change in clinical focus.

Q4. What if I provide SMHS but the assessment has expired?

A4. Providing SMHS past the due date will result in a disallowance, which means Medi-Cal will not reimburse those services.

Q5. If a rule-out or provisional diagnosis is given, what is the process for staff to determine if criteria is met at a later date?

A5. A rule-out or a provisional diagnosis may be used as an initial diagnosis. However, this provisional diagnosis must not be left unresolved. Once a clinician has obtained enough information through ongoing assessment, a revised diagnosis needs to be recorded in the Diagnosis Form in Avatar and an accompanying progress note.

Q6. When non-licensed staff do evaluations with diagnostic impressions such as a CANS assessment, is this considered an “Assessment” for service code activity?

A6. No. Non-licensed staff cannot use the assessment service code but should use an alternate such as “plan development.” See the [Scope of Practice](#) section earlier in this manual.

Q7. When a provider is unable to complete the Assessment and documentation on the same day, is it okay to claim documentation time the next day?

A7. Yes, two notes will need to be written; one for the first day, which must include the actual service duration, and one for the second day, which references the note on the first day and includes only the duration of documentation for the second day.

Q8. When a Clinician does an Assessment, do they need to list the diagnosis on the Progress Note for that service?

A8. No. Staff do not need to list the diagnosis on the Progress Note as long as it is included on the Assessment in the chart. The only time the diagnosis would need to be in the Progress Note would be if the Assessment was not fully completed and the Clinician was documenting a provisional diagnosis.

Q9. How do I document the Assessment when the paperwork was completed on a different day?

A9. A Progress Note needs to be completed on each day a service was provided. The first note would describe the interventions that were provided, as well as the reason why the assessment needed more time to complete. The note on the following day would explain why it was necessary to complete the clinical documentation on the next day. The actual time it took to perform the service (both face-to-face service and documentation time) needs to be identified on each of the corresponding Progress Notes.

Q10. Must the date on the Levels / Medical Necessity Authorization and Diagnosis Form match the date on the Assessment?

A10. Yes, they are due in tandem. They support each other and are all part of the assessment bundle.

Q11. Does an [SB785](#) OOC Assessment (an assessment from a provider while the client was placed out of county) suffice for the initial assessment?

A11. Yes, AB 1299 (Ridley-Thomas, Chapter 603, Statutes 2016) establishes presumptive transfer, a policy to improve the timely and effective provision and payment of SMHS to children in out of county foster care placement.

An example is if Humboldt County is a host county for a foster youth who is the resident of another county, the assessment from the county of residence can be used in establishing local services. This ensures prompt transition of services of these clients.

(For more, see policies [1001.105](#) and [0704.873](#) and full DHCS training [HERE](#).)

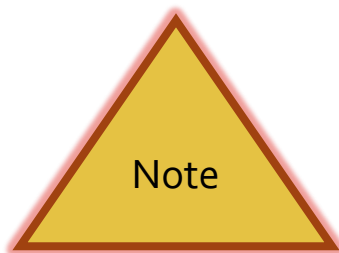
Q12. What are examples of “risk” to be included in an assessment?

A12. Previous inpatient hospitalizations. History of DTS / DTO. Previous suicide attempts. Lack of family or support. Arrest history or legal status. History of drug or alcohol abuse. History of trauma or victimization. History of self-harm behavior. Physical impairments or psychological vulnerabilities.

5. Client Treatment Plan

Purpose

Whereas the Assessment documents the current mental health condition and functional impairments of the client, the Client Treatment Plan, (aka “Care Plan”), *is the guiding force behind the delivery of care*. The plan helps the client and the clinical staff to collaborate on the client’s recovery goals and establishes what types of service interventions will guide the course of recovery.



A copy of the plan must be offered to the client / family member. This copy should be provided in both English and the client’s preferred language.

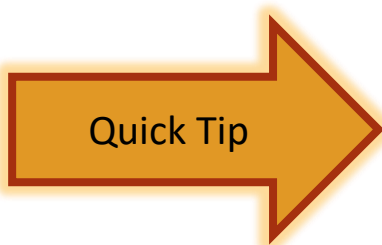
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Client Treatment Plan Basics

- The plan is written by the case coordinator or designated LMHP. Other team members may contribute input.
- The Treatment Plan is an agreement between the client and the treatment team that states which mental health problem(s) will be the focus of treatment. The Treatment Plan consists of specific goals, objectives, and the treatment interventions that will be provided. See the [Signatures](#) section below.
- There needs to be a flow from the DSM diagnosis and functional impairments in the assessment to the problem, goals, objectives, and interventions.
- A Client Treatment Plan is expected to be written in English and be made available in the client’s preferred language.
- The Treatment Plan initiates the main service activities and types of professional intervention to assist the client’s mental health goals.

⁵ CCR, title 9, sections 1840.314 and 1810.440(c)

- A client receiving both general mental health, (including rehabilitation as well as brokerage), and medication support services will have an “integrated client treatment plan.” Integrated plans include both general mental health interventions and medication interventions, which needs to be signed by a med support RN or prescriber.
- The Client Treatment Plan is valid from the date in which the LMHP has signed the plan.
- Whenever possible, clients should sign the plan as well (see section below for further details on [signatures](#)).
- If a client is expected to have short-term treatment only and receiving only one SMHS, their signature is encouraged but not required.⁶
- The effective date for a Medication Support Service Plan is the date the prescriber or med support designee signs the plan.
- In the event of a new diagnosis, an updated Client Treatment Plan may be needed as clinically appropriate. Please consult with your clinical supervisor if needed.
- **A minimum of two goals and two interventions are required per plan.** Plans made for very young children allow for one goal.



Services that can be provided prior to the completion of a new Treatment Plan are Assessment, Plan Development, Crisis Intervention, Crisis Stabilization, Medication Support Services (for assessment, evaluation, or plan development or if there is an urgent documented need), Targeted Case Management and Intensive Care Coordination (ICC) to assist clients in linkage to needed medical, social or educational services.

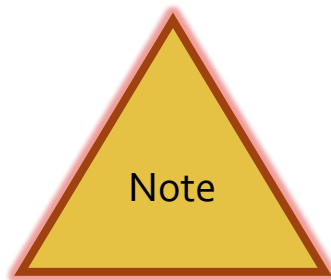
⁶ MHSUDS IN 17-040, item 4 / CCR Title 9 § 1810.440 (c)(2)(A))

Client Treatment Plan Timelines

The completion of the Client Treatment Plan is subject to specific deadlines and signature requirements, as described below:

- **Initial**: The Client Treatment Plan is due within 60 days of the Assessment, which is not always the same date as when the client is opened to Outpatient (OP) Services.
- **Updates and Revisions**: An updated or revised plan is due within 30 days from opening a client to new services.

The Client Treatment Plan must be updated at least annually, or when there are significant changes in the client's condition, as required by our MHP Contract. The anniversary date is the Avatar "Client Plan" date within the current episode.



Our standard of care includes that each Client Treatment Plan can be authorized for up to one year. However, many clients achieve goals prior to a year, and plans shall be updated prior to a year based on goal achievement. A plan should not be the same year after year. If our current plan did not help the client achieve his or her goals, the plan must change. It is not enough to default to a previous plan, as plans should be considered a changing, "living" document.

For a complete list of all documentation, timelines please see the **Document List and Timelines for Completion - Outpatient Services** in [Appendix D](#).

Late Renewal: If the renewal period passes and the next Client Treatment Plan is completed late, there will be disallowed services (e.g. the renewal date is July 1st, but the Plan is completed on July 7th). For the "gap" of time in-between (July 1st through 6th) **no services**, except crisis intervention, would be billable. Services rendered during any gap period should use a "No Bill" code (see [section below](#)).



Quick Tip

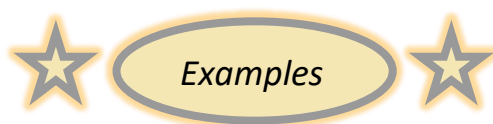
Check the content and the dates of the plan to be sure the services you will deliver are covered in the treatment plan. If you do not agree with the current plan, update it with the client and treatment team!

Client Treatment Plan Components

Treatment Plan Problems

The problem is the focus of treatment based on the mental health diagnosis, which includes current symptoms, behaviors, and impairments in life functioning.

A problem statement might also be thought of as a main obstacle, a description of main impaired life functioning. What mental health-related impairments will this plan address? In what areas of life is this person struggling?



PROBLEM: Due to this DIAGNOSIS, and these SYMPTOMS, this client has these FUNCTIONAL IMPAIRMENTS (*can be several listed*).

- ❖ Due to Schizoaffective Disorder, the client has symptoms of disorganized thinking, paranoia, auditory hallucinations, intense sadness, suicidal thoughts, insomnia and social withdrawal. These symptoms are interfering with their ability to maintain a job, maintain stable housing and have a positive relationship with others.
- ❖ Due to Post Traumatic Stress Disorder, the client is experiencing intense fear or hopelessness, recurrent and intrusive distressing recollections of the event and recurrent distressing dreams of the event, causing the client to avoid activities and places associated with the traumatic event, experience insomnia, avoid leaving the home and irritability. These symptoms are negatively affecting their school performance, employment and personal relationships.

Poor Example of a Problem:

“Client has symptoms of major depressive disorder.”

The specific symptoms / functional impairments are missing.

Treatment Plan Goals

Responding to the problem statement, a goal is a description of what skills, abilities, or other demonstrable signs a client will be able to achieve addressing the mental health impairments. Goals need to be realistic and achievable. Smaller and more reasonable steps can assist the client achieve tangible success.

Trends in mental health care documentation are embracing more person-centered care (See [WIC § 5600.2](#)). This way of documenting can help ensure greater case conceptualization, the consideration of diversity of treatment considerations, as well as increase client buy-in and motivation for recovery.



Quick Tip

Try focusing on person-centered goals and creating interventions that encourage recovery through the steps of hope, empowerment, self-responsibility and meaning.

Create goals that focus on enhancing capacities, building functional and coping skill rather than the reduction of undesirable symptoms.

See Relias for training on the [Recovery Model](#) and [Strengths-Based Clinical Language](#).

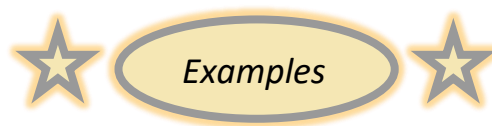
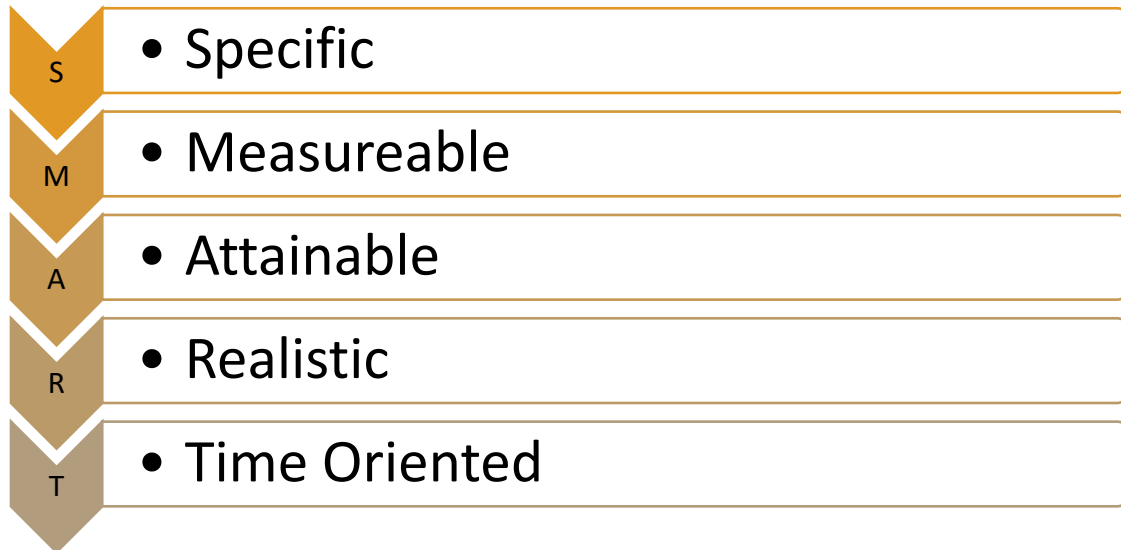
To help with individualizing care plans, and meet the standards of documentation, it may be beneficial to break up the goal into a statement in two parts. The first part individualizes the client's goal to address the problem / obstacle. The second part contains the empirical objective used to measure the achievement of skills.

1ST PART: The person wishes to achieve a SKILL or COMPETENCY or ABILITY (*ideally in terms of their own understanding. It may - but does not require - a quote*).

2ND PART: In the context of the above impairment, this person will be able to DO THIS (achievable) THING for this (reasonable) amount MEASURED SUCCESS and/or for this FREQUENCY/DURATION.

A helpful test to keep in mind to make sure a goal meets the measurable requirements is the S.M.A.R.T. test.

SMART goals are:



- ❖ “I’d like to be able to get a part-time job.” Client will be able to apply for two jobs per week for twelve weeks, or until successful employment.
- ❖ “I can’t get no sleep.” Client wants to have sound sleep hygiene. Client will be able to report having 6-8 hours of sleep per night for 6 nights out of a week.
- ❖ “I don’t want to be depressed.” Pt will increase mood from ____ to ____ or less on a Likert scale from 1 to 10 (1 being very depressed, 10 not at all depressed).
- ❖ Client says he wants to feel self-confident. Increase positive feelings about self by identifying and utilizing 5 core strengths and increasing positive self-talk from 1-2 x per week to 3-5 x per week.

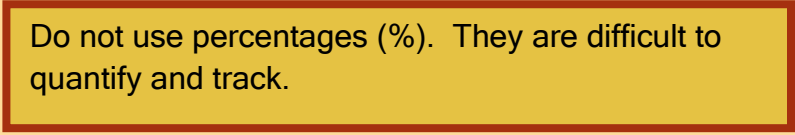
Poor Example of a Goal:

“Decrease psychiatric symptoms.”

This goal lacks specificity with symptom or functional impairment and is difficult to measure objectively. It is also vague and not person-centered.



Quick Tip



Do not use percentages (%). They are difficult to quantify and track.

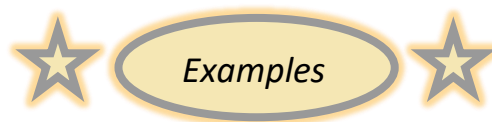
It is important to track and document client progress on goals closely. Make sure to either update the Client Treatment Plan as needed OR begin transitioning client to a lower level of treatment as goals are met or functioning returns.

Please note that problems and goals are to not include any particular discipline’s interventions. Methods, practices and interventions may be explained in the interventions section according to each helper’s scope of practice and the services.

Treatment Plan Interventions

Interventions are the therapeutic activities provided by staff to assist the client in attaining the objective in each goal. In other words, how can staff provide a clinical service to assist the client to meet their goals? Interventions also include what the client or client's collateral support person is going to do to work towards the goal (e.g., therapeutic homework, attending a social skills group, wellness group, etc.).

Interventions must address the objectives and **must include anticipated duration and frequency**. All services must be included in this section. The following template provides a simple way to write an excellent intervention:



Medication Support

- ❖ Client will take all medications as prescribed and call with any concerns between encounters and as needed x 1 year, so that staff can intervene to ensure client's medications are therapeutic and MD will adjust medication dosages as needed, in order to establish client's stability in the community and manage _____ symptoms.
- ❖ Nursing staff will address routine refills to ensure medications are accessible as needed x 1 year, with medications available to client it will aid in clients ability to maintain medication adherent and increase clients opportunity to maintain stability in the community and control _____ symptoms.
- ❖ Nursing staff will complete appropriate referrals as needed for exacerbated symptoms as needed and at each encounter x 1 year, to help guide client towards recovery.
- ❖ Medication Support 1x every three months or as indicated to address to Fx impairment d/t Sxs of _____ for the duration of one year or until Sxs are able to be managed by a lower level of care.

