



# **CLINICAL DOCUMENTATION MANUAL**

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# CHAPTER 1. INTRODUCTION/COMPLIANCE

## 1.1. WHY DO WE HAVE THIS MANUAL?

This manual was developed as a resource for providers within the Contra Costa Behavioral Health Services-Mental Health Plan (CCBHS-MHP), which includes County owned and operated programs and Community Based Organizations (CBOs). It outlines standards and practices required within the Children, Youth and Family; Katie A; Forensics; Transitional Services; and Adult & Older Adult systems of care.

CCBHS-MHP establishes documentation standards in order to help realize the commitment to clinical and service excellence. In addition, accurate and complete documentation protects providers from risk in legal proceedings, helps maintain compliance with all regulatory requirements when claiming for services, and enables professionals to discharge their legal and ethical duties.

CCBHS-MHP submits a claim for each covered service provided by each service provider. All services are documented using Medi-Cal Specialty Mental Health documentation rules regardless of the client's Medi-Cal status. Services for clients with co-occurring mental health and substance use disorders are documented using the rules presented in this manual.

This manual does not address specific documentation rules for services that are claimed to Drug Medi-Cal **Organized Delivery System (ODS) or to Medicare.**

This Documentation Manual should be considered the CCBHS-MHP standard and is the source for all documentation issues. The Utilization Review (UR) Team provides resources as well as trainings, guides and other helpful documents. UR encourages questions and comments at any time.

This manual will be posted at the following website:

<https://cchealth.org/mentalhealth/clinical-documentation/>

Updates to this manual are done to address policy and regulation changes. When updates are available, please be sure to replace old sections with updated sections.

### **Sources of information**

This Clinical Documentation Manual is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements. This manual includes information based on the following sources: Code of Federal Regulations (CFR) 45 and 42, the California Code of Regulations (Title 9 and 22), California Department of Health Care Services (DHCS) Letters and Information Notices, American Health Information Management Association (AHIMA), Contra Costa County policies and procedures, directives & memos; and Quality Improvement & Utilization Review Department's interpretation and determination of documentation standards.

## **1.2. COMPLIANCE**

Contra Costa Behavioral Health Services is a county behavioral health organization that provides services to the community and then seeks reimbursement from state and federal funding sources. There are many rules associated with billing the state and federal government, thus the need for this documentation manual. In general, good ethical standards meet nearly all of the requirements. At times, there is a need to provide some guidance and clarity so staff can efficiently and effectively document for the services they provide.

The CCBHS-MHP Utilization Review Unit has adopted a compliance plan that is based on guidance and standards established by the Office of Inspector General (OIG), US Department of Health and Human Services. The OIG is primarily responsible for investigations of Medicare and Medicaid fraud and provides support to the US Attorney's Office for cases which lead to prosecution. The State of California also has a Medicaid/Medicare Fraud Control Unit. Many California county behavioral health departments have already been investigated by State and Federal agencies; and in all of those counties either severe compliance plans or fraud charges have been implemented.

The intent of this compliance plan is to prevent fraud and abuse at all levels. The compliance plan particularly supports the integrity of all health data submissions; as evidenced by accuracy, reliability, validity, and timeliness. As part of this plan we must work to ensure that all services submitted for reimbursement are based on accurate, complete, and timely documentation. It is the responsibility of every provider to submit a complete and accurate record of the services they provide and to document services in compliance with all applicable laws and regulations.

This manual reflects the current requirements for direct services reimbursed by Medi-Cal Specialty Mental Health Services (Division 1, Title 9, California Code of Regulations (CCR)) and serves as the basis for all documentation and claiming by CCBHS-MHP, regardless of payer source. All staff in County programs, contracted agencies, and contracted providers are expected to abide by the information found in this manual.

Compliance is accomplished by:

- Adherence to legal, ethical, code of conduct and best-practice standards for billing and documentation
- Participation by all providers in proactive training and quality improvement processes.
- Providers working within their professional scope of practice.
- Having a Compliance Plan to ensure there is accountability for all CCBHS-MHP, Community Programs activities and functions. This includes the accuracy of progress note documentation by defined practitioners who will select correct procedure codes and services location to support the documentation of services provided.

### **1.3. UTILIZATION REVIEW**

State regulations and CCBHS-MHP policies specify that all beneficiary health records, regardless of format (electronic or print), must go through the utilization review (UR) process. This process is meant to ensure that all planned clinical services are appropriate to address the client's behavioral health needs. It is also meant to make sure that the records comply with all State and Federal regulations as well as CCBHS-MHP policies. The Utilization Review process includes the evaluation and improvement of services through the following practices:

- Standing Utilization Review
- Contract Provider and or Community Based Organization (CBO) Utilization Review
- Inpatient Utilization Review
- Medication Support Services Utilization Review

Utilization Management/UM has established a Utilization Review Committee (URC) with an aim to review health records of CCBHS-MHP and its Community Based Organizations. The role of the UR reviewers is critical as they provide clinical oversight and function as a "check and balance" system. The reviewers are CCBHS-MHP Clinical health care professional who has appropriate clinical expertise that can address the beneficiary's behavioral health needs. Reviewers are responsible to ensure the following:

- All services meet Medical Necessity standards
- Planned services benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning
- All documents are completed within established CCBHS-MHP standards

Reviewers also monitor that client plans are written in client-centered language and include client signature as evidence of client involvement. Utilizing a UR tool, reviewers provide feedback to the Utilization Review Manager, who is responsible for tracking any findings, following up on any quality issues, and identifying items for disallowance.

## **CHAPTER 2. GENERAL PRINCIPLES OF DOCUMENTATION AND AUTHORIZATION TIMELINES**

### **2.1. GENERAL PRINCIPLES OF DOCUMENTATION**

1. All Providers must refer and adhere to CCBHS-MHP Policy 709-MH, Quality Management/Utilization Review: Documentation Standards.
2. All CBOs who currently utilize an Electronic Health Record (EHR) must adhere to the UR Signature Certification memo of June 1, 2016, regarding EHRs and electronic signatures.
3. All Providers must use CCBHS-MHP-approved forms and templates. Contract providers who utilize an electronic health record system for documentation must incorporate all CCBHS-MHP required documentation elements identified in CCBHS-MHP's Policy 709-MH.
4. Required clinical documents, once entered into the medical record, become part of a legal document. Therefore, the following are not permitted: removal of pages from the record, erasing or amending notes that have already been entered/filed, and/or destroying the content of the medical record.
5. Services can only be entered for billing if there is a corresponding progress note.
6. All services shall be provided by staff within the scope of practice of the individual delivering the service. Licensed clinicians will follow specific scope of practice requirements as determined by the applicable license regulations of their governing board.
7. Each progress note should provide enough detail so that auditors and other service providers can easily ascertain the service provided, the client's current status, and needs without having to refer to previous progress notes. Each progress note must stand "alone".
8. Each progress note must show that the service met "medical and service necessity" criteria
9. Progress notes should clearly indicate the type of service provided and how the service is to address an identified area of impairment, and the progress (or lack of progress) in treatment.
10. Clinical documentation must incorporate the concept of the "Golden Thread". The Golden Thread is the documentation that supports each decision, intervention, or client note that contributes to a complete record of client care that is error free and ready for reimbursement.

The Golden Thread begins with the clinical assessment (identified needs), then pulls through the treatment plan (interventions and goals) to on-going progress notes (client effort, service provided, progress made towards goals).
11. It is crucial that the staff providing the service identify and selects the correct procedure code for the service provided and that the documentation supports and substantiates this service. This ensures that CCBHS-MHP receives the correct reimbursement for services provided.

12. Some services while necessary for the well-being of the client are not billable to the State. Non-billable (540) and non-billable lock out (580) codes block a service from being billed. Non-billable services are meant to include a wide variety of potential services deemed helpful or necessary to the client but are not reimbursable by the State as a mental health service. These services should be documented by staff working with clients.
13. Non-Billable Services Include, but are not limited to: transportation of the client, sending or receiving a fax, listening to voicemails, leaving voicemails, scheduling appointments, or interpretation/ translation services.
14. NOTE: "Travel" is not "Transportation".

**Travel** is when a provider travels from their office location to a field location to provide a mental health service.

**Transportation** is when a provider drives a client/family member to and from a location, without provision of a mental health service (such as to or from a doctor's appointment or to pick up a check or medication). If a mental health service is provided while transporting a client, then the time spent providing the mental health service during transportation may be billed.
15. "Elapsed Time" billed should be documented on each progress note. Elapsed time is billed in minutes, and it includes:
  - a. Time spent providing services to the client (i.e., on the phone, face to face, in the field, etc.).
  - b. Documentation time (maximum of 15 minutes is generally considered reasonable).
  - c. Travel time between the work site and the place where services were rendered.
16. Please remember to bill for "actual" time spent providing a service to the client. Do not bill "blocks of time" (e.g., an hour for weekly individual therapy sessions).
17. Each service contact is documented in a progress note and documentation must be completed in a timely manner. A progress note is completed for each service contact, except for Psychiatric Emergency Services, Crisis Residential Services, and Day Treatment Services.
  - a. **PROGRESS NOTE TIMELINE:** Progress notes must be completed in a timely manner according to the following guidelines:
    - i) Every effort should be made to complete progress notes on the same day of service.
    - ii) Progress notes should be completed within three (3) business days from the delivery of service.
    - iii) If the progress note is not completed within three (3) business days, the clinician must write "late entry" on the progress note.
    - iv) Please remember, documentation time may not be included in the total time billed if the progress note was written more than three (3) business days after service delivery.

18. For group notes, staff must detail the purpose of the group and individualize the note for each client. Documentation must include how the client benefitted from the group, the client's participation, and their individual response to the interventions provided during the group.
19. If a service is provided by multiple staff, each staff is required to complete their own progress note documenting their role in the provision of the service and detailing the specific interventions/ services they provided.
20. Documentation must be legible. Ensure that the spell check function is turned on. Documentation that is not legible is at risk for disallowance
21. APS/CPS Reports, Incident Reports, Unusual Occurrence Forms, Grievances, Notice of Adverse Benefit Determination, Utilization Review Committee recommendations or forms and audit worksheets shall never be filed in the medical record or billed. Questions regarding other forms (not already listed) and their inclusion into the medical record should be directed to QI/UR staff.
22. Confidentiality: Do not write another client's full name in a client's medical record. If another client must be identified in the record do not identify that individual as a behavioral health client unless necessary. Names of family members or support persons should be recorded only when needed to complete intake registration and financial documents; otherwise, refer to the relationship - mother, husband, friend - but do not use names. It is acceptable to use first name or initials of another person when needed for clarification.
23. Copy and paste: Do not copy and paste text into a client's medical record. Each note needs to be specific to the service provided. If you are using a template that brings forward text from a previous progress note, the narrative must be changed to reflect the current service being provided. Progress notes that are submitted and appear to be worded exactly like, or too similarly to, previous entries may be assumed to be a duplication of service, i.e., containing inaccurate, outdated, or false information: therefore, claiming associated with these notes could be considered fraudulent.

## **2.2. SIGNATURES**

Clinical staff signatures are a required element of most clinical documents. At a minimum, signatures must include the first initial of the first name, the full last name, licensure and/or designation (e.g., ASW, MD, LMFT, MHRS, DMHW, PhD waived, etc.), and date of signature.

For those agencies using an EHR, the electronic signature of the service provider will be accepted and considered valid as long as the agency has a current and valid "Electronic Signature Certification" form on file with Contra Costa County.

For forms that require client signatures, their signatures may be either electronic or "wet" signatures.

### **2.2.1. CO-SIGNATURES**

Co-signatures for some staff may be required for several reasons. DHCS requires that some documents (e.g., client plans) be approved by a Licensed Clinician. Additionally, County policy requires that some documents be reviewed and co-signed by a supervisor as part of the authorization process. Also, some staff are required to have progress notes co-signed for specific or indefinite periods. For example, new

and reassigned staff may be required to have co-signatures. Other co-signature requirements may be assigned for purposes of quality assurance and/or compliance. Staff should consult with their supervisor for additional specifics and refer to the most recent CCBHS-MHP Guidelines for Scope of Practice (Appendix D)

## CHAPTER 3. ESTABLISHMENT OF MEDICAL NECESSITY

### 3.1. THE FLOW OF CLINICAL INFORMATION

As each client begins services with CCBHS-MHP, there is a flow of information designed to support staff in providing services that help the clients meet their mental health goals. The concept of the Golden Thread should be apparent through the clinical documentation.



1. The Clinical Assessment is the first step toward establishing Medical Necessity and the start of services.
2. The Assessment supports staff in developing a Clinical Formulation that supports the diagnosis.
3. The Diagnosis records the areas of need and supports Medical Necessity.
4. The Partnership Plan creates a framework for the services we provide. Together with clients, providers develop goals and planned interventions and treatments that support the clients in their recovery.
5. Each documented intervention/service in progress notes shall link back to an issue identified on both the Partnership Plan and the Assessment.

Throughout the course of treatment, from initial assessment to discharge, all services are based on Medical Necessity. Every billable service provided must have documented support reflecting that the service is medically necessary.

### **3.2. THE GOLDEN THREAD**



#### **WHAT IS THE GOLDEN THREAD?**

The golden thread begins with the assessment (identified needs), then pulls through the treatment plan (interventions and goals) to ongoing progress notes (client efforts, services provided, progress made).

It is golden because, if accurately followed through, the documentation that supports each decision, intervention, or client progress note contributes to a complete record of client care that is error-free and ready for reimbursement.

Each piece of documentation must flow logically from one to another so that someone reviewing the record can see the logic.