TCM

- ❖ Targeted Case Management Services (brokerage and rehabilitation) 3x a week or as needed for the duration of one year to support _____ (ex: community stability / independence, self-care and accessing needed services).
- ❖ Case Manager will meet with ct monthly or as needed for the next 6 months to assist client with linkage, brokerage and access to appropriate resources.
- ❖ Case Manager and/or Peer Coach will meet with ct weekly or as needed for the next 12 months to assist client with linkage, brokerage and access to appropriate resources to assist ct in maintaining stability in housing.

Individual Therapy

- ❖ Clinician will work with client in order to support with identification of client's specific clinical needs, identifying and accessing necessary therapeutic services and resources, and maintaining/improving stabilization and community relationships. Use of _____ techniques, _____ therapy interventions, etc. to assist with the above goal, per (timeframe).
- ❖ Clinician will meet with ct monthly or as needed for the next 6 months to utilize Motivational Interviewing techniques to elicit and strengthen ct's motivation to maintain income and housing.

Group Therapy

- ❖ Group counseling 1-3x a week or as needed for the duration of one year to increase ability to access community, take care of self and improve relationships / or manage _____ symptoms.

Peer Coach

- ❖ Peer Coach (PC) will provide brokerage by encouraging and supporting opportunities in accessing community resources such as _____, (per timeframe/frequency).

- ❖ PC will assist with coaching and rehab opportunities (per timeframe/frequency) to learn skills needed for _____ .
- ❖ PC will assist in MH Rehabilitation utilizing skills needed, (per timeframe/frequency) such as budgeting, tasks required in maintaining the home and shopping, to maintain housing and _____ .

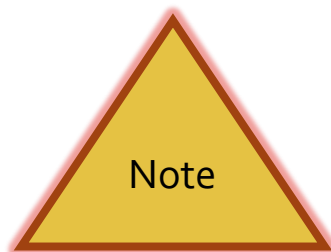
Poor Example of an Intervention:

“Individual therapy.”

This intervention lacks a specificity with how it relates to functional impairment, as well as lacking anticipated frequency and duration.

“Will receive medication as needed.”

This intervention lacks specificity according to regulations (see [IN 17-040 page 12, Q13](#)).



Use of terms “ad hoc,” “prn” or their equivalent do not meet the requirement for proposed frequency interventions. Proposed frequency must be stated specifically or as a range. Duration of services must also be documented. (EX: The client will receive two individual therapy sessions per week for 6 months.)

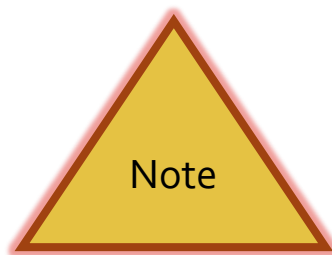
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⁷ IN 17-040 page 12, Q13

Treatment Plan Signatures

The client's participation and understanding of all elements of the plan is essential, expected by our auditors and mandated by state regulations. W&I Code Sec. 5600.2. (a) (2) states "(Persons with mental disabilities) are the central and deciding figure, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. Planning should also include family members and friends as a source of information and support."

This regulation indicates that unless a person has a legal status that removes the client's decision-making power, the client must fully participate in the Treatment Plan. At a minimum, document client participation by obtaining the signature of the client (or their parent or legal guardian). There is no requirement that the client signature needs to be dated.



If you are unable to obtain the necessary client or parent signature(s) within the periods specified due to client or parent unavailability, you must document the reason in your progress note, and then obtain the signature(s) at the next opportunity in order to continue billable services. It is OK to claim for services after the period has expired, but only if 1) there is a progress note explaining why the signature(s) were not obtained, and 2) you obtain the signature(s) at the next opportunity.

8

The plan becomes authorized at the time of signature by the LMHP developing the plan or responsible staff person for the program providing services.⁹

Either the psychiatric prescriber, or their designee, a med support RN involved in treatment, must sign integrated treatment plans that include medication treatment.

⁸ MH Contract pp 25-26, CCR Title 9 Sec. 1810(c)(2)(A)(B)

⁹ MHSUDS IN 17-040

For plans that do not involve medication support services, the provider with the highest licensure is required to sign the plan. If the plan is exclusively for case management services, an LMHP signature is required.

Documenting Client Participation

Documentation of participation in the development of, and agreement with, the client plan may include, but is not limited to,

- Reference in the client plan to the client's participation and agreement with the plan.
- The client's signature; or,
- A description in the progress note of the client's participation in the development of, and agreement with, the client plan.
 - EX: Client participated in treatment planning meeting on (date). The client participated in developing their treatment plan goals and interventions; in particular, the goals for _____. The client was satisfied with the client plan and stated verbal agreement at the meeting on (date)

Client refusals to sign

If a client refuses signature, document an explanation of this refusal and all attempts to obtain signature in a Progress Note. An explanation in the plan is also accepted as evidence of staff diligence to obtain client participation and buy-in to treatment goals.

FAQ - Client Treatment Plan

Q1. Does each provider type need to complete their own plan?

A1. No. It is beneficial to develop an integrated plan with client involvement as well as input from other providers who are working with the client. This ensures that the plan activities are relevant to the provider's scope of practice, and this practice reduces confusion for the client.

Q2. Are Case Managers able to create plans?

A2. The plan must be authored by an LMHP; however, case managers may assist in the creation of goals and interventions within the Client Treatment Plan related to client support activities that are within their scope of practice. See [Scope of Practice](#).

Q3. California minor consent laws say some minors can sign their own plans. Exactly when is this possible?

A3. Each case is different. If you have a minor that you believe should be able to sign his / her plan without a legal guardian's signature, then consult your supervisor. ([See Cal Family Code § 6924\(b\) & Health and Safety. Code § 124260\(b\)](#)).

Q4. Does the psychiatric prescriber need to sign the plan?

A4. Only if they have made specific input into the client plan which is unique to their scope of practice.

Q5. What is a "significant change" that would require an updated client plan?

A5. There is no specific language established for this. Though it is reasonable to assume to major life changes such as: having a child, losing or gaining a job, the death of a family member, change in relationship status, change in residence or living situation, change in one's physical health, or risk factors like new suicidal thoughts, all may warrant client plan updates.

Q6. What is the difference between a "proposed intervention" on a client plan and an "actual intervention"?

A6. Proposed interventions are ones that the provider anticipates delivering to the client at the time of the plan's preparation. These may not line up exactly with actual interventions delivered and documented in the progress notes. In particular, services like linkage and brokerage and collateral support may not be anticipated with great fidelity.

Q7. Can the frequency for delivery of an intervention in a client plan be specified as "PRN," "as needed," or "ad hoc" or as a range of frequencies (example 1-4 x per week)?

A7. Use of terms "ad hoc" or their equivalent do not meet the requirement for proposed frequency interventions. Proposed frequency must be stated either specifically or as a range. Duration of services must also be documented. (EX: The client will receive two individual therapy sessions per week for 6 months.)

Q8. What services are reimbursable during the time that there is a "gap" between plans?

A8. A "gap" between plans results when the client plan is expired and there is a time gap before a plan update takes effect. When there is a gap, the same services that can be approved prior to the initial client plan approval remain reimbursable. Other services, however, are not.

6. Progress Notes

Purpose

Progress notes are a summary description of what was accomplished or attempted at the time of service that was delivered to a client. Progress notes mark progress towards a client's identified goals and are a required element of good clinical documentation.

Progress notes should be written objectively, citing observable evidence and available measures, and tie the service performed to the goals and interventions in the treatment plan to justify the specialty mental health service. Refrain from using negative language about clients. Also, refrain from providing long narratives to describe what happened during the service. Good progress notes may also explain clinical judgment that is relevant to the course of treatment.

Progress Note Basics

1. Every service activity must have a separate, corresponding note (whether claimable or not).
2. All progress notes need to include the following items:
 - a. Date of each service
 - b. Duration of service in exact minutes
 - c. Specific goal being charted to
 - d. Specific clinical intervention and / or decisions
 - e. Client response to the service
 - f. Record of any therapeutic assignments (homework) for the time between sessions
 - g. Must be legible

- h. Service provider's approved electronic signature including title (automatic in Avatar, there is no need to sign progress notes additionally)
- i. Signatures must include: staff's professional degree, license or job title (automatic, see Quick Tip below)

If including travel time, type out the following additional (see [Travel Time](#) for more):

- j. Duration of documentation time
- k. Duration of travel time
- l. Duration of face-to-face time



Quick Tip

Avatar automatically includes some of the progress note aspects, including your title in your electronic signatures and having everything be legible because it is typed.

- 3. Every service is expected to be documented in a timely manner. (See [Note Due Date](#))
- 4. When two staff provide the same service to a client, they both must write a progress note. **It is essential to document the reason more than one staff member was necessary.**

Group Notes

A group is defined as two or more participants. There is no maximum limit set. When doing group notes, utilize the group note from of Humboldt Progress Notes (also known as "scratch note.") While each individual's note in the group can describe the group activity and purpose, it remains that each progress note should be individualized and address the interventions relevant to each client's functional impairment. See Relias training on using Group Notes in Avatar for instructions that are more specific.

Multiple Group Facilitators

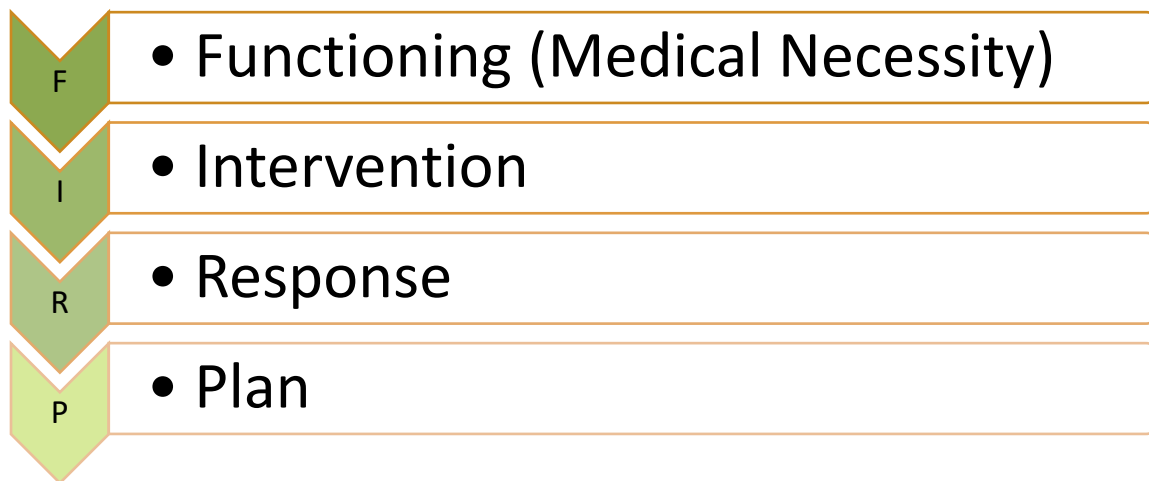
When more than one staff member facilitates a group service, each staff member will write a note in Avatar for the service.¹⁰ This ensures that each facilitator with a valid NPI number is cleared to provide said services. One staff must be designated as the primary practitioner, the other as a co-practitioner. Due to Medi-Cal billing conventions, if one facilitator is an LCSW, or a clinical psychologist, they should be considered a primary over an alternative licensure. A licensed practitioner should be considered primary, an intern secondary. (See Bulletin [18-A005](#)).

¹⁰ MHSUS IN 18-002

F.I.R.P. Format

FIRP format must be used when writing progress notes. FIRP is an expected format that can help keep a note clear and provide organization which auditors are familiar.

FIRP is essentially an outline of what should be included in a progress note. Each FIRP paragraph begins with the corresponding initial followed by the appropriate paragraph. (For example F - _____.)



There is no single style with which to write progress notes. Each staff member providing services brings their own skills, focus, and use of language. Diversity is a strength, and notes should strive towards individualization and customization rather than fitting into certain forms or boilerplates.

The examples on the following pages, borrowed from actual notes, offer some suggestions and guidance to help focus thinking around the function of progress notes. These examples are to be considered suggestions only to inspire note creation. For more on style, see [FAQ - Progress Notes](#).

F - Functioning

To inspire a functional impairment statement you may borrow language from the Client Plan or the Assessment. Alternatively, you can look at notes of other members of the treatment team for the same client.

1. What is the **current medical necessity** for services?
 - Must document continued medical / service necessity to justify all services provided. This needs not be an exhaustive explanation of all components of medical necessity but enough to cohere with the service intervention.
 - Was the provided service appropriate to address the client's service need?
2. What observations were there made about their current condition or status?
 - Should be objective, factual, and non-judgmental.



- ❖ F - Functional impairment exists due to client's mood instability, manic/depressive episodes, inability to care for basic needs, which interfere with his ability to maintain healthy socialization, connection to community resources, track and attend appointments and maintain housing independently.
- ❖ F - Due to mood instability, disorganized thinking, poor impulse control and poor boundaries, which impair the client's ability to maintain skills for independent living (including housing) and appropriate self-care.
- ❖ F - Client's disorganized thinking, poor impulse control and poor boundaries cause functional impairment, which interferes with client's ability to manage her daily affairs.
- ❖ F - Mr. XXX suffers from confusion, poor judgement, poor impulse control and poor boundaries all of which interfere with her social relationships, and hinders her ability to maintain housing.
- ❖ F - Functional impairment exists due to delusional thoughts, grandiosity, paranoia, and unstable affect and suicidal ideation, which interferes with client's ability to make and carry out plans of daily functioning.

I - Intervention

1. What were the conditions of the encounter? (Field / Office / Clinic / Home / Group, etc.)
2. What type of service was offered?
3. What did you do in the context of the encounter?
4. Describe the intervention in such a way that the intervention was clinically appropriate to the impairments addressed and how the service offered reduce impairments, overcome obstacles, restore functioning, prevent deterioration.
5. Describe which skills, interventions, and techniques were employed.
6. Any referrals were made?



- ❖ I - This writer utilized solution focused interviewing techniques to support ct processing current stressors. Offered ct validation and redirection in order to decrease ct's lability and to stimulate ct's motivation for recovery. Modeled appropriate social bx and coached ct on bxs.
- ❖ I - This writer utilized motivational interviewing techniques to facilitate discussion of ct's current stressors, interests, successes etc. Redirected and reframed ct's negative narratives about roommates. Validated ct's resilience and adaptive coping with recent MH struggles and encouraged ct to continue to develop coping strategies that increase recovery. Stimulated motivation and hopefulness for ct's recovery process and encouraged ct to persevere through struggles.
- ❖ I - This writer modeled appropriate social bx and coached ct on bxs by ...
- ❖ I - CM is following and assisting the client in maintaining community stability, participating in meaningful activities that reduce anxiety/depression and providing her with normalized interactions.

R - Response

1. Factual, brief, and observations relevant to the goals and objectives, if possible.
2. What was the client's response to the intervention?
 - Address this in specific terms based on behavior and / or client report
 - Quotes can be very helpful.
3. How was the intervention effective or ineffective?
 - Describe in terms of measurable or observable changes in behavior
4. What signs or symptoms of the diagnosis are present, if any?
 - (Links to medical necessity and appropriateness of current treatment)
5. What was done outside the session?
 - If homework was given at the previous session this is a good place to address what the client did or did not accomplish.
 - If the client self-initiated any interventions, report them as well (e.g. joining a self-help group, or using a new coping skill).
6. What are the client's current impairments and strengths?
 - Again, this addresses medical and service necessity and should describe current levels of functional impairments **and** strengths to overcome them



- ❖ R - Client was appropriate and linear in his thinking, demonstrating good communication skills. He is groomed well with good hygiene. Client stated that he is optimistic about future and enjoyed meeting peer and receiving advice.
- ❖ R - Client sounded like she was slurring her words. Client complained in tangential, vague ways about her case manager, her situation, her rent and her roommate. Client blamed everyone else for her emotional distress and appeared to have lack of insight into the impact of her behavior on others. Client stated, "XXXX!" Client stated that she had not talked about her needs or difficulties with her case manager. Client stated, "I was told XXXXXX." Client could not articulate XXXX. Client hung up on this writer. Client was appropriate and linear in his thinking, demonstrating good communication

skills. He was groomed well with good hygiene. Client stated that he is optimistic about future and enjoyed meeting peer and receiving advice.

- ❖ R -Client was calm, communicative and cooperative. He was dressed appropriately with good hygiene. He was happy for opportunity to go on outing. Client seemed optimistic about new setting and remains focused on goal to obtain greater independence. He expressed interest in getting a gym membership.



Quick Tip

Collateral notes without the client present can include the “R” responses of collateral contacts.

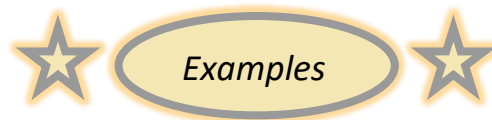


Quick Tip

For services done for a client without direct client contact, the response section may be omitted. For instance, completing documentation, finalizing a treatment plan, or brokerage without the client present.

P - Plan

1. What will be done outside the session?
 - Describe any activities that will occur before the next contact, e.g., planned, referrals, etc.
2. What type of follow-up will be made?
 - Similar to above, could consist of planned collateral contacts. State the planned time for the next contact with the client.

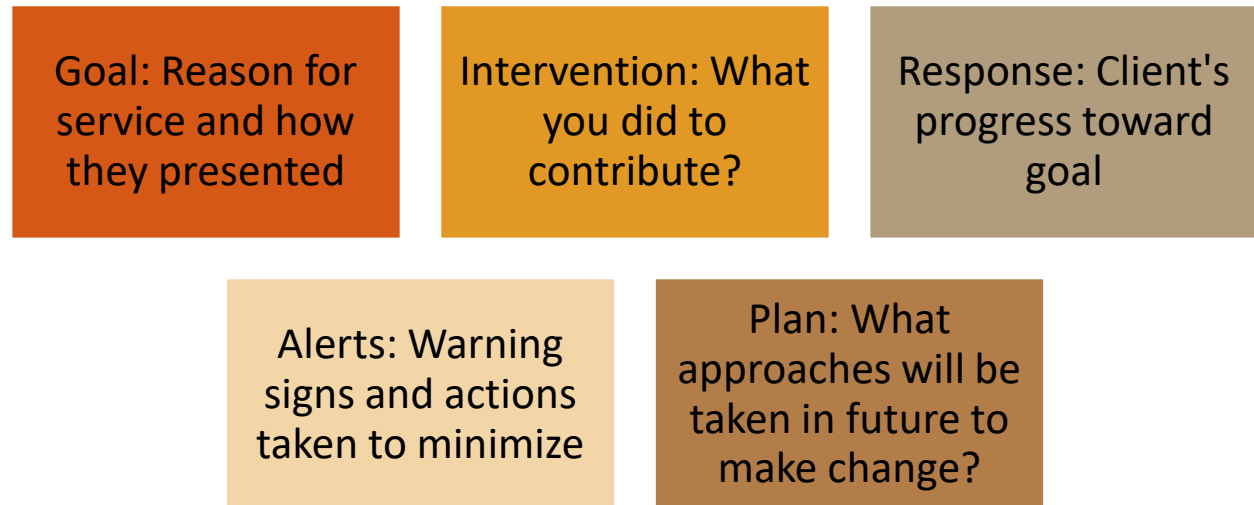


- ❖ P -CM will continue to support Ct's education in independent living skills, interpersonal skills as well as support with maintaining and growing healthy, stable relationships 2x wk. CM will provide coping skills material to Ct.
- ❖ P - Writer followed up and informed the client's case manager and clinician for follow up this week. Writer will continue to support the client in her mental health recovery and independent in the community.
- ❖ P - Writer will promote and encourage the client in his mental health recovery and long-term goals. Case manager will meet with the client weekly to work with him to achieve his client plan goals and make strides towards his mental health recovery.
- ❖ P - This writer will continue to work with ct to build therapeutic alliance and support ct healing/stability, meeting with her monthly for therapeutic support as well as providing crisis interventions as needed.

Quick Tip

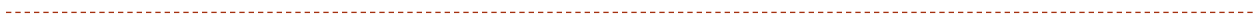
For a Crisis Intervention, state the imminent crisis that led to the unplanned service, what intervention you provided to stabilize the crisis, and what the next steps are for follow-up and continued stability.

Point of view – Remember that you are an agent to help improve the client’s condition, so you will address:



Accounting for Time

Title 9 and the Mental Health Plan Contract with DHCS stipulate that billing for any SMHS needs to be recorded in the exact minutes of time.¹¹ Rounding billing time either up or down is prohibited. Documentation of the total time equation (below) must always be included in the body of the Progress Note.



Travel Time

The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day at the reimbursable service activity¹², as follows:

- Travel time is defined as time used to travel to an off-site location to deliver services. This is time spent without direct contact with service beneficiaries.

¹¹ Title 9 § 1840.316.

¹² MHHSUDS IN 17-040

- Travel time begins when you depart from your work site (a site with a provider number) to an off-site location where claimable Medi-Cal SMHS is made. The travel time must be directly linked or related to the services provided which should be clearly documented in the progress note. In addition, the amounts of travel time and service time should each be reflected in the progress note.
- Travel time does not need to be separately identified in all cases, but if travel is a large portion of the total time of the service described in the notes, an appropriate explanation is needed. This usually means having to travel to another town, or to remote rural areas of Humboldt County.
- Travel time from a staff member's residence and beneficiary's residence may be claimed if all other guidelines of travel are met.¹³
- If traveling to a chain of off-site locations, travel time may be attributed to each note relevant to each claimable service among that chain of events. If traveling to a single site to perform multiple service events, travel to the site can be included in the first of such events, and travel returning can be included in the last event.
- Travel time between mental health programs or provider sites is not covered, nor is time between a staff member's residence to the provider site.
- Travel time that results in no successful client contact (FTA) or support person cannot be claimed. This includes leaving notes or messages or other such clerical work, which does not meet the requirements of SMHS.
- Transportation of clients is considered separate from travel time and is of, by itself, not a claimable SMHS. There are community resources that provide transportation alone. However, SMHS can be provided in conjunction with transporting a client, such as Targeted Case Management (aka "linkage and brokerage").
 - Example: "Case manager drove Client to medication assessment appointment. This writer discussed what to expect in the

¹³ MHSUDS IN 17-040

appointment and led Client through deep breathing exercises to address Client’s anxiety about the appointment. Client expressed that he was still nervous about meeting a new doctor but that the deep breathing helped enough to follow through with the appointment.”

Duration = Travel time + Duration of SMHS time + Documentation time



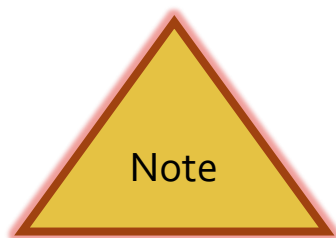
- ❖ 172 minutes or 2:52 hours (**Total time**) = 140 minutes (**Travel time**) + 22 minutes (**Duration of SMHS time**) + 10 minutes (**Documentation time**)
- ❖ 66 minutes or 1:06 hours (**Total time**) = 38 minutes (**Travel time**) + 17 minutes (**Duration of SMHS time**) + 11 minutes (**Documentation time**)

Progress Note Timelines

Notes must be written and submitted by 5:00 p.m. the next working day.

Late Entry:

There is no need to mark notes as “late entry” in the body of the note. Avatar records the date of service and the time of note submission.



Document regardless of the date as late notes can still be claimable services.

Claiming for Chart Review

Time spent reviewing a client chart is reimbursable when the activity is a contiguous part of one of these services: Assessment, Plan Development, Collateral, Rehabilitation,

Therapy, Targeted Case Management, Medication Support Services or Crisis Intervention. Chart review time is not permitted in isolation from one of these services.

If the provider reviews a chart in preparation for a session with a client and the client fails to appear, time spent in preparation may be claimed if the provider documents the circumstances of the no-show and anticipatory review activity.¹⁴

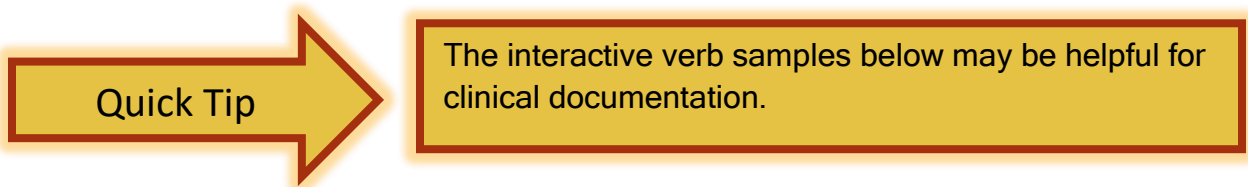
A service cannot be claimed for clerical duties such as scheduling appointments or leaving messages. These tasks do not fall under the scope of SMHS.

On Clinical Language and Best Practices for Progress Notes

- The essential characteristics of an effective progress note are establishing current functional impairment, (or, medical necessity), and the description of a staff intervention that is relevant to assisting in helping the client overcome that impairment.
- It is best to reduce or limit psychiatric or mental health jargon in notes. Jargon can tend to be vague, non-descriptive, analyzing and not person-centered. Rather, it is better to *describe* interventions and spell out what occurred.
- Staff with different scopes of practice have varied comfort levels with mental health terms and should use their own discretion within their own competence.
- In a response section, quote the client, if appropriate. Quoting can help give a chart the impression that a person's helpers understand the client and respect their frame of reference.
 - ❖ During the session, the client continued to struggle with concentration and appeared to have a difficult time focusing, as evidenced by him not answering questions and being unable to stay on topic. The client stated that he has been "easily distracted at school."
- Avoid opinionated notes. Strive to remain objective.
- Summarize and be succinct. Only include details as needed to communicate the goal or objective for the activity, the intervention(s) provided, the client's response, and the follow up plan.

¹⁴ MH SUDS IN 12-040

- Indicate the therapeutic interventions and / or techniques that were employed and how effective they were.
- Use active verbs to describe what you did (see text box on following page)
 - ❖ Role-modeled, demonstrated, taught, educated, processed, encouraged, discussed, etc.
- Indicate the purpose of your intervention:
 - ❖ “to assist client’s understanding of symptoms”
 - ❖ “to increase the use of coping skills”
 - ❖ “to reduce outbursts of anger”
- Show how the contact or service addressed the client plan goals
- Include clinical observations about the client, including the presence or absence of signs and symptoms of the client’s illness
 - ❖ During the session, the client became tearful on several occasions...
 - ❖ The client presented with a flat affect...
 - ❖ The client demonstrated improved ability to express feelings...



Quick Tip The interactive verb samples below may be helpful for clinical documentation.

Acknowledged	Analyzed	Assisted
Assured	Clarified	Confronted
Consulted	Demonstrated	Discussed
Encouraged	Examined	Explained
Explored	Helped	Interpreted
Offered feedback	Processed	Reality tested
Reframed	Reviewed	Role-modeled

FAQ - Progress notes

Q1. When documenting phone calls to or from, voice mails left or received, and client complaints reported by staff, does time of day need to be included in the note?

A1. This is not a requirement. However, if you feel that noting the time of day is relevant to the communication provided then you may note the time.

Q2. When providers wish to add something to a previously completed note, how do they make addendums?

A2. Use Avatar form called Append Progress Notes, which can recall a note and give a place to make new comments to the original note.

Q3. Do Progress Notes need to have the “F-I-R-P” completely separated from each other in the body of the note?

A3. DHCS auditors have noted how helpful it is to document in this manner. Separate them to ensure that all required elements are addressed.

Q4. Can I document a Progress Note for Zero minutes?

A4. No, write an “Independent Note” instead, which does not generate a new service charge.

Q5. What if I have done two or more services during a single client contact?

A5. When two or more significant and distinct services or service type are delivered within a single contact, document each service in a different progress note that meets documentation requirements. It is not appropriate to combine multiple significant and distinct services under a single note that uses the predominant service code. An exception to this is the use of Plan Development, which can include the other undeveloped plans under a single documented contact.

7. Specialty Mental Health Services (SMHS)

Overview

Specialty Mental Health Services are referenced in Avatar using the term “Service Charge Codes”. Staff will only provide services based on their credential (e.g., license, education, training, and experience). See the [Scope of Practice](#) section for more information.

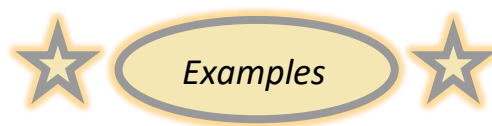
Assessment

Assessment is a service activity designed to evaluate the status of a client’s current mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the client’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.¹⁵ For information on how to complete an assessment document, see the [Assessment](#) section.

Codes: 3331 (*add P if phone, T if telehealth*)

Activities:

Assessment activities are usually face-to-face or by telephone with or without the client or significant support persons and may be provided in the office or in the community. An assessment may also include gathering information from other professionals.



- ❖ Documenting in the 1096 Assessment, 1173 Mental Status Exam, and Diagnosis, 1038 / 1039 Levels are examples of primary uses for this code.

¹⁵ CCR Title 9 Division 1, §1810.204

- ❖ Interviewing the client and / or significant support persons to obtain information to assist in providing focused treatment
- ❖ Administering, scoring, and analyzing psychological tests and outcome measures such as CANS and the MORS (*Caveat: non-licensed staff cannot use the assessment service code, but could use “plan development” instead. See scope of practice grid.*)
- ❖ In some instances, gathering information from other professionals (e.g., teachers, previous providers, etc.) and reviewing / analyzing clinical documents / other relevant documents may be justified as contributing toward the assessment.
- ❖ Observing the client in a setting, (such as home, work, school, etc.), may be indicated for clinical purposes.

Progress Notes - Assessment:

Each assessment activity requires a progress note. The note should contain a brief summary of what was completed during the assessment interview / session, who was present / participated in the service delivery, and specify the exact length of the assessment time, documentation time as well as any travel time.

The final of the assessment progress note’s date should match the date the assessment is finalized in Avatar. Write an additional progress note each time an assessment is appended or updated.

Plan Development

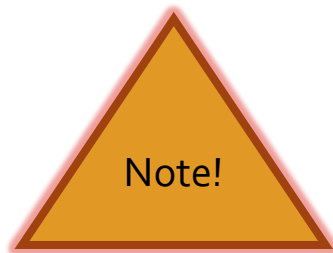
Plan Development (3391) is a service, which consists of development of client plans, approval of client plans, and / or monitoring progress related to the client plan.¹⁶ Client plans drive services and are based on the functional impairment identified in the assessment.

¹⁶ CCR Title 9 Division 1, §1810.232

Plan Development is expected to be provided during the development and approval of the initial Client Treatment Plan and subsequent Treatment Plans.

However, Plan Development can be provided at other times, as clinically indicated. For example, the client's status changes (through either significant improvement or decline) and there may be a need to update the Client Treatment Plan.

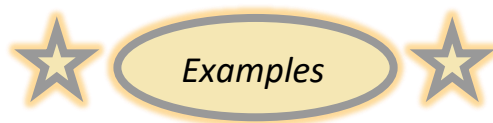
Codes: 3391 (add P if phone, T if telehealth)



Plan Development may also include contact with other professionals consistent with “case conferencing” with direct service providers or support persons involved in a particular case. Each provider must document how the meeting concerned the client’s plan and the significance of their role in the treatment. If the meeting was consistent with Plan Development, use that code. If it was about assessment, use Assessment code. If it was about linkage or referrals, use Targeted Case Management.

Activities:

Plan Development activities may be face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.



Plan development activities with or without the client include following:

- ❖ Development of the Client Treatment Plan
- ❖ Approval of the Client Treatment Plan with client and their legal representative
- ❖ Updating of the Client Treatment Plan
- ❖ Monitoring the client’s progress in relation to the Client Treatment Plan
- ❖ Discharge (with client present)

Progress Notes - Plan Development:

- Plan Development progress notes must refer to the Client Treatment Plan (e.g., development, approval, updating, or monitoring and / or discussing updating the client’s diagnosis)
- Treatment summaries document the termination and / or transition of services, and provide closure for a treatment episode and referrals as appropriate

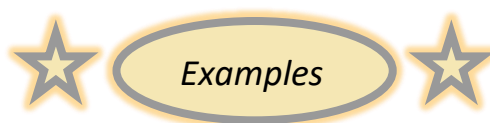
Collateral

Collateral is a “service to a significant support person in a client’s life for the purpose of meeting the needs of the client in terms of achieving the goals of the client’s plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the collateral support person(s). The client may or may not be present for this service.”¹⁷

Codes: 3313 (add P if phone, T if telehealth)

Activities:

Collateral activities are usually face-to-face or by telephone with the significant support person and may be provided in the office or in the community. The client may or may not be present.