#### **Documentation Linkage - a “Reflection” of the Golden Thread**



### **3.3. MEDICAL NECESSITY**

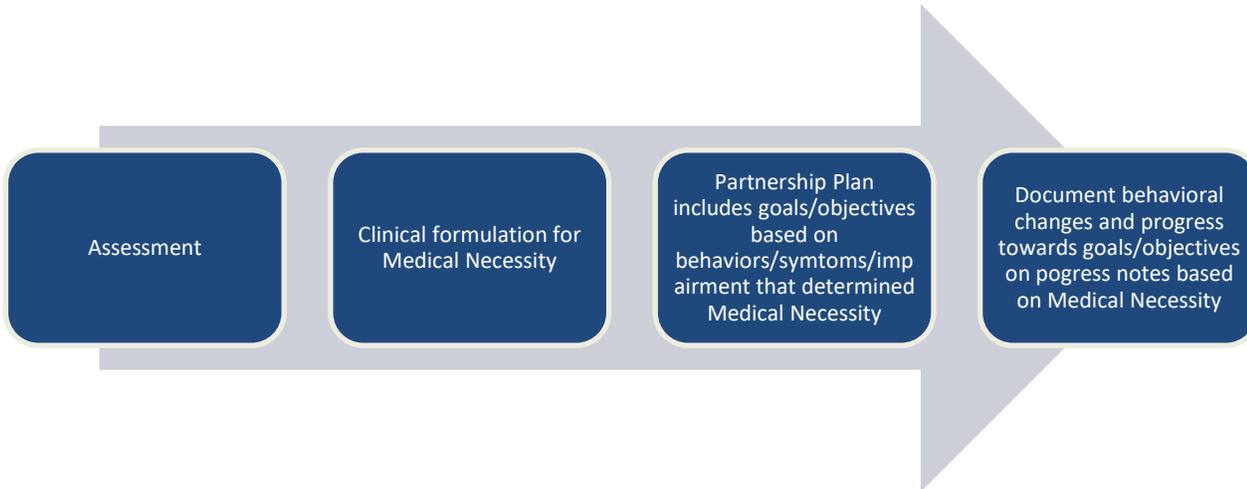
Medical Necessity is established through the Assessment, while appropriate services are identified through the Partnership Plan (Treatment Plan) process. Diagnosis and identification of the client’s functional impairments further strengthen and reaffirm the need for behavioral health services that support the client’s and family’s road to recovery. Medical Necessity must be established prior to the provision of Specialty Mental Health Services.

During the assessment process, the clinician should identify mental health symptoms that are serious enough to disrupt the client’s ability to cope and perform various age- and culturally-related social, personal, occupational, scholastic, or behavioral functions. The service provider should identify the client’s areas of life functioning that are impacted by their behavioral health. Examples are listed below.

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems

- Economic problems
- Problems with access to healthcare services
- Problems related to interaction with legal system/crime
- Other psychological or environmental problems

*A medically necessary service is one that attempts to impact a functional impairment brought about by a symptom of an included diagnosis.*



### **3.4. COMPONENTS OF MEDICAL NECESSITY**

According to Title 9, CCR §1830.205, to be eligible for Medi-Cal reimbursement for Outpatient/Specialty Mental Health Services, a service must meet the following three criteria for Medical Necessity:

- Included Diagnosis Criteria.
- Functional Impairment Criteria.
- Intervention Related Criteria.

*See Appendix B for current CCBHS-MHP ICD-10-DSM-5 Included Crosswalk List*

#### **3.4.1. DIAGNOSTIC CRITERIA**

The focus of the service should be directed to functional impairments related to an Included Diagnosis. Refer to MHSUDS Information Notice 17-004 and MHSUDS Information Notice 16-051.

Please note that having a diagnosis that is not “included” does not exclude a client from receiving services. Clients may receive services if they have an excluded diagnosis as long as an included diagnosis is also present and is the primary focus of treatment or the primary diagnosis. Clinicians are expected to include any substance-related diagnosis (as a secondary diagnosis) that presents.

HDHCS requires that all claims to the State shall utilize the DSM-5 diagnosis.

All clinical documentation (progress notes) must include both the DSM-5 diagnosis code and ICD-10 code. The Assessment must include the ICD-10 Code, the DSM-5 Code and the full DSM-5 diagnosis narrative fully written out (for example, “Major Depressive Disorder” instead of “MDD”).

## ***DIAGNOSIS & MENTAL STATUS***

A diagnosis and mental status exam can only be provided by a physician, licensed psychologist, licensed clinical social worker, licensed marriage and family therapist, or nurse practitioner with a Psychiatric Certification. These clinicians are often referred to as an LPHA, Licensed Practitioner of the Healing Arts. The LPHA is responsible for conducting the mental status exam and assigning the diagnosis. License-eligible staff; including trainees, waived psychologists or post-doctorate clinicians, associate social workers, and associate marriage and family therapists; can also assign a diagnosis and complete the mental status exam if under the supervision of a licensed clinician. Also, please see Appendix D, Scope of Practice Grid, to see which license-eligible staff will require a co-signature.

## ***CHANGE OF DIAGNOSIS***

Diagnoses may be changed at any time during the course of treatment, and they should be reviewed and updated annually or biannually in reassessments. If a change in diagnosis occurs, the diagnosing clinician/NP/MD must submit a Change of Diagnosis Request Form (MHA-002) to update the diagnosis in the ShareCare billing system.

### **3.4.2. IMPAIRMENT CRITERIA**

The client must have at least one of the following as a result of the mental disorder(s) identified in the diagnostic criteria:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability that the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

### **3.4.3. INTERVENTION RELATED CRITERIA**

Must meet all conditions listed below:

1. The focus of the proposed intervention is to address the condition identified in impairment criteria above.
2. It is expected the proposed intervention will benefit the consumer by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated).
3. The condition would not be adequately responsive to physical healthcare-based treatment.

## **3.2. ASSESSMENT**

The Assessment is the first step towards building a trusting and therapeutic relationship between the client and service provider. The Initial Assessment is designed to provide a comprehensive clinical picture of the client, to establish medical necessity, to help treatment teams and clients define goals and objectives, and to fulfill State and Federal requirements.

The Initial Assessment is an important clinical tool to get a clear account of the current impairments in life functioning. Providers have a responsibility to fully understand how culture and social context shape an individual and family's behavioral health symptoms, presentation, meaning and coping styles along with attitudes towards seeking help, stigma and the willingness to trust.

Per DHCS, an assessment must include the following elements:

1. Presenting problem(s). The beneficiary's chief complaint and history of presenting problem(s), including current level of functioning, relevant family history, and current family information.
2. Relevant conditions and psychosocial factors affecting the beneficiary's physical health including, as applicable, living situation, daily activities, social support, cultural and linguistic factors.
3. History of trauma and exposure to trauma.
4. Mental health history. Previous treatments, including providers, therapeutic modalities (e.g., medications, psychosocial treatment) and response and inpatient admissions.
5. Medical History including:
  - a. Physical health conditions reported by the beneficiary or significant support person.
  - b. Name and address of current source of medical treatment.
  - c. For children and adolescents, the history must include prenatal, perinatal events and relevant/significant development history.
6. Medications, including:
  - a. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment.
  - b. Documentation of the absence or presence of allergies or adverse reactions to medications.
  - c. Documentation of informed consent for medications.
7. Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, and caffeine, CAM (complementary and Alternative Medications), and over-the-counter drugs, and illicit drugs.
8. Client and/or family strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).
9. Risks. Situations that present a risk to the beneficiary and others, including past and current trauma. Barriers relevant to achieving client plan goals, including past or current trauma, psychosocial factors which may present a risk in decompensation and/or escalation of the client's condition (e.g., history of danger to self, danger to others, previous hospitalizations, suicide attempts, lack of family, prior arrests, prior drug use, history of self-harm [cutting or assaultive

behavior], physical impairments which makes the client vulnerable to others [e.g., wheelchair bound, visual impairment, deaf).