- ❖ Educating the support person about the client’s mental illness
- ❖ Training the support person to better support or work with the client
- ❖ Family counseling without the client present

¹⁷ CCR Title 9 Division 1, 1810.206

Progress Notes - Collateral:

- Collateral progress notes, as with all progress notes, must link the interventions to the functional impairments of the client.
- Collateral progress notes must include the staff intervention(s) identified on the client plan (e.g., educating, training, etc.)
- Collateral progress notes should include the role of the significant support person (e.g., parent, guardian, etc.)
- Documentation should substantiate that the support person is significant in the client's life.
- If you are billing consultation with a significant other as a collateral service, documentation must include how the helper educated or trained the significant other to better understand or support the client.
- Collateral groups (e.g., parenting groups) are billable with or without the client. The note must reflect how the interventions benefit the client.
- Collateral progress notes billed under collateral service codes must have interventions consistent with collateral meetings in the scope of consulting, training, educating, supporting, primary supports of the client.
- An excellent collateral progress note should document the changes that occurred as a result of educating and training the significant other, (e.g., show how parents learned and demonstrated new ways of dealing with their child's symptoms or behaviors).

Rehabilitation

Rehabilitation is a service which includes, but is not limited to assistance in **improving, maintaining, or restoring** a client's or group of clients' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, support resources, and / or medication education.¹⁸

Codes: 3301 (add P if phone, T if telehealth)

3302 Group Rehabilitation (add C if co-facilitator)

Activities:

Rehabilitation activities are usually face-to-face or by telephone with the client and may be provided in the office or in the community.

- Individual Rehabilitation
- Group Rehabilitation (for two or more clients)
- Education and / or training of, and counseling for the client in relation to the four following functional skills:
 1. Health - medication education and compliance, grooming and personal hygiene skills, meal preparation skills
 2. Daily Activities - money management, leisure skills
 3. Social Relationships - social skills, developing and maintaining a support system
 4. Living Arrangement - maintaining current housing situation

Progress Notes - Group Rehabilitation:

When providing Group Rehabilitation (e.g. two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:

¹⁸ CCR Title 9 Division 1, 1810.243

1. Type or name of group
2. Total group time, which is the time spent in group plus documentation time and may also include travel time
3. Number of clients
4. FIRP elements that are specific to each client, including an intervention tied to their individual client treatment plan

When providing Group Rehabilitation with more than one staff member:

1. Each facilitator of the group must write their own notes in Avatar
2. Number of staff members, their names with appropriate credentials, and their time spent providing the group service
3. Document the need for more than one facilitator

Group Note Training

Consult Relias for specific Avatar instructions using group note functions.

Therapy

Therapy is a “therapeutic intervention focused primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.”¹⁹

Codes: 3341 Individual (add P if phone, T if telehealth)
3351 Group (Add c if co-facilitator)
3311 Family with primary present (P if phone, T if telehealth),
3312 Family therapy without primary client present (P if phone, T if telehealth)

Activities:

Therapy can be face-to-face, or over the telephone, or via telemedicine with the client(s) or family and may be provided in the office or in the community.

- Individual Therapy
- Group Therapy (for two or more clients)
- Family Therapy with the primary client present

Progress Notes - Group Therapy:

When providing Group Therapy (e.g., two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:

1. Type or name of group
2. Total group time, which is the time spent in group plus documentation time and may also include travel time
3. Number of clients

¹⁹ CCR Title 9 Division 1, 1810.250

4. FIRP elements that are specific to each client, including an intervention tied to their individual client treatment plan

When providing Group Therapy with more than one clinician:

1. Each facilitator of the group must write their own notes in Avatar
2. Number of clinicians, their names with appropriate credentials, and their time spent providing the group service
3. Document the need for more than one facilitator

For help using group notes in Avatar, see [Relias](#) course on Group Notes.

Targeted Case Management

Targeted Case Management (TCM) - (formerly “Linkage and Brokerage”) means “services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development.”²⁰

Codes: 3303 (add P if phone, T if telehealth)

Activities:

TCM activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These services may also include contact with other professionals.

- Communicating, consulting, coordinating and corresponding with the client and / or others to establish the need for services and a plan for accessing these services
- Establishing and making referrals
- Monitoring the client’s access to services
- Monitoring the client’s progress once access to services has been established
- Locating and securing an appropriate living arrangement, including linkage to resources; e.g., Board and Care, Section 8 Housing, or transitional living
- Arranging and conducting pre-placement visits, including negotiating housing or placement contracts

²⁰ CCR Title 9 Division 1, 1810.249

Progress Notes - Targeted Case Management:

A TCM progress note focuses on the assistance or intervention provided to the client (e.g., accessing dental services) and justifies the need for this service based on mental health symptoms / issues; (e.g. who was spoken to, what was discussed with professional, what is the plan, was there a referral to an outside service and what is the next step needed to assist the client).

Crisis Intervention

Crisis Intervention means a service, lasting less than 24 hours, to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit. Crisis Intervention is an unplanned immediate emergency response that is intended to help the client cope with a crisis (e.g., potential danger to self or others; potentially life altering event; severe reaction that is above the client's normal baseline, etc.).

Codes: 3371 Crisis Intervention (add P if phone)

Difference between Crisis Intervention and Crisis Stabilization:

Crisis Intervention is performed in the office, field or in the community, in person or on the phone. Crisis Stabilization, however, is specific to the services for those clients admitted to the Crisis Stabilization Unit, which has the requisite contract, site and staffing requirements of crisis stabilization. ²¹

Activities:

Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.

These include:

- Assessment of the client's mental status, acuity of symptoms and current need

²¹ CCR Title 9 Division 1, Sections 1840.338 and 1840.348)

- Therapeutic services for the client
- Education, training, counseling, or therapy for significant support persons involved

Progress Notes - Crisis Intervention:

- An excellent Crisis Intervention progress note contains a clear description of the “crisis” in order to distinguish the situation from a routine event and the interventions used to help stabilize the client.
- All services provided (e.g., Crisis Assessment, safety plan, Collateral, Individual / Family Therapy, TCM - Linkage and Brokerage) shall be billed as Crisis Intervention.
- Once the crisis is resolved, any follow-up cannot be billed as Crisis
- The maximum amount claimable to Medi-Cal for crisis intervention in a 24-hour period is 8 hours (480 minutes) per client

Crisis Stabilization

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

Requirements:

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 the MHP to perform crisis stabilization. Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All clients receiving Crisis Stabilization shall receive an assessment of their physical and mental health. If needing outside services, make a referral that corresponds with the client’s needs.²²

²² W&I Code Sections 5778 and 14680

Staffing Requirements:

A Psychiatric Prescriber must be on call at all times for the provision of Crisis Stabilization Services that may only be provided by a physician. There shall be a minimum of one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times clients are present. The ratio must be a minimum of one licensed mental health or waived / registered professional for every four clients receiving Crisis Stabilization. If the client evaluated needs service activities that can only be provided by a specific type of licensed professional, that person must be available.²³

Difference between Crisis Intervention and Crisis Stabilization:

Crisis Stabilization distinguishes from crisis intervention in that they are delivered by providers who meet the crisis stabilization contact, site, and staffing requirements.²⁴

See [CSU Documentation Manual](#) for more details.

Medication Support

Medication Support Services are those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to development related to the delivery of the service and / or assessment of the client. ²⁵

Codes: 3361 Med Support MD (add P if phone, T if telehealth)

3362 Med Support NP / PA (add P if phone, T if telehealth)

3363 Med Support Nurse (add P if phone, T if telehealth)

²³ W&I Code Sections 5778 and 14680

²⁴ CCR Title 9 Sections 1840.338 and 1840

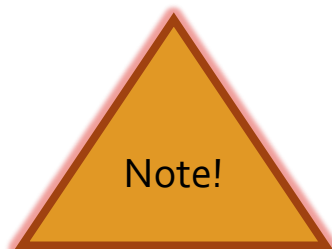
²⁵ CCR Title 9 Division 1, 1810.225

3364 Med Support Group Nurse
3365 Med Support Injection

Activities:

Medication Support Services activities are usually face-to-face or by telephone or telehealth with the client or significant support persons and may be provided in the office or in the community. These services include:

- Evaluation of the need for psychiatric medication
- Evaluation of clinical effectiveness and side effects of psychiatric medication
- Medication education, including discussing risks, benefits and alternatives with the client or support persons
- Ongoing monitoring of the client's progress in relation to the psychiatric medication
- Prescribing, dispensing, and administering of psychiatric medications



The maximum amount claimable to Medi-Cal for medication support services in a 24-hour period is 4 hours (240 minutes) per client.

Progress Notes - Medication Support:

Med support may enter their own templates for their standard of care. Nursing Med Support Notes usually differ from the notes of psychiatric prescribers.

Psychological Testing

Psychological Testing Services are formalized measures of mental functioning, and include written, visual, or verbal evaluations to assess the cognitive and emotional functioning of children and adults. They must be performed and interpreted by a

clinically trained examiner who must be a Licensed Psychologist or Psychologist Intern. Psychological tests are used to assess a variety of mental abilities and attributes, including achievement and ability, personality, and neurological functioning.

Code: 3321 Psychological Testing

Activities: Administering psychological tests.

Progress Notes - Psychological Testing:

Notes should indicate methods used, conditions of psychological testing, and how results of tests were used and filed. The notes should also reflect accurate service duration.

Supplemental

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) are a Medi-Cal benefit of individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows periodic screenings to determine health care needs, both mental and physical. Based upon the identified health care need, diagnostic and treatment services provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a client under the age of 21 may receive additional medically necessary services.

See the [EPSDT Chart Documentation manual](#) for more information.

Pathways to Wellbeing (formerly Katie A. / Continuum of Care Reform (CCR))

DHCS contracted with California Institute for Behavioral Solutions (CIBHS) to offer support in the continued implementation of Pathways to Wellbeing to develop resources and tools in assisting the provision of services and implementation of the Core Practice Model.

Tools available include Evidence-Based Practice Models such as Aggression Replacement Training, Functional Family Therapy, and Trauma-Focused Cognitive Behavioral Therapy.

Helpful Links:

[California Integrated Core Practice Model \(ICPM\) & Core Practice Model Guide & California Institute for Behavioral Health Solutions](#)

Katie A. Subclass

Katie A. Subclass are a group of service types targeting children in need of early mental health intervention. Created in 2011, this group of services responded to the [Settlement Agreement](#) resulting from case law *Katie A. v. Bonta*. Young clients in these programs receive services in their own home, family setting or the most homelike setting; will be most likely to improve their safety, performance and well-being.

Therapeutic Foster Care (TFC)

TFC is a program that works collaboratively between Social Services, Mental Health and Probation; created for minors with special needs / emotional problems, who need more structure and supervision than regular foster care, and are at risk of an out-of-county placement, or returning from an out-of-county placement.

Helpful Links:

[Medi-Cal Manual for ICC, IHBS, and TFC](#)

[Therapeutic Foster Care Training Resource Toolkit](#)

Intensive Care Coordination (ICC)

ICC is a targeted case management service. An ICC coordinator will work with the family to ensure that their voice is being heard and that the CPM is being followed. The ICC coordinator will also work with the family to organize a Child and Family Team (CFT) or enhance an existing team.

Helpful Links:

[Medi-Cal Manual for ICC, IHBS, and TFC](#)

Intensive Home-Based Services (IHBS)

Intensive Home-Based Services are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of a child / youth and their significant support persons to help them develop skills and

achieve the goals and objectives of the client plan. IHBS are not traditional therapeutic services.

These services target the Katie A. Subclass (and their significant support persons). Services are expected to be of significant intensity to address the intensive mental health needs of the child / youth, consistent with the client plan and core practice model.

Services may be delivered in the community, school, home or office settings. IHBS services include, but are not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms.
- Development of functional skills to improve self-regulation or self-care
- Education of the child / youth / family /caregiver about how to manage symptoms
- Support the development, maintenance and use of social networks and community resources.
- Support to address behaviors that interfere with the achievement of a stable and permanent family life and stable housing, obtain and maintain employment and achieve educational objectives.

Helpful Links:

[Medi-Cal Manual for ICC, IHBS, and TFC](#)

Short-Term Residential Therapeutic Programs (STRTPs)

Residential facilities operated by either a public or a private organization, providing integrated specialized and integrated care, support, treatment and round-the-clock supervision to minors.

Helpful Links:

[California Department of Social Services: STRTP](#)

Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one to one, short-term, outpatient treatment intervention. It is designed for clients up to age 21 with Serious Emotional Disturbances (SED) who are experiencing a stressful transition or life crisis that is placing the individual at risk of an out-of-home placement in a certified group home, or are at risk of a psychiatric emergency.

Referral Qualifications:

1. Must be under 21 years of age
2. Must have serious emotional challenges
3. Must be eligible for full-scope Medi-Cal
4. Must have at least one of the following:
 - a. Be at risk of placement in a group home (whether or not that group home is available)
 - b. Be at risk of placement in a psychiatric hospital (whether or not a psychiatric hospital is available)
 - c. Have a history of psychiatric hospitalization within the past 24 months
 - d. Be placed in a group home and be at risk of placement failure without TBS

Activities:

TBS activities are usually face-to-face with the client in most settings. TBS-related activities may also be provided to significant collateral support persons and other supporting professionals.

- One-to-one therapeutic contact typically models / teaches, trains or supports appropriate behavioral changes
 - TBS activities may also include assessment, collateral, and plan development, which are coded as TBS
 - TBS is provided only by trained providers while under clinical supervision
-

Q1. What are Specialty Mental Health Services (SMHS)?

A1. The Department of Health Care Services (DHCS) administers California’s Medicaid (Medi-Cal) program. The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. As the single state Medicaid agency, DHCS is responsible for administering the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet medical necessity criteria, consistent with the beneficiaries’ mental health treatment needs and goals.

Q2. Who is a Specialty Mental Health Provider?

A2. A “Specialty Mental Health Provider” is a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services. Specialty Mental Health Providers include but are not limited to:

1. Clinics
2. Hospital Outpatient departments
3. Certified residential treatment facilities
4. Psychiatric health facilities
5. Hospitals
6. Licensed mental health professionals; including Psychiatrists, Psychologists, Licensed Clinical Social Workers, Marriage and Family Therapists, and Registered Nurses.

8. (No Bill) and Missed Appointment Codes

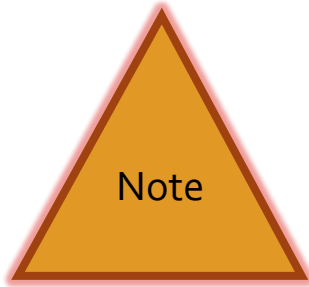
There are varieties of reasons why notes are written while not meeting criteria for a SMHS claims. Examples include documenting notes for clients who do not meet criteria, or cancelled appointments. If there is no option to make a claim for any services, a no-bill note can be written. As with a claimable service, the narrative of the note must match the service code chosen.

4000 Codes

In the past, activities performed for a client that were not direct billable services, staff typically used code 8304, Direct No Bill. In 2019, 4000 codes went into effect seeking to address the high usage rates of the 8304 code. 4000 codes reflect useful information about what types of services were rendered and may be reviewed for potential claims.

Examples of the proper use of a 4000 code is the process of conducting service events while a client is not open for services, has an excluded primary diagnosis, or has an expired assessment or treatment plan. 4000 codes resemble all 3000 codes described earlier in this manual with the exception of 4 replacing 3. They are:

- 4301 - (No Bill) MH Rehabilitation
- 4302 - (No Bill) CM Group Rehabilitation
- 4303 - (No Bill) CM Brokerage
- 4304 - (No Bill) ICC
- 4311 - (No Bill) Family Therapy
- 4313 - (No Bill) Collateral
- 4331 - (No Bill) Assessment
- 4341 - (No Bill) Ind. Therapy
- 4351 - (No Bill) Group Therapy
- 4361 - (No Bill) Med Support
- 4363 - (No Bill) Med Support Nurse
- 4371 - (No Bill) Crisis Intervention
- 4391 - (No Bill) Plan Development



If you are charting for a service program which itself is no-bill, (such as PATH, Jail, HumWorks), Avatar will consider this a redundancy to use no-bill codes in a no-bill program. If charting for a no-bill program use 3000 codes.

8304 No Bill

Whenever possible, use 4000 codes over 8304. However, continue to use 8304 if none of these other options is a better fit.

Cancellation, Missed, or Failure to Appear

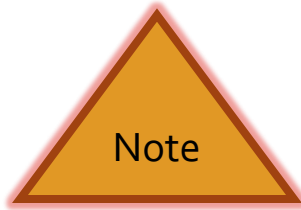
Whenever a client cancels or fails to appear for a scheduled appointment, it is best practice to document this in a Missed Appointment progress note.²⁶

- MISS1 for FTA (Failure to Appear)
- MISS2 for client-cancelled
- MISS3 for staff-cancelled

Write a Humboldt Progress Note to explain the missed connection, attempts to reach, or any anticipated actions.

While in the calendar, use the “status update” feature to cancel any scheduled appointments. Then use any 8000 code, such as 8303, to note ancillary time in place of what would have been direct service time documented in notes.

²⁶ Avatar Bulletin 19-A010



If you were able to get hold of the client or a collateral contact, this may be considered a billable event. Time spent in chart review in anticipation of an appointment which was cancelled may also be claimed.

Further Training on MISS Notes

See “Missed Appointments” training in Relias or Bulletin 19-A010.

FTA at Med Support

For failure to appear to an appointment in Med Support, psychiatric prescriber notes should indicate, for example:

- “Client failed to appear for Med Support appointment”
- Reviewed Chart
- Requested RN to follow up
- Refill medication for 30 days
- No medication refills until ct sees MD
- Continue same medications until next scheduled MD appt.
- New medication orders.

9. Lockouts

Overview

A lockout is a service activity that is not reimbursable through Medi-Cal because the client resides in, and / or receives mental health services in, one of the settings listed below. A Clinician may provide the service (e.g., targeted case management) for a client residing in an IMD (a psychiatric institution or hospital), but it would be reimbursable only under certain circumstances.

Note: Services provided by CSU staff while the client is on the CSU are billed as Crisis Stabilization. Other outpatient services provided while the client is on the CSU by non-CSU staff members are not reimbursable. (The same is true for clients on Sempervirens PHF.)

Medi-Cal Lockouts

No service activities are reimbursable if the client resides in one of these settings (except for the day of admission and discharge):

- Jail / Prison
- Juvenile Hall (not adjudicated)
- IMD
- Psychiatric Inpatient*
- Psychiatric Nursing Facility*
- Crisis Stabilization Unit (CSU)**

***Exception:** Medication Support Services or Targeted Case Management (for placement purposes only within 30 days of discharge) are reimbursable.

****Exception:** Targeted Case Management *for placement purposes only* is reimbursable while client is at the Crisis Stabilization Unit

If serving a client during a lockout does not fit the above exceptions, consider 3309 CM Lockout (No Bill).

Note: For ICC and IHBS, see [Katie A. Medi-Cal Documentation Manual](#) for Lockouts.

Lockout Grid:

Service Site or During the Hours of Operation	Lockout for Outpatient Mental Health Service	Lockout for Outpatient Medication Support Service	Lockout for Outpatient Targeted Case Management Service
Crisis Residential	Yes ¹	No	No
Crisis Stabilization Unit (CSU)	Yes ²	Yes	No
Day Treatment Programs (Intensive and Rehabilitation)	No ³	Yes	No
Juvenile Hall, Jail, or Similar Detention (Not adjudicated for Placement)	Yes ⁴	Yes ³	Yes ³
Psychiatric Inpatient Hospital	Yes ^{1,4}	Yes	Yes ⁵
Psychiatric Health Facility (PHF)	Yes ¹	Yes	Yes ⁵
Psychiatric Nursing Facility	Yes ¹	Yes	Yes ⁵
Physical Health Care Hospital	No	No	No

¹ Except on the day of admission

² No other Specialty Mental Health Service is reimbursable during the same period in which the service is reimbursed

³ Except by the same Day Treatment Program Staff

⁴ Except when there is evidence that the court has ordered suitable placement (post-adjudication for placement) in a group home or other setting other than a correctional institution, jail and other similar settings.

⁵ Except on the day of admission, and 30 calendar days immediately prior to the day of discharge, for a maximum of three non-consecutive periods of 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement

Disallowances

A disallowance is a claim adjustment agreed upon by the medical provider and insurance company. It is an amount of funding expected to never be collected, by virtue of laws, regulations, contracts or internal policies applicable to the services provided by the entity.

Find common DHCS Disallowances on [Reasons for Recoupment for FY 2018-2019](#).

10. Coordination of Care

Coordination of care is information-sharing across providers, clients, types and levels of service, sites and times to ensure efficient and high-quality care. Clients with multiple needs that cannot be met by a single Clinician, agency, or organization will benefit from care coordination to help meet their needs. Multiple providers working together can share clinical information and have clear, shared expectations about their roles with the client. When documenting, each provider must include a rationale for multiple team members being involved in client care.

Care coordination's goal is to keep participants involved in the client's care informed and to ensure that effective referrals and transitions take place. Staff exchanging information with other participants will obtain a Release of Information₁ and its appropriate attachment(s), prior to coordination activities.

11. Treatment Summary

Complete a Treatment Summary 1077 when a client either has met their goals and can transition to a lower level of care or discontinues a specialty mental health service.

If a client is discontinuing one service but remains an active client in another, do a Treatment Summary clarifying which services are being closed (such as closing with counseling but remaining with medication support). Mark the relevant treatment interventions as “met” on the client plan, and explain any changes in treatment direction with a progress note. Keep the episode open for other activities to continue to chart in. If the client later completes the program or is discharged entirely from care, then proceed with a full integrated treatment summary.

Complete the Treatment Summary must be completed by the assigned licensed or waived LMHP practitioner who is coordinating care. In absence of the coordinating practitioner, the summary must be done by a supervisor or another designated LMHP practitioner. This is true whether the client was open to therapy or case management.

The discharge bundle in AVATAR includes a Treatment Summary, a complimentary progress note to document the transition, as well as a completed Diagnosis Form to record the client’s discharge diagnosis.



Quick Tip

This discharge bundle can also be utilized when a client discontinues services without notifying staff and fails to respond to phone calls or letters offering additional services.

If changing the diagnosis at discharge from a covered to an uncovered diagnosis, Avatar will not be able to bill for the discharge service. If this is the case and the client has improved no longer meeting SMHS criteria, diagnoses of diagnosis deferred (R69) or No Diagnosis (z03.89) may be used.

12. Outcome Measures & Evidence-Based Practices (EBPs)

Overview

DHHS-MH is committed to providing integrated services that are outcome driven—with proven or promising results. DHHS offers child, youth and adult focused Evidence-Based Practices (EBP), providing prevention, early intervention and focused treatment interventions.²⁷

DHHS keeps a list of [EBP Outcome Measures by Treatment Focus](#) and an [EBP Summary Info Sheet](#) on the DHHS bulletin board.

Look out for the forthcoming Children's Assessment, which will include CANS.

Child and Adolescent Needs and Strengths (CANS)

Overview - CANS:

Now available in Avatar, the Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 25 states in child welfare, mental health, juvenile justice, and early intervention applications. A comprehensive, multi-system version exists as well. The CANS is an open domain tool that is free for anyone to use.

Usage - CANS:

CANS is used to monitor outcomes in two ways. First, items initially rated a '2' or '3' are monitored over time to determine the percent of youth who move to a rating of '0' or '1' (resolved need, built strength). Alternatively, dimension scores can be generated by summing items within each of the dimensions (Problems, Risk Behaviors, Functioning, etc.). These scores are compared over the course of treatment.

²⁷ DHCS

Training - CANS:

The DHHS Dashboard introduction to CANS is located [HERE](#).

CANS training from the Praed Foundation Collaborative Training Website is located [HERE](#).

History / Development - CANS:

The CANS developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is easy to learn and well-liked by parents, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to an individual child and family.

Research / Reliability / Validity - CANS:

CANS has demonstrated statistical reliability and validity. The average reliability of the CANS is 0.75 with vignettes, 0.84 with case records, and can be above 0.90 with live cases. The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level. CANS is instrumental in demonstrating statistical validity in the relationship to level of care decisions and other similar measures of symptoms, risk behaviors, and functioning.

Pediatric Symptom Checklist (PSC-35)

DHHS provides the [1227 Pediatric Symptom Checklist](#) (PSC-35) as part of a statewide effort to monitor effectiveness of publicly funded specialty mental health services. Provide the PSC-35 to parent(s) / caregiver(s) of all children and youth aged 4 to 18 receiving specialty mental health services.

The admitting practitioner (case coordinator) will provide the tool to the parent / caregiver within the first 60 days of case opening, then every six months of treatment, and the end of treatment. (See policy no [1001.801](#)). After completing the tool, the form will be routed to Medical Records for scanning into the record.

Milestones of Recovery Scale (MORS)

Overview - MORS:

MORS is an effective evaluation tool for tracking the process of recovery for individuals with mental illness. Humboldt County uses this tool with adults. It provides easy to use data that allows staff, supervisors and administrators to see how individual programs and agencies are performing. MORS can help systems and programs demonstrate to funding sources, politicians and the public that mental health systems can be cost-effective and achieve positive outcomes. It has been extensively tested and researched for validity and reliability.

Usage - MORS:

MORS is a one-page, single score assessment that takes just a few minutes to complete. It focuses on the here and now, providing a snapshot of an individual's progress toward recovery. It can help staff tailor services to fit each individual's needs, assign individuals to the right level of care and create "flow" through a mental health system by quantifying the stages of an individual's recovery using milestones that range from extreme risk to advanced recovery and everywhere in between. MORS has in-depth descriptions of what individuals at each stage might typically look like in terms of their levels of risk, engagement and support from others.

Training - MORS:

MORS concepts and use can be learned by attending three hours of training with a licensed MORS trainer. See your supervisor to schedule a training with QMS or see Relias for upcoming trainings.

History / Development - MORS:

MORS is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and service utilization. It

operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.

The MORS Scale was created in 2002, by Dave Pilon, Ph.D. and Mark Ragins, M.D., both from Mental Health America of Los Angeles (MHA). The idea for MORS grew out of a 1997 workgroup assembled by the California Association of Social Rehabilitation Agencies (CASRA) that was made up of 50 individuals who identified themselves as clients, family members, mental health program staff and program directors. The group's task was to try to identify important indicators of recovery. After many meetings filled with lively discussions, the group participants came to a conclusion: individuals in the recovery process could be assigned to clusters based on their level of risk, their level of coping skills and their level of engagement with the mental health system. They also concluded that an individual's movement from cluster to cluster could be seen as a description of "the process of recovery." Five years later, Dr. Pilon and Dr. Ragins, both participants in the CASRA group, expanded on the group's conclusions by developing the Milestones of Recovery Scale.

Research / Reliability / Validity - MORS:

MORS was tested for reliability at the MHA Village in Long Beach, California and Vinfen Corp in Cambridge, Massachusetts. Its validity was substantiated by the Center for Behavioral Research and Services (CBRS) at California State University Long Beach in 2005. An article entitled "Psychometric Properties of an Assessment for Mental Health Recovery Programs," about the creation of the scale and related research, was published in the Community Mental Health Journal in July 2009.

MORS Widget:

A MORS widget has been implemented in Avatar to gauge trends in client recovery and help inform clinical decision-making.

12 - Notices of Adverse Benefit Determination (NOABD)

What an NOABD is

A Notice of Adverse Benefit Determination (NOABD) is a document issued to a client or provider to advise them of a determination that our agency has made as it relates to the provision of SMHS. These determinations could include the denial, limitation, reduction, suspension, or adjustments in the provision of mental health services. The NOABD is important because it is used to advise the client of the decision made and to provide information to the client of their right to appeal the decision. Before completing a NOABD, a practitioner should consult with their supervisor.²⁸

Types of NOABD

1. 1045 - Denial
2. 1045 - Delivery System
3. 1045 - Termination
4. 1045 - Modification
5. 1045 - Payment Denial
6. 1045 - Timely Access
7. 1045 - Authorization Delay
8. 1045 - Grievance / Appeal Resolution
9. 1045 - Financial Liability

To find the appropriate NOABD, check the [DHHS form repository](#) in the DHHS intranet for the latest..

NOABD Training

See “NOABD Training” in [Relias](#) for a more thorough review of policy and procedure.

²⁸ Title 9, CCR, Section 1850.205.

Sections 5777, 5778, and 14684, Welfare and Institutions Code and Title 42, Code of Federal Regulations, Part 438, Subpart F

When and how to give an NOABD to a client

With exceptions, the NOABD must be hand-delivered or put in the mail **no later than the third working day after the action was taken**. The completed NOABD must be provided to the client via US Mail along with the page which explains the client's rights to appeal the decision made by the MHP should they not agree with the proposed decision. Whenever possible, the staff shall make all appropriate efforts to assist client in preparing for the proposed action, including, but not limited to, pointing out alternate resources and / or support such as self-help groups and other community services. Also, the clients shall be advised, where appropriate, that they may become eligible for an increased level of services if their condition worsen and inform the client that they will not be subjected to any discrimination, penalty sanction, or restriction, for filing a complaint.

Each NOABD must include the following attachments:

- QI-108 NOABD Know Your Rights
- QI-109 Beneficiary Non-Discrimination Notice, and
- QI-110 Language Assistance Taglines

Who receives a copy of the NOABD

All NOABDs are given to the client. A copy needs to go to Medical Records for scanning into the chart and another copy to Quality Improvement for logging and tracking.

FAQ - NOABD

Q1: Is the NOABD still addressed to the client when the client is a minor?

A1: Unless it is a minor consent case, the original should be sent to the minor and a copy should be sent to the minor's parent or legal guardian. For minor consent cases, the NOABD should be handled in one of the following ways:

1. Given to the minor in person

2. Given to the minor's eligibility worker to give to the minor next time she / he comes in
3. Held by the practitioner until the next time the minor comes into the office / clinic.

In minor consent cases, the NOABD must not be mailed to the minor's address and the minor's parent / guardian must not receive a copy or be otherwise notified.

Q2: Must an NOABD be issued when a network provider does an Assessment which determines the beneficiary does not meet medical necessity?

A2: Yes, the client must be provided with a NOABD regardless of whether the Assessment is completed by DHHS-MH or respective organizational providers.

Q3: Can we simply issue an NOABD when the county does not provide a particular SMHS that the client needs?

A3: No. If we determine the client is in need of particular SMHS, we are obligated to provide and arrange for that service. The issuing of a NOABD does not excuse Mental Health from meeting its contractual obligation to provide medically necessary services to beneficiaries.

Q4: Must an NOABD be issued if the County offers a SMHS, but not necessarily the service requested by the client?

A4: No, however, the client must participate in development of the care plan. The county should ensure that services, to the extent possible, are client-centered. A client who requires additional services as necessary has the right to challenge the County and provider decisions through the client appeal and state fair hearing process.

Q5: Must a NOABD be issued when the beneficiary is not approved for a service they requested?

A5: No, unless the county determines that no specialty mental health services will be provided.

Q6: Must a NOABD be issued if a treatment team determines a lack of medical necessity?

A6: Yes, a NOABD is required for decisions by the county or its providers. The treatment team, acting as a provider, is deciding that the client will not receive services from the county.

Q7: Must an NOABD be issued when a client, who originally asked for services, changes their mind during the Assessment process and, as a result, no services were offered?

A7: No, assuming the decision was the client's. The NOABD is only required when the decision to decline services was denied by the provider.