10. Documentation of the Mental Status Examination.
11. Complete Diagnosis. A diagnosis from the most current CCBHS-MHP Outpatient Included Diagnosis List. The diagnosis must be consistent with the presenting problems, history, mental health status exam and/or other clinical data, including any current medical diagnosis.
12. For children and adolescents age 0-20. Child and Adolescent Needs and Strengths (CANS) Core 50 Elements will be incorporated within the current Initial Assessment.
13. Additional clarifying formulation information, as needed.

The Clinician filling out the Assessment must ensure that all sections are completely and accurately filled out. Do not leave any sections blank, as these may cause a mandated section to remain unassessed and may lead to disallowances.

The Assessment is not considered complete without a valid signature and date by the assessing clinician

### **3.2.1. CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)**

The Child and Adolescent Needs and Strengths (CANS) Core 50 Elements will be incorporated within the current Initial Clinical Assessment and Annual Clinical Assessment for clients age 0-20. This is a requirement at Initial and Annual Assessment and every 6 months.

### **3.2.2 DOCUMENTATION OF FUNCTIONAL IMPAIRMENT**

The identification of functional impairment through the assessment shall be identified to be considered eligible for most mental health services, a person's mental illness must "*result in functional impairment that substantially interferes with or limits one or more major life activities.*"

Activity areas may include feeling, mood, and affect; thinking; family relationships; interpersonal relationships/social isolation; role/work performance; socio-legal conduct; and self-care/activities of daily living.

For the Child and Adolescent System of Care, the Functional Impairment ratings are located within the CANS domains of "Life Functioning" (clients age 6-20) or "Functioning" (clients age 0-5). In order to qualify for services for this level of care, the child/adolescent must have at least one area of life functioning that has been substantially impacted by the behaviors and/or symptoms stemming from the diagnosis. Severity of the impairments are validated with at least one "moderate" (equivalent to a CANS score of "2") or one "severe" (equivalent to a CANS score of "3") rating.

For the Adult System of Care, the Functional Impairments are within the Initial/Annual Assessment and Re-Assessment forms. The client must have a documented severe impairment in at least one area of life functioning.

The initial assessment, update assessment, and annual assessment notes should include documentation supporting the functional impairment.

## **TIMELINESS OF ASSESSMENTS**

The Initial Assessment shall be completed and submitted for review and co-signed (if required) within 60 days of initial opening if new to the county system, or 30 days of initial opening if already to open (multiple providers) to other clinics/providers.

Clients under the age of 21, CCBHS-MHP requires the completion and submission of the Child and Adolescent Needs and Strengths (CANS) assessment tool as part of the assessment. CCBHS-MHP redesigned the clinical assessment for the Children’s System of Care to remove any duplicative information and reduce the size of the overall assessment. In order to receive service authorization, each assessment, whether an initial or annual, must be accompanied by a CANS (either imbedded within the assessment or standalone).

*New information may be added to the chart, at any time, by completing an Update Assessment or including the new material in the next Annual Assessment.*

Assessment information must be updated on an annual basis for clients receiving clinical mental health services (e.g., therapy and case management). Annual Updates are to be completed prior to the end of the Established UR Track. For those clients receiving medication-only services, the psychiatric reassessment is required at least once every two years.

## **CHAPTER 4. TREATMENT PLANNING**

### **4.1. PARTNERSHIP PLAN FOR WELLNESS**

Key points when creating the Partnership Plan (Treatment Plan):

1. Provides the focus of treatment
2. Contains Client's Goals, including their Life Goals
3. Highlights client's/family's strengths to achieve their goals
4. Lists Clinical Goal(s) to be accomplished by the treatment
5. Treatment Goals objectives shall have "specific observable, and/or specific quantifiable" as related to the beneficiary's mental health needs and functional impairment as a result of the mental health diagnosis.
6. Identifies the propose type of interventions or modalities to achieve goals – include a detailed description of intervention or modalities to be provided.
7. Includes the frequency and duration of the intervention(s)/strategies
8. Intervention(s)/strategies are focused and address the identified functional impairment as a result of mental disorder or emotional disturbance.
9. Intervention(s)/modalities are consistent with client plan goal(s) or treatment objectives
10. Intervention(s)/modalities are consistent with an Included Diagnosis.
11. Must be completed prior to the delivery of planned mental health services
12. Documents the client's/legal responsible party's participation in the development of, and agreement with, the treatment plan
13. Includes the Client/Legal Responsible Party signature
14. Documents that Clients are offered a copy of the plan and whether they accept or decline

The Partnership Plan, which is co-created by the client/family and the provider, outlines the goals, objectives, interventions and timeframes. The Plan must substantiate ongoing medical necessity by focusing on diminishing/managing the mental health symptom(s) that lead to functional impairment(s), and/or the prevention of deterioration that has been identified through the assessment process. The impairment(s) and/or deterioration to be addressed must be consistent with the diagnosis that is the focus of treatment. Treatment goals should be consistent with the client's/family's goals as well. The plan should

be person-centered and focused on the client’s recovery and wellness issues. The plan must be individualized, strength-based, and should address cultural and linguistic needs.

The client’s participation and understanding of all elements of the plan is essential for successful outcomes and is required by state regulations. The only exception is when a person has a legal status that removes his/her decision-making power, e.g., an LPS Conservatorship.

*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.”*

Translating Client Goals into specific, observable and/or quantifiable/measurable treatment objectives requires considerable skill. Usually what is involved is uncovering concrete issues, behaviors, or barriers that are preventing the client from accomplishing their goal. Following this is a discussion to frame the issue/barrier in a way that is acceptable to the client but is also meaningful in terms of focusing services. These discussions can all be claimed as Plan Development. An ideal clinical treatment goal is one that that meets both the client’s needs in working towards the goal and is specific and measurable enough to be able to chart progress.

Providing services prior to the establishment of Medical Necessity (completion of the Assessment and Partnership Plan):

To ensure that services are focused on creating goals and strategies in the Partnership Plan, the services that may be provided prior to the Plan’s completion are limited to doing a thorough assessment and developing the plan. In other words, until the plan is finalized, only Assessment (331), Plan Development (315), Crisis Intervention (371), Med/Eval/Rx (361), Med Plan Development (364) can be used for Medical claiming.