Q8: Is an Assessment to determine Medical Necessity considered a SMHS? In particular, if a client is found to not meet Medical Necessity criteria after the end of the Assessment period, do we need to issue a NOABD?

A8: Yes, the County needs to issue an NOABD, if a client is found not to meet Medical Necessity. An Assessment to determine Medical Necessity for SMHS is covered by the County. A client does not need to meet criteria to receive the Assessment service itself. The NOABD applies to the determination that future services will not be provided because the client being assessed does not meet medical necessity.

Appendix A - Glossary of Terms and Acronyms

These are some of the commonly used acronyms and terms used by Mental Health. These along with the approved abbreviations in the next section, are the only approved ways to write words and terms without spelling them out. (See [CMS Glossary](#))

Term / Acronym	Full Name
AA	Alcoholics Anonymous OR Administrative Analyst
ABHRS	Adult Behavioral Health and Recovery Services
ACT	Assertive Community Treatment
ADHC	Adult Day Health Center
AMFT	Associate Marriage and Family Therapist (formerly called Marriage and Family Therapist Intern - MFTi)
Annual Plan	The documentation that must be completed no later than on an annual basis. “Care Plan”, “Client Plan” or “Treatment Plan” are used interchangeably with Client Treatment Plan and describe a plan for the provision of specialty mental health services to an individual client who meets the medical necessity criteria in CCR Title 9 Sections 1830.205 or 1830.210
AOD	(see SUD) formerly Alcohol and Other Drugs
APCC	Associate Professional Clinical Counselor
Appdev	Application development, Avatar development team
ART	Aggression Replacement Therapy OR Alternate Response Team
ASOC	Adult System of Care
ASW	Associate Social Worker
AT	Activity Therapist
Authorization to Use, Exchange, and / or Disclosure of Confidential	Documents signed by client and provider that permits specified information to be shared among designated persons and / or agencies regarding client’s services and or treatment plan, for a designated period of time.

Term / Acronym	Full Name
Mental Health Information Release of Information (ROI)	
BC	Behavioral Coaching
B&C	Board and Care
BHB	Behavioral Health Board
BOS	Board of Supervisors
CANS	Child and Adolescent Needs and Strengths (CANS) is an instrument used to help identify the client's and family's strengths and needs.
CAR	Central Access Registration
CAR Staff	Certain staff who are trained and are responsible for authorizing services for clients to see contract providers
CAST	Child Abuse Services Team
CCT	Comprehensive Community Treatment, an intensive "WRAP" program for adults (See ACT)
CIF	Client Information Form
CBH	Crestwood Behavioral Health
CBHDA	California Behavioral Health Directors Association
CCP	Cultural Competency Plan
CCR	California Code of Regulations OR Continuum of Care Reform
CCRC	Community Corrections Resource Center
CFMG	California Forensic Medical Group
CFR	Code of Federal Regulations
Changing Tides	An Organizational Provider for DHHS-MH
CIBHS	California Institute for Behavioral Health Solutions
CMHC	The computer program used by MH through March 2014 that includes client database, claiming and tracking

Term / Acronym	Full Name
CMS	Centers for Medicare and Medicaid Services
	Case Management Services
Co-occurring Disorder	Youths, adults, and older adults are considered to have a co-occurring disorder when they exhibit the co-occurrence of mental health and substance use / abuse problems, whether or not they have already been diagnosed.
CQI	Continuous Quality Improvement
CQIC	Continuous Quality Improvement Committee
CSOC	Children’s System of Care
CSU	Crisis Stabilization Unit MH’s emergency room for psychiatric emergencies, located on the 2 nd floor of the Main Building (formerly known as Psychiatric Emergency Services or PES)
CWS	Child Welfare Services (DHHS-SS)
C&FS	Children and Family Services
CYFS	Child, Youth & Family Services (see also C&FS)
DCP	Discharge Planner
DHCS	Department of Health Care Services
DHHS	Department of Health and Human Services
Disallowance	A claim for a service which is denied or recouped due to not meeting regulatory standards
DT or DTC	Day Treatment or Day Treatment Center
EAP	Employee Assistance Program OR Emergency Action Plan
ERMHS	Educationally-Related Mental Health Services: Free, appropriate public education in the least restrictive environment for children with mental health challenges.
ECHC	Eureka Community Health Center
EHR / EMR	Electronic Health Record OR Electronic Medical Record

Term / Acronym	Full Name
EPSDT	Early Periodic Screening Diagnosis and Treatment
FA	Fiscal Assistant
FY	Fiscal Year, e.g. July 1, 2014 - June 30, 2015
FIT	Family Intervention Team
GR	General Relief
GV or G'Ville	Garberville
HCCF	Humboldt County Correctional Facility or Jail
HCL	Humboldt Central Lab
HCP	Henderson Center Pharmacy
HCPR	Humboldt County Programs for Recovery
HCMH	Humboldt County Mental Health
HCTAYC	Humboldt County Transition Age Youth Collaboration
HF	Healthy Families
HFSC	Humboldt Family Service Center - An Organizational Provider for DHHS-MH
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996 refers to the protection of the privacy of individually identifiable health information. As part of this protection, release of information is required to share any information pertaining to client's care / services.
HMP	Healthy Moms Program (Perinatal MH / SUD Program)
HumWORKs	Humboldt County Work Opportunity & Responsibility for Kids (the Mental Health program in CalWORKs)
ICC	Intensive Care Coordination
IDEA	Individuals with Disabilities Act
IHBS	In-Home Behavioral Services (provided by org providers)
IHSS	In-Home Supportive Services
IMD	Institute for Mental Disease

Term / Acronym	Full Name
Interventions	Refers to what the practitioner will do in order to assist client with meeting their objective and life goals. These are what drive reimbursements.
IP	Inpatient
IPC	Interagency Placement Committee
JH	Juvenile Hall
LCSW	Licensed Clinical Social Worker
LE	Law Enforcement OR Legal Entity: Each county mental health department or agency and the corporations, partnerships, or agencies, providing public mental health services under contract with the county mental health department or agency.
LMFT	Licensed Marriage and Family Therapist
LMHP	License Mental Health Professional
LPCC	Licensed Professional Clinical Counselor
LMHP	Licensed Practitioner of the Healing Arts: psychiatrist, clinical psychologist, licensed or waived MFT, LCSW, RN with Master's degree in Psychiatric Nursing
LPT	Licensed Psychiatric Technician
LVN	Licensed Vocational Nurse
MAA	Medi-Cal Administrative Activities
MAB	Management of Aggressive Behavior
MC	Managed Care
MCO	Managed Care Organization: MCO clients: clients who have Medi-Cal as their only insurance
Medi-Cal	California's Medicaid program, from which reimbursements for medically necessary services are received
Medicare	Federal Medical Aid
Meditrieve	HCMH on-line medical records system (see

Term / Acronym	Full Name
	Sceris - no longer used)
MEDS	Medi-Cal Eligibility Data System
Mental Health Medi-Cal	Another name for the program which oversees Short-Doyle / Medi-Cal claiming
MFT	Marriage and Family Therapist (also “LMFT”)
MH	DHHS - Mental Health
MHAB	Mental Health Advisory Board
MHB	Mental Health Branch
MHCCC	Mental Health Cultural Competence Committee
MHP	Mental Health Plan, agreement between DHHS Mental Health and the State of California
MHRC	Mental Health Recovery Center (Crestwood Behavioral Health is an MHRC)
MHRS	Mental Health Rehabilitation Specialist: a person who possesses either a Baccalaureate degree plus 4 years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment; a Master’s degree plus 2 years of experience as above; or Associate degree plus 6 years of experience as above.
MHS	Mental Health Services
MHW	Mental Health Worker
MO	Mobile Outreach
MOA	Medical Office Assistant OR Memorandum of Agreement
MORS	Milestones of Recovery is an effective evaluation tool for tracking the process of recovery for individuals with mental illness
MSW	Masters in Social Work

Term / Acronym	Full Name
NARF	Network Access Request Form
Netsmart	Software company, creator of Avatar
NP	Nurse Practitioner
NPI	National Provider Identifier
NOABD	Notice of Adverse Benefit Determination is a letter sent by a provider to communicate changes in services to clients and their families. See section on NOABD for details.
NSMH	Non-Specialty Mental Health (see SMH)
OA	Office Assistant
OCHIN	A Health Information Network
OP	Outpatient
P&P	Policy and Procedure
PA	Physician's Assistant
PATH	Projects for the Assistance in Transition from Homelessness. Mental Health grant program-providing services for the houseless.
Pathways	A supplier of mental health services in California supported by county mental health programs
Peer specialists	Service providers who are also clients (aka peer coach)
Parent partners (PP)	Service providers who are family members of clients
Perceptive	Part of Avatar showing scanned documents
PH	DHHS - Public Health
PHF	Psychiatric Health Facility - Sempervirens is a PHF as well as an acute psychiatric hospital
PHI	Protected Health Information
PHP	Public Health Pharmacy
PM	Program Manager
Practitioner	Licensed / Licensed-Waived/ Trainee
Provider	A supplier of mental health services in California that are supported by county mental health programs

Term / Acronym	Full Name
PRC	Peer Recovery Center
Psychiatric Prescriber	MD, DO, NP or PA
PT	Psychiatric Technician
PURT	Peer Utilization Review Team or process
QA	Quality Assurance, (similar to QI)
QC	Quality Control
QI	Quality Improvement, (similar to QA)
QM	Quality Management
QIC	Quality Improvement Committee OR Quality Improvement Coordinator
R / A	Rite Aid Pharmacy
RAS	Request to Access Services: the form and the process, to be completed on all new clients when they request services
RCAA	Redwood Community Action Agency -an Organizational Provider
RCL	Rate Class Level set forth by Community Care Licensing
RCP	Red Cross Pharmacy
RCRC	Redwood Coast Regional Center
RF	Regional Facility
RN	Registered Nurse
ROI	Release of Information (authorization to release PHI) Documents signed by client and provider that permit specified information to be shared among designated persons and / or agencies regarding client's services and or treatment plan, for a designated period of time.
RV	Remi Vista; an Organizational Provider for DHHS-MH
RWD	Recovery, Wellness, and Discovery
SAC	Substance Abuse Counselor
SAMHSA	Substance Abuse & Mental Health Services Administration

Term / Acronym	Full Name
SCERIS	A network database (no longer used as of 2017)
Sempervirens	SV-MH's Psychiatric Health Facility (PHF)
Service Charge Code	Billing code used to denote service type
SED	Seriously Emotionally Disturbed: minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.
SET	Support and Education Team
Significant Support Person	Refers to persons, in the opinion of the client or the person providing services, who may a significant role in the successful outcome of treatment, including but not limited to a parent, legal guardian, other family member, or other unrelated individual of a client who is a minor, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client.
SMH	Specialty Mental Health: MHB's target population, the statewide definition of which includes certain mental health diagnoses, impairment and intervention-related criteria
SOC	Share of Cost OR System of Care
SPMP	Skilled Professional Medical Personnel
SS	Support Staff OR Social Services
Stage of Recovery	Refers to practitioner's impression of where the client is; Client's stage of readiness to make changes to improve

Term / Acronym	Full Name
	their quality of life; stage of change will inform treatment plan goals and interventions.
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorder
SV	Sempervirens-MH's Psychiatric Health Facility (PHF)
SW	Social worker OR Staff Worksheet
TAY	Transition Age Youth (16-26)
TBA	Therapeutic Behavioral Aid (see TBS)
TBS	Therapeutic Behavioral Services: intensive 1:1 services for at-risk children who meet the criteria. This service is called BC (Behavioral Coaching) when the service is provided in a lockout situation (like on SV)
TFC	Therapeutic Foster Care
Title 9	Portion of California Code of Regulations Community Mental Health Services
TRTF	Transitional Residential Treatment Facility
UMDAP	Uniform Method of Determining Ability to Pay
UR	Utilization Review
USC	U.S. Government Code
WRS	Waterfront Recovery Services (an RCAA program, medical detox and residential treatment facility in Eureka)
WIC or W&I Code	Welfare and Institutions Code
WRAP	Wellness Recovery Action Plan
YAB	Youth Advisory Board

Appendix B - Approved Abbreviations

Abbreviation	Word
abd.	abdomen
ac	before meals
ADHD	Attention Deficit Hyperactivity Disorder
ADL	activities of daily living
ad lib	as often as desired
A/H	auditory hallucinations
AIMS	abnormal involuntary movements
AKA	also known as
AMA	against medical advice
amb	ambulatory
AMB	As manifested by
amphet	amphetamines
amt	amount
ant.	anterior
A.P.	apical pulse
APAP	Tylenol or acetaminophen
approx, ≈	approximately
approp.	appropriate(ly)
appt.	appointment
apt.	apartment
ASAP, asap	as soon as possible
ASA	aspirin
assess.	Assessment
A.T.	Activities Therapist
a.t.t.	at this time
attn.	attention
BAD	Bipolar Affective Disorder
b/f	boyfriend

Abbreviation	Word
BG	blood glucose
BIB	brought in by
BID	twice daily
bkf.	Breakfast
B.M.	bowel movement
B/P	blood pressure
BPD	Borderline Personality Disorder or Bipolar Disorder (must specify with DSM code)
br	bathroom
bro	brother
BS	breath sounds or bowel sounds
BUN	blood urea nitrogen
bx	behavior
Ca	calcium
cap	capsule
Cauc	Caucasian
CBC	complete blood count
CC	chief complaint
cc	cubic centimeter
Coll.	Collateral
cm	centimeter
c/o	complains of
conc.	Concentrate
cont.	continued
coop	cooperative
coord.	coordinate or coordinator
COPD	Chronic Obstructive Pulmonary Disease
COS	change of shift
CP	Client Plan
CPT Schiz	Chronic Paranoid Type Schizophrenia

Abbreviation	Word
Cpz	Chlorpromazine, Thorazine
CS	Crisis Specialist
CSF	cerebrospinal fluid
ct.	client
CUT Schiz	Chronic Undifferentiated Type Schizophrenia
CXR	chest x-ray
D/C or DC	discontinue or discharge
Da or Dau	daughter
Dec	Decanoate or “dec shot”
D/O or d/o	disorder
DOB	date of birth
DON	Director of Nurses
DP	Discharge Planner
d/r	dining room
DSM	Diagnostic and Statistical Manual
D/S	Discharge Summary
d/t	due to
DT	delirium tremens
DTO	danger to others
DTS	danger to self
Dx	diagnosis
DWF/DWM	divorced white female / male
ECG or EKG	electrocardiogram
ECT	electroconvulsive therapy
educ	educate, education
EEG	electroencephalogram
e.g.	for example
elix	elixir
enc	encourage(d)
ENT	ear, nose and throat

Abbreviation	Word
EPR	extrapyramidal reaction
EPS	extrapyramidal symptoms
eq	equal
ER, ED	Emergency Room, Department
ETOH	alcohol
eval	evaluation
F	female
Fa	father
FAS	fetal alcohol syndrome
FBS	fasting blood sugar
FG	fasting glucose
fl	fluid
FOI	flight of ideas
freq	frequent(ly)
FTA	failed to appear
F/T	full time
FTD	formal thought disorder
f/u	follow up
fx	fracture
GD	gravely disabled
g/f	girlfriend
GI	gastrointestinal
GM	grand mal
Gm, gm	gram
gr	grains
grp(s)	group(s)
gtts	drops
GU	genitourinary
hr	hour
H/A	headache

Abbreviation	Word
Hct	hematocrit
Hgb	hemoglobin
H/H	hematocrit / hemoglobin
H/I	homicidal ideation
H/O or h/o	history of
HS or hs	bedtime (hour of sleep)
Hsb	husband
Ht., ht.	height
H/V	home visit
Hx or hx	history
H ₂ O	water
IDDM	Insulin Dependent Diabetes Mellitus
e.g.	that is, for example
ICD	International Classification of Diseases
IM	intramuscular
immed	immediate(ly)
incl	include, including, inclusive
indep	independent(ly)
IP	inpatient
IQ	intelligence quotient, intellect
IU/L	international units per Liter
interv.	intervention(s)
I&O	intake and output
IOR	ideas of reference
IV	intravenous
K	potassium
Kg	kilogram
L	liter
LAF/LAM	Latin American female / male
lb., #	pound

Abbreviation	Word
LD	left deltoid
LiCo	Lithium Carbonate
liq	liquid
LLQ	left lower quadrant
LLT	left lateral thigh
LMP	last menstrual period
LOA	leave of absence
LOC	loss of consciousness
LT	long term
LUOQ	left upper outer quadrant (gluteus)
Marital status:	
D	divorced
M	married
S	single
W	widowed
M	male
MAOI	mono-amine Oxidase Inhibitor
max	maximum
M/C	Medi-Cal
mcg	micrograms
MDD	Major Depressive Disorder
Med Nec	medical necessity
MS	medication support
med(s)	medication(s)
mEq	milliequivalents
meth	methamphetamine
mg	milligram
MH	Mental Health
min	minute(s)
MJ	marijuana

Abbreviation	Word
ml	milliliter
mm	millimeter
Mo	mother
mo(s)	month(s)
MR	may repeat
MSE	Mental Status Exam
ms, msg	message
mtg	meeting
MVA	motor vehicle accident
Na	sodium
narc	narcotic
neg	negative
NIDDM	Non-Insulin Dependent Diabetes Mellitus
NL	normal
NLT	no later than
No., #	number
noc	night
NPO	nothing by mouth
N/V	nausea and / or vomiting
n/s	nurses' station
NTE	not to exceed
NMT	no more than
OBS	Organic Brain Syndrome
OCD	Obsessive Compulsive Disorder
O/D or OD	overdose
O.D.	ocular dexter (right eye)
oint	ointment
oob	out of bed
ooc	out of county
ooh	out of hospital

Abbreviation	Word
OPC, OPD	Outpatient Clinic, Department
O/R	own recognizance
os	mouth
O.S.	left eye (ocular sinister)
O.T.	Occupational Therapist
O.U.	both eyes (ocular units)
Ox4	oriented times 4
oz.	ounce
P	pulse
PAP	papanicolaou test
PC	Probable Cause
P.C.	Penal Code
p.c.	after meals
p/c	phone calls
PD	Personality Disorder
P.E.	physical examination
PE	psychiatric examination
PERRL	pupils equal, round and reactive to light
pg	pregnant
PGO	Public Guardian's Office
pH	potential of hydrogen - degree of acidity or alkalinity
ph	phone
PD	Plan Development
pm	after noon
PMA	psychomotor activity
PO	by mouth, orally - per os
p.p.	after meals - post prandial
PPD	tuberculin skin test (for TB)
ppr	per patient request
pprwk	paperwork

Abbreviation	Word
PN	progress note
PR	Peer Review
PRA	Patients' Rights Advocate, Public Records Act
PRN, prn	as needed
PRA	Patients' Rights Advocate
prob	problem(s)
prog	program
pro time	prothrombin time
PT	Psychiatric Tech
pt.	patient
P/T	part time
PTSD	Post-Traumatic Stress Disorder
p/u	pick up
q	every
qd	every day
QHS	every bedtime
QID	four times a day
QOD	every other day
qt	quart
R&B	risks and benefits
RBC	red blood count
R.D.	right deltoid
Re, RE	regarding
rec.	recreation
rec'd	received
ref.	refused
reg.	regular
Reg(s)	regulation(s)
rev.	review
R.L.Q.	right lower quadrant

Abbreviation	Word
R.L.T.	right lateral thigh
R.N.	registered nurse
R/O or r/o	rule out
R.O.M.	range of motion
RTC	return to clinic
R.U.O.Q.	right upper outer quadrant (gluteus)
Rx	prescription; take
Rxn	reaction
sub., subj	subject
S /A	suicide attempt
S.A.	substance abuse
Serv Nec	service necessity
S /I	suicidal ideation
sig.	label
Sis	sister
S.L.	sublingual
S.O.B.	shortness of breath
Sol	solution
s /p	status post
spec.	specimen
$\bar{s} \bar{s}$	one half
S /S	signs and symptoms
S.S.E.	Social Service Evaluation
SSI	Supplemental Security Income
S/SX	Signs and Symptoms
S.T.	short term
STAT	at once, immediately
Sub q	subcutaneous(ly)
supp.	Suppository
Sx	symptoms

Abbreviation	Word
Sz	seizure(s)
tab	tablet
Tbsp	tablespoon
T.C.A.	tricyclic antidepressants
T-con	temporary conservatorship
TD	Tardive Dyskinesia
TDD	total daily dose
temp.	temperature
O	oral
R	rectal
Ax	axillary
THC	tetrahydrocannabinol, the active ingredient in MJ
TID	three times a day
Tinct.	Tincture
T.O.	telephone order
TPR	temperature, pulse, respirations
tsp	teaspoon
Tx, tx	treatment or therapy
UA	urinalysis
U.G.I.	upper gastrointestinal series
URI	upper respiratory infection
UTI	urinary tract infection
VD	venereal disease
VDRL	test for syphilis
VH, V/H	visual hallucination(s)
V/O	verbal order
vol	voluntary
V.S., V/S	vital signs
WBC	white blood count
w/c	wheelchair

Abbreviation	Word
WD/WN	well-developed, well-nourished
W/E	weekend
wk	week
wnl, WNL	within normal limits
Wt., wt	weight
x	times
y/o, y.o.	year(s) old
yr(s)	year(s)

Appendix C - Approved Symbols

Symbol	Word
@	at
+	plus
#	number, pound
%	percent
=	equal
>	greater than
<	less than
Δ	change
♂	male
♀	female
\$	money, dollar
°	degree
-	minus
≈, ~	approximately
±	plus or minus
↑	increase, up, elevated
↓	decrease, down, depressed
✓(ed,s,ing)	check (ed,s,ing)
≥	greater than or equal to
≤	lesser than or equal to
1:1	one-to-one
h	hours
'	minutes or feet
"	seconds or inches
5150	WIC 72 hour hold for mental health evaluation
5250 (or 14-day Cert)	WIC 14 day hold
0	no, none, not
a	before
c	with
s	without
Ⓛ	left
Ⓜ	Murmur
p	after
Ⓡ	right

Appendix D -Document Timelines for Completion

Informing Materials Packet

Name of Document	Initially Completed	Updated
<ol style="list-style-type: none"> Voter Preference Form (Adults Only) Advanced Directive (Adults Only) Beneficiary Handbook Provider List Problem Resolution Guide Notice of Privacy Practices 	Required documents reviewed with client at intake.	Provided as Requested
<ol style="list-style-type: none"> Access Brochure (Information about Humboldt County Mental Health) Patients' Rights Advocacy Guide Mental Health Services List Community Resource List 	Courtesy documents reviewed with client at intake.	Provided as Requested

Financial / Administrative Documents

Name of Document	Initially Completed	Updated
Client Information Form #1012	Obtained the day of the first face-to-face contact. <i>Should be as complete as possible with contact information, consent, emergency contacts, etc.</i>	Annually (or if client moves)
Client Information Form #1127 - MCO (Org Provider)	Obtained the day of the first face-to-face contact.	Annually (or if client moves)
Demographic Information Update Form #1162	Obtained the day of the first face-to-face contact.	Ongoing

Name of Document	Initially Completed	Updated
Copy of Medi-Cal or other insurance card (front and back)	Obtained the day of the first face-to-face contact.	Annually and each time changes occur
Consent for Emergency Medical Treatment Form	Obtained the day of the first face-to-face contact, if needed.	Each time changes occur
Consent for Participation and Transportation of Child / Adolescent Form #1017	Obtained the day of the first face-to-face contact, if needed.	Prior to expiration date noted on form.

Clinical Documents

Name of Document	Initially Completed	Updated
Informed Consent for Outpatient Services Form	Obtained the day of the first face-to-face contact.	Once per episode
Release of Information Form # 1006 and 1007 (Authorization for Use or Disclosure of Protected Health Information)	As needed to obtain, disclose, or exchange protected health information.	Annually (unless otherwise specified in release or updated as needed)
Initial Assessment Form #1096	At first assessment appointment, within 60 calendar days of first face-to-face contact.	Annually, or as clinically needed.
Diagnosis Form	At time of initial assessment	As needed
Client Plan Form #1014	No later than 60 days from opening date. Until a client plan is finalized with necessary signatures, the only services that can be provided are assessment, plan development, CMB and crisis intervention.	At least annually - best practice to update as client meets goals and / or needs to establish new goals
Levels / Med Necessity Authorization Adult Form #1038	Obtained at time of assessment	Annually, or as clinically needed.

Name of Document	Initially Completed	Updated
Levels / Med Necessity Authorization Minor Form #1039	Obtained at time of assessment	At least annually
Health History Form #1028	Obtained the day of the first face-to-face contact.	Annually
Progress Note Form #1058	At time of each client service.	N/A
Outpatient Medication Advisement Form # 1042	By prescriber when medication is prescribed.	Annually or as needed
Medical Necessity Criteria for Therapeutic Behavioral Services Form # 1172	At time of referral.	As needed
Family Intervention Team Case Summary and Referral Form # 1130	At time of referral.	As needed
Family Intervention Team Level X to XII Placement Indicator Checklist and Review	At time of referral. At FIT meeting.	As needed
FIT ROI Form # 1007	At time of referral.	As needed
Therapeutic Behavioral Services (TBS) Assessment Form #1068	At time of referral.	As needed
Informing Materials Packet #1196	Obtained at time of assessment	As needed, readily available
Intensive Home Based Services (IHBS) Authorization and Medical Necessity #1212	At time of referral	Annually
Treatment Summary Form # 1077	Complete at time of last service with client to close or transfer case. Enter discharge diagnosis as well as completing Avatar Discharge option.	N/A
Notice of Adverse Benefit Determination (NOABD) Forms	Complete and provide client with NOABD. Send copy to QI.	N/A

Name of Document	Initially Completed	Updated
Humboldt CANS	Completed at Intake	Significant life event, every six months, at discharge. Also completed at the beginning and end of implementing an evidence-based practice (EBP)
Pediatric Symptom Checklist (PSC-35)	Completed at Intake	Significant life event, every six months, and at discharge. Also completed at the beginning and end of implementing an evidence-based practice (EBP)
MORS	At Assessment	During each client contact; at least once per month per policy

Clinical Documents for Full Service Partnership (FSP)

Name of Document	Initially Completed	Updated
Provider Assessment Form (PAF)	Initially completed in Data Collection & Reporting (DCR)	N/A
3 M (Three Month) Forms	Completed in Data Collection & Reporting (DCR) three months after PAF	Quarterly updates
Key Event Tracking	Initially completed in DCR	As needed upon key event changes defined in DCR

Appendix E - Release of Information

All information and records obtained in the course of providing services are confidential. A Release of Information is a statement signed by the client, or legal guardian, authorizing a contact person to give information about the client's situation for any purpose. The ROI is also co-signed by a witness providing the form.

The Authorization once signed may be valid for a designated period of time or no longer than one year.

In addition to listing the client's demographic information, the ROI must indicate the types of released information, the purpose of the disclosure and the unit or authorized agency within DHHS-Mental Health.

If the ROI is signed by anyone other than the client, note the relation and authority to sign on behalf of the client. Signed releases are to be filed in the hard chart to be scanned into Avatar for recordkeeping.

ROI policies have been updated to maintain compliance with current HIPAA and CFR 42. Please use the updated forms in the forms [repository](#).

FAQ - ROI

Q1: Can a remote party, such as an attorney, use DocuSign for release of information?

A1: Yes, with certain verifications of identity and legibility. ([See ADM 125](#))

Q2: Can minors sign consent and consent to release information?

A2: Be aware that under California law, minors may be able to consent for their own treatment and ROIs in some circumstances. It is expected that minors have the right to privacy and maintain legal privilege of their records. ([See SB 543, Chapter 503](#))

ROI Links

[1006 - Release of Information](#)

A release of information for adult clients. Releases may include following attachments.

[1006C – Children’s Release of Information](#)

A 1006C is to be used for all children under the age of 18.

[1006A - Family Intervention Team \(FIT\) / Resource Allocation Committee \(RAC\)](#)

An attachment to the 1006C, signing the 1006A gives permission to members of the FIT/RAC to share information for purposes of coordinating treatment.

[1006 Attachment TAY - Transition-Age Youth \(TAY\) Multi-Agency Release](#)

For TAY clients, specifies which departments or agencies we share information.

[1006 Attachment S - Substance Use Disorders Multi-Agency Release](#)

For SUD clients, specifies which departments or agencies we share information.

[1006 Attachment HW - HumWORKs Multi-Agency Release](#)

For HumWORKS clients, specifies which departments or agencies we share information.

[1006 Attachment RF - Regional Facility Multi-Agency Release](#)

For Regional Facility clients, specifies which departments or agencies we share information.

[1006 Attachment TBS - Therapeutic Behavioral Service \(TBS\) Multi-Agency Release](#)

For TBS clients, specifies which departments or agencies we share information.

Appendix F - Websites

The following websites are available for additional resources:

- [California Code of Regulations](https://govt.westlaw.com/calregs/)
<https://govt.westlaw.com/calregs/>
- [California Substance Use Disorder \(SUD\) Services - MHSUDS](http://www.dhcs.ca.gov/services/Pages/MHSUDS.aspx)
<http://www.dhcs.ca.gov/services/Pages/MHSUDS.aspx>
- [California Department of Health Care Services \(DHCS\)](http://www.dhcs.ca.gov/Pages/default.aspx)
<http://www.dhcs.ca.gov/Pages/default.aspx>
- [California Institute for Behavioral Health Solutions](https://www.cibhs.org/)
<https://www.cibhs.org/>
- [California Penal Code](https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml)
<https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml>
- [Humboldt County Homepage](http://www.humboldt.gov/)
<http://www.humboldt.gov/>
- [Humboldt County Department of Health and Human Services \(DHHS\) Bulletin Board](http://dhhsbulletinboard/SitePages/Home.aspx)
<http://dhhsbulletinboard/SitePages/Home.aspx>
- [North Coast Health Improvement and Information Network](https://www.nchiin.org/)
<https://www.nchiin.org/>
- [Mental Health Services Act](http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx)
http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx
- [Title 9. Rehabilitative and Developmental Services \(CCR\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulation)
<https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulation>
- [W & I Codes](https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC)
<https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC>

Appendix G - Covered Diagnoses

Per [DHCS IN 18-053](#)

Covered Diagnoses - Outpatient Specialty Mental Health Services

Diagnosis Code	Diagnosis Description
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorder
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
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
F31.0	Bipolar Disorder, Current Episode Hypomanic
F31.10	Bipolar Disorder, Current Episode Manic, Without Psychotic features, Unspecified
F31.11	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Mild
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features

Diagnosis Code	Diagnosis Description
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, Without 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
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.74	Bipolar Disorder, in Full Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
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
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.5	Major Depressive Disorder, Single Episode, in Full Remission
F32.89	Other Specified Depressive Episodes
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate
F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.40	Major Depressive Disorder, Recurrent, in Remission, Unspecified
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.42	Major Depressive Disorder, Recurrent, in Full Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified

Diagnosis Code	Diagnosis Description
F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.01	Agoraphobia With Panic Disorder
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.210	Arachnophobia
F40.218	Other Animal Type Phobia
F40.220	Fear of Thunderstorms
F40.228	Other Natural Environment Type Phobia
F40.230	Fear of Blood
F40.231	Fear of Injections and Transfusions
F40.232	Fear of Other Medical Care
F40.233	Fear of Injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of Bridges
F40.243	Fear of Flying
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.291	Gynophobia
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F40.9	Phobic Anxiety Disorder, Unspecified
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety Disorder]
F41.1	Generalized Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified

Diagnosis Code	Diagnosis Description
F43.0	Acute Stress Reaction
F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder With Depressed Mood
F43.22	Adjustment Disorder With Anxiety
F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder with Disturbance of Conduct
F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder With Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.4	Conversion Disorder With Motor Symptom or Deficit
F44.5	Conversion Disorder With Seizures or Convulsions
F44.6	Conversion Disorder With Sensory Symptom or Deficit
F44.7	Conversion Disorder With Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.20	Hypochondriacal Disorder, Unspecified
F45.21	Hypochondriasis (DSM 5: Illness Anxiety 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
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.8	Other Eating Disorders