Unplanned Services allowed for claiming prior to provision of Assessment and Treatment Plan	Planned Services allowed after provision of Assessment and Treatment Plan
Assessment (331) Plan Development (315) Crisis Intervention (371) Crisis Stabilization (PES) Med/Eval/Rx (361) – Only for assessment purposes and urgent conditions Med Plan Development (364)	Rehab Support (317) Individual Therapy (341) Group Rehabilitation (355) Group Therapy (351) IHBS (358) TBS Case Management Services (541, 561, 571) ICC (364) ICC – CFT (365) Medication Services (361, 362, 363, 369) Adult Residential Services Day Treatment Services Crisis Residential Services

#### **4.1.1. CLIENT PARTICIPATION/AGREEMENT AND SIGNATURES**

1. Client participation and agreement with plan is documented by obtaining the signature of the client/ parent/ legal responsible party on the Partnership Plan. The following signatures should be present and dated:
  - a. Signature or electronic equivalent of the service provider completing the Plan;
  - b. Client, or Legal Responsible Party if the client is under the age of 12 or is a conserved adult.
    - i) Contra Costa County does not recognize the foster parent as the “legal responsible party” unless court documents are provided clearly stating that the foster parent has been granted the ability to sign for mental health treatment.
  - c. A minor can legally sign their Plan if they are at least 12 years old.
    - i) It is encouraged that a parent/legal responsible party, i.e., CFS worker, conservator, etc. signature be obtained whenever possible.
  - d. A co-signature of a Licensed Practitioner of the Healing Arts (LPHA) is needed when the staff member completing the Partnership Plan is required per CCBHS-MHP Guidelines for Scope of Practice.
  - e. Signature of providers of all disciplines providing the service(s), or representing the team, or program providing the service(s), or person representing CCBHS-MHP providing the service(s). This includes Psychiatrist & Psychiatric Nurse Practitioner for medication services.
  - f. Signature of the County Authorizing Committee Member once Plan has been approved for services.
  
2. If a client or parent/legal responsible party refuses to sign or is unavailable to sign, the provider must document on the Partnership Plan the reason why the client or parent/legal responsible party’s signature was not obtained in a timely manner. Continued attempts to get the client’s/legal responsible party’s signature are required. Mental health providers shall document these attempts in the Partnership Plan itself.
  - a. If the client refuses to sign the document, the date the client refused to sign shall be used for the signature date and, along with the documentation of signature attempts, will fulfil the signature requirement.
  - b. The following signature-related activities should be documented.
    - i) Phone contact(s) or letters filed in chart with the corresponding Progress Notes.
    - ii) Discussions between client/family and provider when the provider discusses the Plan goals over the phone and the parent/legal responsible party/client accepts/agrees to the Plan goals.
    - iii) When a copy of the Plan is mailed/faxed to parent/legal responsible party for a signature along with any followup until the signed copy is received and filed.

- c. The service provider is required to offer a copy of the signed Partnership Plan to the client/legal responsible party. The service provider needs to indicate on the plan whether a copy of the plan was accepted or declined.

#### **4.1.2. TIMELINESS OF PARTNERSHIP PLANS**

The Initial Partnership Plan must be completed within sixty (60) days of the admission date for both Adult and Children’s System of Care providers in which the client is not receiving any other services within the county. For clients who have an active admission/services with another county provider, a Partnership Plan must be completed within thirty (30) days of the admission to the additional program.

The client’s participation and agreement with the treatment plan (obtaining the client/legal responsible party’s signature and date of signature) must be documented and entered into the record within the same time frame.

Contra Costa Behavioral Health uses a “track system” to monitor service authorization. Partnership Plans must be reviewed and revised on an annual UR Track basis. For example, if the “established UR Track period” is 10/1/2019 – 9/30/2020, the Annual Partnership Plan must be completed and signatures obtained by the last day (end of the month) of the track so that there is no break in service authorization. In this case, the plan would need to be completed and brought for authorization by 9/30/2020.

If the authorization expires (i.e., the Partnership Plan was not completed or submitted for review within the last month of the track), services provided during the time period in which there is no authorized treatment plans will be denied, so it is important to avoid lapses in renewals of annual Partnership Plans.

#### **ccLink Users**

- Revisions in ccLink must be created as an Addendum to the original Initial or Annual Partnership Plan.

#### **4.1.3. REVISIONS TO THE PLAN**

The Partnership Plan may be revised at any time during the UR authorization period and should be updated any time there is a significant development or change in the focus of treatment (e.g., Client’s needs were assessed and the service provider believes that the client/family would benefit from attending weekly family therapy sessions. The Partnership Plan was then revised to include family therapy.)

If this happens mid-year, the existing Partnership Plan may be revised by adding to it the new goals and strategies, as well as documenting the date of revision to reflect the change in treatment.

If revisions are necessary, the Partnership Plan does not have to be resubmitted for review by the UR Authorization Committee unless new service modalities not already authorized were added. It is recommended, however, that the client/legal responsible party be asked to re-sign the revised Partnership Plan in order to acknowledge the change in treatment.

#### **4.1.4. COMPONENTS OF THE PARTNERSHIP PLAN**

The Partnership Plan contains the following components, which reflect the elements and processes which fulfill the regulatory requirements as well as facilitate sound clinical practice.

- Strengths
- Other Services/Agencies involved
- Life Goals
- Clinical Treatment Goals
- Strategies to Achieve Goals
- Treatment Modalities
- Revisions, if any
- Proposed Duration
- All Required Signatures
- Indication that a copy of the plan was offered
- If applicable, documentation of the reason why client/legal responsible party signature missing

#### **4.1.5. PARTNERSHIP PLAN PROCESS ELEMENTS**

The overall process of creating the Partnership Plan is outlined below and is followed by sub-sections with more specific details and examples for each component of the process. When creating a Partnership Plan, the service provider will:

- Include information gathered from the assessment, CANS and the client and/or family, to establish treatment goals.
- Consider what strengths the client and/or family brings to treatment that could help achieve the goals.
- Discuss with the client and/or family any potential obstacles that could prevent his/her achievement of the goals.
- Formulate specific clinical goals and strategies to decrease identified impairments (an important areas of life functioning as identified in the Assessment/CANS) and their impact primarily through decreasing mental health symptoms . Collaborate with the client and/or family so that they are agreeable to the client and/or family, formulate clinical direction, and satisfy CCBHS-MHP requirements.
- Confirm client/and or legal responsible party signature and client copy are all addressed.
- Obtain co-signature of Licensed Supervisor and/or Medical Doctor as appropriate.
- Submit for review by the Authorization Committee.

### **4.4. COMPONENT DETAILS AND EXAMPLES**

#### **4.4.1. PARTNERSHIP PLAN DATES**

The Partnership Plan should be completed and/or signed by all required parties within the initial sixty (60)-day authorization period or within thirty (30) days from the date any additional service providers creates a new admission. The date a Partnership Plan becomes valid is determined by the signature date of the client/legal responsible party or the date of the documentation of why the signature was not

obtained. If the Partnership Plan was not completed and/or signed within the initial authorization period, a lapse in service authorization will occur and continue until all elements are completed and/or required signatures obtained.

For example:

1. If the admission date was 1/23/2019, the Initial Partnership Plan is due within sixty (60) days, which is 3/22/2019. As long as the client is not receiving services from any other service provider outside of their reporting unit, the UR Track would be 1/2019 - 12/2019.
2. The Partnership Plan must be completed and signed by the service provider and client/legal responsible party and submitted to the authorization committee by 3/22/2019. If the client/legal responsible party was unable to sign the plan by 3/22/2019, then on the bottom of the plan, the service provider must document **why** this was not obtained prior submission to the authorization committee.
3. The Partnership Plan must be rewritten annually. In general, the annual requirement is determined by the established UR track. If the UR Track was 1/2019 – 12/2019, the Partnership Plan must be completed by the end of the track, which is December 31, 2019 in order for there not to be a lapse in authorization.

**NOTE:** The Partnership Plan can be approved for a maximum of twelve (12) months.

#### 4.4.2. CLIENT STRENGTHS

Strengths are qualities that the client brings to treatment that help increase the likelihood of achievement of goals. Client strengths are internal and external factors that should be identified and emphasized as helpful to the treatment process.

Examples are:

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

- The service provider completing the plan with the client/family must complete the box indicating the client's strengths
- **Remember, ALL clients have strengths!**
- Do NOT leave this blank or write "N/A" or "None".

*What to do if they say "I have no strengths".*

- *If they're in your office talking about treatment, then use "willing to seek treatment".*
- *If they were brought by friends/family, then use "client has support".*

- Motivation to change
- Employed/engaged in volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Has knowledge of his/her illness
- Values medication as a recovery tool
- Has a spiritual program/connected to a church
- Good physical health
- Adaptive coping skills/ help seeking behaviors
- Capable of independent living

A goal should be stated in the client's and/or family's own words.

For example:

*"I want a job."*

*"I want to go back to school to get a degree."*

*"I want to be less depressed."*

*"I want a girlfriend/boyfriend."*

*"I want to live in an apartment by myself."*

*"I want to get off of SSI and be self-sufficient."*

*"I want my kids back!"*

*"I want to be a movie star."*

*"I want to be normal."*

When considering strengths, it is beneficial to explore different areas. Examples may be an individual's most significant or most valued accomplishment, what motivates them, educational achievements, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, personal heroes, most meaningful compliment ever received, etc.

It is important to take the time to acknowledge the value of the individual's existing relationships and connections. If it is the individual's preference, significant effort should be made to include these "natural supports" and unpaid participants, as they often have critical input and support to offer to the treatment team. Treatment should complement, not interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones.

Strengths should be utilized in every part of the treatment process.

- Strengths identified in the assessment process
- Set objectives to build on strengths in the Partnership Plan
- The progress notes help us show how our interventions help build up the strengths that help individuals thrive.

#### **4.4.3. LIFE GOALS**

The client's Life Goals are located at the beginning of the Plan and it is intended to be a space where the client's goals are freely stated. The Life Goal identified what the client or family hopes to achieve or work toward. The service provider should use the person's own words. This may include the person's hopes and dreams, as appropriate.

Life Goals are:

- Ideally expressed in the words of the individual, their family and/or other supportive individuals.
- Easily understandable in the client's preferred language.
- Appropriate to the person's culture; reflects values, traditions, identity, etc.
- Written in positive terms.
- Consistent with abilities/strengths, preferences and needs.

- Embody hope/alternative to current circumstances.

The focus could be on a short-term goal (within one year) or a long-term goal (over one year). The service provider can discuss the desired life goals with the client to break them down into more realistic steps to create meaningful treatment goals.

#### 4.4.4. CLINICAL TREATMENT GOALS

The treatment goal is to assist the client and family to identify areas of their life in which an improvement in functioning is desired.

Clinical Treatment Goals must be “*specific observable*” and/or “*specific quantifiable/measurable*” and stated in terms of the specific impairment identified in the Assessment, diagnosis and clinical formulation of Medical Necessity.

They should be related to specific life functioning areas such as living situation, activities of daily living, school, work, social support, legal issues, safety physical health, substance abuse and psychiatric symptoms.

Characteristics of Treatment Goals:

- Incremental achievements on the path toward reaching a Life Goal
- Specific enough to achieve a high degree of inter-provider understanding
- Achievable in a timeframe that is realistic and meaningful to the client
- Clear enough that the client can effectively direct effort toward their achievement
- Appropriate to the setting/level of need/stage of change
- Appropriate for the person’s age, development and culture
- Observable and/or measurable and quantifiable
- Time limited

What does “specific observable” and/or “specific quantifiable/measurable” mean?

“Specific observable and/or specific quantifiable/measurable” means that the mental health behavior/symptom exhibited is characterized by the beneficiary measure of duration, frequency, and/or intensity. A Likert Scale is fine to use (on a scale of 1 to 10). These shall include a baseline (current number) and goal number. Specific, observable and/or “Specific quantifiable/measurable” requires, first, that the symptom be specific - for a diagnosis like major depressive disorder, “depression” in and of itself does not suffice. You need to write specific symptoms, such as refusing to get out of the house, sleeping

#### *Formulating a Treatment Goal:*

- Jessica is a 15 year old girl
- Jessica and her parents came to the county for help with her anger issues
- Jessica fights with her parents and does not like to follow rules
- She frequently yells to get what she wants
- She pushes her younger siblings when she becomes angry at her parents
- She reports she is jealous of her younger siblings and feels like her parents favor them
- Her parents are fearful that she will hurt someone when she is upset

**Goal = Subject (client) + Action Word + symptom+ functional impairment + Measurement**

Goal:

- ✓ Subject (client): Jessica
- ✓ Action Word: verbalize her anger  
symptom: rather than physical assault when functional impairment: family and social functioning
- ✓ Measurement: by

*“Jessica will decrease angry outbursts (which impair family and social functioning) from 3 times per week to 1 time per week. Reported by parents.”*

all day, poor concentration in class. The second part is who will be doing the observing, be it the client, clinician, caregivers, or others.

**Note:** Not every goal need be a symptom-reduction goal. It is permissible for goals to be the development of skills, but must, in any case, recognize the functional impairment meant to be ameliorated. For example, “Client will be able get out of the house in order improve her mood and to get along with others and have friends at least 2-3x/week.” The service provider can elect to use percentages when creating a treatment goal, however, they must give a baseline so that an auditor can determine success towards goals.

### **When?**

If treatment goals are meant to be met in less than 12 months or for the remained of the track, please indicate the time frame. Shorter, interim goals in the service of a longer-term goal can be helpful.

Refer to Chapter 11, Wording Samples, for sample treatment plan goals.

### **4.4.5. STRATEGIES TO ACHIEVE GOALS**

The Strategies section on the Partnership Plan defines the concrete strategies and techniques the service provider proposes to utilize to facilitate the client’s progress of the clinical treatment goals. These strategies are behavioral health interventions and address the impairment(s) identified in the Assessment. They are best stated using the five W’s:

- **Who:** Clinical discipline of practitioner (e.g., Therapist, case manager)
- **What:** Modality and service provided
- **When:** Frequency/intensity/duration
- **Where:** Location (if not at the office)
- **Why:** Purpose/intent/impact to address a specific mental health impairment

This section should define concrete strategies/actions that will be utilized to assist the client/family to meet the identified clinical treatment goals. They should depict what the provider intends to actually do.

There may be multiple strategies (different service types) for the same clinical treatment goal. Service types may include medication services, group therapy, individual therapy, case management brokerage, and for the full-service partnership clients, intensive case management. Each of the strategies needs to be specific/provide description of service modality (e.g., Individual therapy using DBT, CBT, motivational interviewing, and CBSST) and include frequency of service (e.g., 1x/week, 4-6x/month). Be sure to allow for a range of frequency in the event your frequency often varies. This is especially true for case managed clients who, at times, may require more intensive care. Non-specific frequency such as “as needed” and/or “ad hoc” do not meet documentation requirements. Case management strategies usually are expressed as in the service of the development of independent living skills, and not on symptoms per se.