Diagnosis Code	Diagnosis Description
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive-Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.0	Pathological Gambling
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania
F63.81	Intermittent Explosive Disorder
F63.89	Other Impulse Disorders
F63.9	Impulse Disorder, Unspecified
F64.0	Transsexualism
F64.2	Gender Identity Disorder of Childhood
F64.8	Other Gender Identity Disorders
F64.9	Gender Identity Disorder, Unspecified
F65.0	Fetishism
F65.1	Transvestic Fetishism
F65.2	Exhibitionism
F65.3	Voyeurism
F65.4	Pedophilia
F65.50	Sadomasochism, Unspecified
F65.51	Sexual Masochism
F65.52	Sexual Sadism
F65.81	Frotteurism
F65.89	Other Paraphilias
F65.9	Paraphilia, Unspecified
F68.10	Factitious Disorder Imposed on Self, Unspecified

Diagnosis Code	Diagnosis Description
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
F80.82	Social (Pragmatic) Communication Disorder
F80.9	Developmental Disorder of Speech and Language, Unspecified
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome
F84.8	Other Pervasive Developmental Disorders
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive Type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactive Disorder, Other Type
F90.9	Attention Deficit/Hyperactivity Disorder, Unspecified Type
F91.0	Conduct Disorder Confined to Family Context
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.8	Other Conduct Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood
F94.2	Disinhibited Social Engagement Disorder
F94.8	Other Childhood Disorders of Social Functioning
F94.9	Childhood Disorder of Social Functioning, Unspecified
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.0	Enuresis Not Due to a Substance or Known Physiological Condition

Diagnosis Code	Diagnosis Description
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Early Childhood
F98.3	Pica of Infancy and Childhood
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
G21.0	Neuroleptic Malignant Syndrome
G21.11	Neuroleptic-Induced Parkinsonism
G24.4	Idiopathic Orofacial Dystonia
G25.1	Drug-Induced Tremor (DSM 5: Medication-Induced Postural Tremor)
G25.70	Drug-Induced Movement Disorder, Unspecified
G25.71	Medication-Induced Acute Akathisia (DSM 5: Tardive Akathisia)
G25.9	Extrapyramidal and Movement Disorder, Unspecified
R15.0	Incomplete Defecation
R15.9	Full incontinence of feces
R69	Diagnosis Deferred
Z03.89	No Diagnosis

Covered Diagnoses - Inpatient Specialty Mental Health Services

Diagnosis Code	Diagnosis Description
F01.51	Vascular Dementia With Behavioral Disturbance
F10.14	Alcohol Abuse With Alcohol-Induced Mood Disorder
F10.150	Alcohol Abuse With Alcohol-Induced Psychotic Disorder With Delusions
F10.151	Alcohol Abuse With Alcohol-Induced Psychotic Disorder With Hallucinations
F10.180	Alcohol Abuse With Alcohol-Induced Anxiety Disorder
F10.24	Alcohol Dependence With Alcohol-Induced Mood Disorder
F10.250	Alcohol Dependence With Alcohol-Induced Psychotic Disorder With Delusions
F10.251	Alcohol Dependence With Alcohol-Induced Psychotic Disorder With Hallucinations
F10.280	Alcohol Dependence With Alcohol-Induced Anxiety Disorder
F10.94	Alcohol Use, Unspecified, With Alcohol-Induced Mood Disorder
F10.950	Alcohol Use, Unspecified, With Alcohol-Induced Psychotic Disorder With Delusions
F10.951	Alcohol Use, Unspecified, With Alcohol-Induced Psychotic Disorder With Hallucinations
F11.14	Opioid Abuse With Opioid-Induced Mood Disorder
F11.150	Opioid Abuse With Opioid-Induced Psychotic Disorder With Delusions
F11.151	Opioid Abuse With Opioid-Induced Psychotic Disorder With Hallucinations
F11.24	Opioid Dependence With Opioid-Induced Mood Disorder
F11.250	Opioid Dependence With Opioid-Induced Psychotic Disorder With Delusions
F11.251	Opioid Dependence With Opioid-Induced Psychotic Disorder With Hallucinations
F11.94	Opioid Use, Unspecified, With Opioid-Induced Mood Disorder
F11.950	Opioid Use, Unspecified, With Opioid-Induced Psychotic Disorder With Delusions
F11.951	Opioid Use, Unspecified, With Opioid-Induced Psychotic Disorder With Hallucinations
F11.988	Opioid-Induced Anxiety Disorder Without Opioid Use Disorder
F12.150	Cannabis Abuse With Psychotic Disorder With Delusions
F12.151	Cannabis Abuse With Cannabis-Induced Psychotic Disorder With Hallucinations
F12.180	Cannabis Abuse With Cannabis-Induced Anxiety Disorder
F12.250	Cannabis Dependence With Psychotic Disorder With Delusions
F12.251	Cannabis Dependence With Cannabis-Induced Psychotic Disorder With Hallucinations
F12.280	Cannabis Dependence With Cannabis-Induced Anxiety Disorder
F12.950	Cannabis Use, Unspecified, With Psychotic Disorder With Delusions
F12.951	Cannabis Use, Unspecified, With Cannabis-Induced Psychotic Disorder With Hallucinations
F12.980	Cannabis Use, Unspecified, With Cannabis-Induced Anxiety Disorder
F13.14	Sedative, Hypnotic or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder

Diagnosis Code	Diagnosis Description
F13.150	Sedative, Hypnotic, or Anxiolytic Abuse with Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Delusions
F13.151	Sedative, Hypnotic, or Anxiolytic Abuse With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Hallucinations
F13.180	Sedative, Hypnotic or Anxiolytic Abuse With Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F13.24	Sedative, Hypnotic or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
F13.250	Sedative, Hypnotic, or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Delusions
F13.251	Sedative, Hypnotic, or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Hallucinations
F13.280	Sedative, Hypnotic or Anxiolytic Dependence With Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F13.94	Sedative, Hypnotic or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
F13.950	Sedative, Hypnotic, or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Delusions
F13.951	Sedative, Hypnotic, or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Hallucinations
F13.980	Sedative, Hypnotic or Anxiolytic Use, Unspecified, With Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
F14.14	Cocaine Abuse With Cocaine-Induced Mood Disorder
F14.150	Cocaine Abuse With Cocaine-Induced Psychotic Disorder With Delusions
F14.151	Cocaine Abuse With Cocaine-Induced Psychotic Disorder With Hallucinations
F14.180	Cocaine Abuse With Cocaine-Induced Anxiety Disorder
F14.24	Cocaine Dependence With Cocaine-Induced Mood Disorder
F14.250	Cocaine Dependence With Cocaine-Induced Psychotic Disorder With Delusions
F14.251	Cocaine Dependence With Cocaine-Induced Psychotic Disorder With Hallucinations
F14.280	Cocaine Dependence With Cocaine-Induced Anxiety Disorder
F14.94	Cocaine Use, Unspecified, With Cocaine-Induced Mood Disorder
F14.950	Cocaine Use, Unspecified, With Cocaine-Induced Psychotic Disorder With Delusions
F14.951	Cocaine Use, Unspecified, With Cocaine-Induced Psychotic Disorder With Hallucinations
F14.980	Cocaine Use, Unspecified, With Cocaine-Induced Anxiety Disorder
F15.14	Other Stimulant Abuse With Stimulant-Induced Mood Disorder
F15.150	Other Stimulant Abuse With Stimulant-Induced Psychotic Disorder With Delusions

Diagnosis Code	Diagnosis Description
F15.151	Other Stimulant Abuse With Stimulant-Induced Psychotic Disorder With Hallucinations
F15.180	Other Stimulant Abuse With Stimulant-Induced Anxiety Disorder
F15.24	Other Stimulant Dependence With Stimulant-Induced Mood Disorder
F15.250	Other Stimulant Dependence With Stimulant-Induced Psychotic Disorder With Delusions
F15.251	Other Stimulant Dependence With Stimulant-Induced Psychotic Disorder With Hallucinations
F15.280	Other Stimulant Dependence With Stimulant-Induced Anxiety Disorder
F15.94	Other Stimulant Use, Unspecified, With Stimulant-Induced Mood Disorder
F15.950	Other Stimulant Use, Unspecified, With Stimulant-Induced Psychotic Disorder With Delusions
F15.951	Other Stimulant Use, Unspecified, With Stimulant-Induced Psychotic Disorder With Hallucinations
F15.980	Other Stimulant Use, Unspecified, With Stimulant-Induced Anxiety Disorder
F16.14	Hallucinogen Abuse With Hallucinogen-Induced Mood Disorder
F16.150	Hallucinogen Abuse With Hallucinogen-Induced Psychotic Disorder With Delusions
F16.151	Hallucinogen Abuse With Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.180	Hallucinogen Abuse With Hallucinogen-Induced Anxiety Disorder
F16.183	Hallucinogen Abuse With Hallucinogen Persisting Perception Disorder (Flashbacks)
F16.24	Hallucinogen Dependence With Hallucinogen-Induced Mood Disorder
F16.250	Hallucinogen Dependence With Hallucinogen-Induced Psychotic Disorder With Delusions
F16.251	Hallucinogen Dependence With Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.280	Hallucinogen Dependence With Hallucinogen-Induced Anxiety Disorder
F16.283	Hallucinogen Dependence With Hallucinogen Persisting Perception Disorder (Flashbacks)
F16.94	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Mood Disorder
F16.950	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Psychotic Disorder With Delusions
F16.951	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Psychotic Disorder With Hallucinations
F16.980	Hallucinogen Use, Unspecified, With Hallucinogen-Induced Anxiety Disorder
F16.983	Hallucinogen Use, Unspecified, With Hallucinogen Persisting Perception Disorder (Flashbacks)
F18.14	Inhalant Abuse With Inhalant-Induced Mood Disorder

Diagnosis Code	Diagnosis Description
F18.150	Inhalant Abuse With Inhalant-Induced Psychotic Disorder With Delusions
F18.151	Inhalant Abuse With Inhalant-Induced Psychotic Disorder With Hallucinations
F18.180	Inhalant Abuse With Inhalant-Induced Anxiety Disorder
F18.24	Inhalant Dependence With Inhalant-Induced Mood Disorder
F18.250	Inhalant Dependence With Inhalant-Induced Psychotic Disorder With Delusions
F18.251	Inhalant Dependence With Inhalant-Induced Psychotic Disorder With Hallucinations
F18.280	Inhalant Dependence With Inhalant-Induced Anxiety Disorder
F18.94	Inhalant Use, Unspecified, With Inhalant-Induced Mood Disorder
F18.950	Inhalant Use, Unspecified, With Inhalant-Induced Psychotic Disorder With Delusions
F18.951	Inhalant Use, Unspecified, With Inhalant-Induced Psychotic Disorder With Hallucinations
F18.980	Inhalant Use, Unspecified, With Inhalant-Induced Anxiety Disorder
F19.14	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Mood Disorder
F19.150	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.151	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.180	Other Psychoactive Substance Abuse With Psychoactive Substance-Induced Anxiety Disorder
F19.24	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Mood Disorder
F19.250	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.251	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.280	Other Psychoactive Substance Dependence With Psychoactive Substance-Induced Anxiety Disorder
F19.94	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Mood Disorder
F19.950	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Psychotic Disorder With Delusions
F19.951	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Psychotic Disorder With Hallucinations
F19.980	Other Psychoactive Substance Use, Unspecified, With Psychoactive Substance-Induced Anxiety Disorder
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia

Diagnosis Code	Diagnosis Description
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorders
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
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
F30.8	Other Manic Episodes
F30.9	Manic Episode, Unspecified
F31.0	Bipolar Disorder, Current Episode Hypomanic
F31.10	Bipolar Disorder, Current Episode Manic Without Psychotic Features, Unspecified
F31.11	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Mild
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, Without Psychotic Features
F31.5	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified

Diagnosis Code	Diagnosis Description
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
F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate
F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified
F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.01	Agoraphobia With Panic Disorder
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.210	Arachnophobia
F40.218	Other Animal Type Phobia
F40.220	Fear of Thunderstorms
F40.228	Other Natural Environment Type Phobia

Diagnosis Code	Diagnosis Description
F40.230	Fear of Blood
F40.231	Fear of Injections and Transfusions
F40.232	Fear of Other Medical Care
F40.233	Fear of Injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of Bridges
F40.243	Fear of Flying
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.291	Gynophobia
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety]
F41.1	Generalized Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified
F43.0	Acute Stress Reaction
F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder With Depressed Mood
F43.22	Adjustment Disorder With Anxiety
F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder With Disturbance of Conduct
F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder with Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor

Diagnosis Code	Diagnosis Description
F44.4	Conversion Disorder With Motor Symptom or Deficit
F44.5	Conversion Disorder With Seizures or Convulsions
F44.6	Conversion Disorder With Sensory Symptom or Deficit
F44.7	Conversion Disorder With Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.20	Hypochondriacal Disorder, Unspecified
F45.21	Hypochondriasis
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
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.2	Antisocial Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.1	Pyromania

Diagnosis Code	Diagnosis Description
F63.81	Intermittent Explosive Disorder
F63.89	Impulse Disorder, Unspecified
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome
F84.8	Other Pervasive Developmental Disorder
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactivity Disorder, Other Type
F90.9	Attention-Deficit/Hyperactivity Disorder, Unspecified Type
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.8	Other Conduct Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood
F94.2	Disinhibited Attachment Disorder of Childhood
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.0	Enuresis Not Due to a Substance or Known Physiological Condition
F98.1	Encopresis Not Due to a Substance or Known Physiological Condition
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Early Childhood
F98.3	Pica of Infancy and Childhood
F98.4	Stereotyped Movement Disorders
R15.0	Incomplete Defecation
R15.9	Full Incontinence of Feces
R69	Diagnosis Deferred
Z03.89	No Diagnosis

Appendix H - Subject Matter Experts

Integrated Clinical and Administrative Information System (ICAIS)
 Management and Subject Matter Expert Stakeholder Group

Last Updated 4/05/2019 Scott Irvin

Updated list on the network [HERE](#).

Program	Management Stakeholder	Process SME
HCPR (SUD)	Raena West	Debbie Todd
CCRC	Donna Bullard	Donna Bullard, Amy Giacomini
CCT	Patricia 'PK' Hawk	Patricia 'PK' Hawk, Jessica Duke
C&FS OP Clinic	Karla Howe	Rachel Davis Packer
C&FS Med Support	Marta Preusser , Whitney Williamson	Marta Preusser
Foster Care	Martin Stephan	Eric Wilcox
Garberville	Kelly Johnson	Zach Stevens
CSU	Eli Reissner	Joy Sabia, Gaylynn Carothers-Olsen, Scott Landis
Adult OP (Wood St.)	Teri Vodden	Jen Blair
Adult Med Support	Whitney Williamson, Jamie Gormly	Stephanie Smith, Anne Seaquist
Healthy Mom's	Raena West	Vesta Wunner, Julie Branson
Hope Center	Patricia 'PK' Hawk	Patricia 'PK' Hawk
HumWorks	Teri Vodden / Roxanne Halczak	Rebecca Gillette
Jail	Donna Bullard	Donna Bullard
Juvenile Hall	Marian Vasilevich	Marian Vasilevich
Older Adults	Teri Vodden / Jennifer Blair	Carie Myers / Shaunna Howell
Regional Facility	Marian Vasilevich	Marian Vasilevich
Mobile Outreach (Rose)	Sally Hewitt	Thomas Nash
SV	Cyanne Brocious, Daryn Nimmo	Tobias Griggs, Mark Yoder, Samuel Navarra, Nina Urrutia, Menna Newmeyer
TAY	Dana Taylor	Ryan Green, Sarah Duncan
SDS (Same Day Services)	Jennifer Blair	Morgan Eubank
MIST	Kelly Johnson	Anna Anguiano

Program	Management Stakeholder	Process SME
Adult Mobile Response Team	Kelly Johnson	Cassie Lethin
Children's Mobile Response	Jet DeKruise	Christina Reihm
GR (general fund)	Teri Vodden / Roxanne Halczak	Jeannie Patterson
Adult OP Case Managers	Roxanne Halczak	Anne Seaquist

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