Examples of Strategies include:

- Therapist will provide individual therapy weekly for the next 12 months and use CBT (e.g., learning to replace harmful thoughts with helpful ones) to improve mood and self-worth.

- Therapist will provide mindfulness techniques (including breathing, sensate awareness, and improving concentration) in weekly group therapy sessions for the next three months at the clinic to reduce anxiety.
- Provider will support client to express unresolved grief to reduce symptoms of depression in weekly individual sessions for the next 12 months.
- Over the next six months, case manager will meet with the client—primarily in the field--one to six times per week to teach, model, and implement skills (social and adult living skills) necessary to help maintain housing.
- Mental Health Clinic to provide medication management one to eight times per three months (appointments, prescriptions, injections, and refills) to decrease anxiety.
- The case manager will collaborate with treatment team, including psychiatrist, psychotherapist, and/or community support workers one to four times per month to provide continuity of care.

<b>Example of a <u>weak and/or unacceptable</u> documentation of a strategy:</b>	<b>Example of an <u>acceptably documented</u> intervention:</b>	<b>Explanation of acceptable documentation:</b>
<b>As-needed Case Management</b>	Case Manager will provide case management services twice monthly for the next year to support the client in maintaining current residential placement.	In the acceptable strategy the documentation is specific and will help the client to understand intended services.
<b>Group services for 12 months</b>	Therapist will facilitate the depression group weekly for the next 12 months to help reduce her feelings of isolation.	This intervention has a specific group and duration. It also documents medical necessity regarding the client's symptoms of isolation.
<b>Medication support</b>	Psychiatrist and nurses will provide medication management services (prescriptions, refills, and shots) 1-8 times every 3 months to manage impulsivity and anxiety.	These are specific and clear. The client could read these interventions and know why medication support may help them.

#### **4.4.6. TREATMENT OPTIONS (FORMERLY KNOWN AS SERVICE MODALITIES)**

Treatment Options must be indicated on the Partnership Plan. Their focus must be consistent with the mental health goals and strategies identified on the plan.

CCBHS-MHP Treatment Options Include:

- Individual Therapy
- Family Therapy/Collateral
- Medication Services
- Case Management
- Group Therapy
- Rehab Services
- Day Treatment
- TBS Services (Must be documented if a referral for TBS services is needed)
- WRAP
- Child Wraparound
- Other: ICC
- Other: IHBS



**Note:** Any mental health service modalities that are not documented on the plan are not authorized and therefore should not be provided. If a service modality needs to be added, then this would need to be documented in an addended plan or on the back of the Partnership Plan.

See Sample Partnership Plans in Chapter 11.5.

#### **4.4.7. DOCUMENTING LANGUAGE ON THE PARTNERSHIP PLAN**

Accommodation must be made for non-English-speaking clients/families to ensure the partnership plan was developed in a manner that was understood and agreed upon by the client/families. The partnership plan for monolingual client/families must be submitted in the one of the following ways:

- Two partnership plans – one plan written in the client's primary language and one plan written in English
- One partnership plan written in the client's primary language with the English translation listed below
- One partnership plan written in English, but has a corresponding progress note indicating that the Service Provider completing the plan conducted the planning session in the Client's/Family's primary language; **OR** the progress note indicates that an interpreter was used

## CHAPTER 5. UTILIZATION REVIEW TRACK

CCBHS-MHP created the Utilization Review (UR) Track system in order to maintain the timeliness of Assessments and Partnership Plans (CCBHS-MHP, Policy 706, Utilization Review: Specialty Mental Health Service Authorization Process).

CCBHS-MHP defines a long-term client as Contra Costa Beneficiaries receiving specialty mental health services, other than crisis intervention, for 60 days or more.

### **5.1. ESTABLISHMENT OF THE UR TRACK/ TIMEFRAMES FOR SUBMISSION OF DOCUMENTATION FOR INITIAL SERVICE AUTHORIZATION**

#### **New Admission (new client with no active admissions):**

The admission date will establish when initial paperwork will need to be completed. If this is a new client (currently not receiving any services), the service provider will have sixty (60) days from the admission date to complete their documents for service authorization. The admission date in turn establishes the annual UR track.

Example:

Admission Date: 2/10/2019

Initial Paperwork due: 4/9/2019

UR Track Will be: 2/10/2019 – 1/31/2020

Annual paperwork due: 1/2020 (all paperwork must be started/completed and submitted for review by end of month)

Required Documents for initial service authorization include:

- Completed Assessment with a valid Included diagnosis. See Appendix B.
- Medical Necessity Criteria Form (Children's Services Only)
- CANS (beneficiaries 0-20 years)
- PSC-35 (beneficiaries 3-18 years)
- Partnership Plan with all required signatures
- LOCUS (beneficiaries in the adult system of care for whom an ANSA has not been completed)

#### **Additional Admissions (established Client/ has at least one active admission):**

If the client is receiving services from other service providers/agencies within CCBHS-MHP, the new (add-on) service provider will have thirty (30) days from the admission date to complete their documents for service authorization. The UR track has already been established and the new service provider will need to adhere to the annual UR track and complete all paperwork on the current timeline. In the event

services are being transferred from one clinic to another and the client is still open on the original track, it is recommended the new provider complete an initial assessment.

**Example:**

Admission Date: 9/15/2019  
Initial Paperwork due: 10/14/2019  
Current UR Track: 2/10/19 – 1/31/2020 (already established by initial admission)  
Annual paperwork due: 1/2020 (all paperwork must be started/completed and submitted for review by end of month)

Required Documents for additional initial service provider’s authorization include:

- Partnership Plan with all required signatures
- PSC-35 (beneficiaries 3-18 years)
- Copies of the Initial Assessment/Annual Update, CANS (beneficiaries 0-20 years), Medical Necessity Form, LOCUS (unless an ANSA was completed) from “other” service provider.
- For county providers, these documents must be scanned into ccLink

**NOTE:** Assessments are good only for 12 months. Use of another agency’s assessment may result in a partial authorization.

## **5.2. ANNUAL RENEWAL OF SERVICES**

On an annual basis, a reevaluation of the individual’s status and needs must be completed in order to obtain continued authorization for services. It is good practice to review the risks and benefits of the services with the individual as often as clinically relevant.

During the last month of the UR Track, each service provider (**FACility/PROGRAM**) is responsible for the completion of their program-specific Partnership Plan and should coordinate with all active service providers to ensure that all goals and strategies are both covered and differentiated by provider. That is, if therapy and case management are done by different providers, it is permissible for just one plan to be written that belongs to the same **FAC/PROG**, but the goals and strategies of each should be present and differentiated. If they write two separate plans, there again they need to differentiate services provided to prevent overlap.

Each provider (**FAC/PROG**) is responsible for either the completion of the following forms or obtaining copies of the following forms:

- Completed Annual Update, with a valid/included DSM-5 diagnosis corresponding ICD-10 Code and DSM-5 code narrative
- CANS (beneficiaries 0-20 years)
- PSC-35 (beneficiaries 3-18 years)
- CSI Periodic Form
- LOCUS (beneficiaries over age of 19 for whom an ANSA was not completed)

## CHAPTER 6. PROGRESS NOTES

**Important:** “Cut and Paste” notes occur when a progress note (individual, group, etc.) is worded exactly like or similar to previous entries in the record, which is considered a misrepresentation of the medical necessity requirement for coverage of services. State of California considers this **FRAUD!**

Regardless of which service provider completes the forms, all forms must have been completed and submitted to UR during the last month of the authorization. If client signature was unable to be attained, a statement explaining why should be added at the bottom of the plan and submitted to UR. The provider should continue to make attempts and document such attempts on progress notes.

**REMEMBER**  
*Progress Notes  
are  
Legal Documents!*

Progress notes are used to record the services that result in claims (billing). Please remember that when clinical staff complete a progress note, a claim to the state is submitted; therefore, all progress notes must be accurate and factual. Errors in documentation (e.g., using an incorrect location or procedure code) directly affect the ability of CCBHS-MHP to submit accurate claims. This is an aspect of compliance, and compliance is the personal responsibility of all clinical and administrative staff.

What makes a good progress note? A good progress note accurately represents the services provided. Each progress note needs to justify the service provided. Every billable service must be medically necessary. Medical Necessity is established by ensuring that interventions meet the following two criteria:

1. The focus of the proposed intervention is to address the mental health symptoms identified in association with an “included diagnosis”, and
2. It is expected the proposed intervention will benefit the consumer by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning. The proposed intervention(s) should help the client improve or maintain his/her functioning in an important area(s) of life.

Progress notes are used to inform other clinical staff about the client’s treatment, to document and claim for services, and to provide a legal record. Progress notes may be read by clients/family members. Use your judgment about what to include. Aim for clarity and brevity when writing notes. Lengthy narrative notes are discouraged.

Clear and concise documentation is crucial to client care. Progress notes are used to not only to claim for services, but also to document the client/family’s course and progress in treatment. Progress notes should clearly indicate the type of service provided; how the service is medically necessary to address an identified area of impairment; and the progress (or lack of progress) in treatment.

In order to meet regulatory and compliance standards, Progress Notes:

1. Must be related to the client’s progress in treatment

2. Must provide timely documentation of relevant aspects of client care
3. Must document:
  - a. Client encounters
  - b. Date, location, and duration of services
  - c. Context of services
  - d. Interventions
  - e. Clients' responses to interventions
  - f. Clinical decisions
  - g. New assessment information
  - h. Referrals to community responses
  - i. Signature and date of the person providing the service, including professional degree, licensure, or job title
  - j. If service is provided in a language other than English, document the language used. If an interpreter is used, include the name of the interpreter in the progress note.
4. Progress notes are the method by which other treatment team members or other reviewers (such as the State, Federal or contracted reviewers) are able to determine Medical Necessity and level of care/treatment for the client.
5. Each progress note must have components that show what has been done to help a client reach their goals.
6. If two clinical staff are providing a service for a client together, each staff person's role and interventions need to be clearly documented.

## **6.1. GENERAL GUIDELINES FOR DOCUMENTING MEDICAL NECESSITY FOR PROGRESS NOTES**

CCBHS-MHP requires that clinical staff use the approved CCBHS-MHP Progress Note form (MHC-017). A completed Progress Note includes treatment goals addressed, description of Current Situation, focus of activity, and plan sections.

<b>Treatment Goals</b>	<b>Treatment Goals Addressed:</b> In this section (if appropriate), document the treatment goals that are addressed during the session. If this is a client without a partnership plan, someone who one might be seen at a clinic as the officer of the day or in crisis, then it is appropriate to write "not applicable" or "n/a."
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<p><b>Description of Current Situation/Reason for Contact</b></p>	<p>Reason for Contact: Document clearly the client's reason for seeking treatment, including condition(s) or complaint(s) presented during session. This needs to document why this service is necessary and is not to be confused with just a statement of a diagnosis.</p> <ul style="list-style-type: none"> <li>• Medically necessary reason for client-related contact. This might be a response, for example, to increased mental health acuity, problems in the home or in relationships, problems with housing, or problems getting to appointments.</li> <li>• A client's declared reason for you to provide treatment may not be your reason, and you need to, at minimum, include your reason.</li> <li>• If you are to help a client with a service that is at jeopardy of not meeting medical necessity (such as helping with grocery shopping), be sure to state clearly why you are necessary above and beyond providing a taxi service. For example, the client's anxiety impairs him from doing so alone.</li> </ul> <p>Your intervention later in the note must reflect this.</p> <ul style="list-style-type: none"> <li>• Observation of client's presentation at time of service, including mental status notes about, for example, hygiene, speech, mood, and orientation</li> <li>• Is progress being made?</li> <li>• Diagnosis change?</li> <li>• What are the remaining impairment(s)?</li> </ul>
<p><b>Focus of Activity (Intervention &amp; Response)</b></p>	<p>The Intervention: Be sure to use descriptive verbs to describe the staff's interventions (what did you do). Did you help the client cope/adapt/respond/problem solve? Did you teach/model/practice?</p> <p>The interventions must document:</p> <ul style="list-style-type: none"> <li>• Staff interventions</li> <li>• Staff assessments, which should include risk assessments if applicable</li> </ul> <p>Use descriptive verbs (see Examples 11.2) when documenting interventions to describe services provided.</p>
<p><b>Plan</b></p>	<p>The Plan: The Plan section outlines clinical assessment-informed treatment planning (what interventions you might try next), collateral contact, referrals to be made, follow-up items, homework assignments, treatment meetings to be convened, and others. Any referrals to community resources and other agencies when appropriate, and any follow-up appointments may also be included.</p> <ul style="list-style-type: none"> <li>• Are new goals needed?</li> <li>• Document that the treatment goals remain appropriate or revise as needed.</li> <li>• If lack of improvement, obtain a consultation to verify the diagnosis or consider change in treatment strategy.</li> <li>• Consider treatment titration and plan for discharge.</li> <li>• Explain the need for additional treatment due to Medical Necessity.</li> </ul>

## ***DON'T FORGET:***

Your progress note should address clinical interventions that relate to mental health symptoms or functional impairments.

Make sure your progress note relates to the identified Partnership Plan goals.

Remember to fill out ALL sections of the note.

## **6.2. TIMELINESS OF DOCUMENTATION OF SERVICES**

All Progress Notes should be completed within twenty-four (24) business hours after the service was provided. CCBHS-MHP understands that extenuating circumstances may occur and thus allows service providers three business days.

When documentation does not occur within the three business day period, the service provider will note the date of service delivery in the billing section and indicate “late entry” on the progress note.

If documentation is not completed within three business days of service, the service provider may not bill for documentation time.

Any other documents related to a client (e.g., discharge summaries) must also be filed (if received in hard-copy form) or simply completed (if they are completed within an electronic health record). State regulations drive timeliness standards, which are based on the idea that documentation completed in timely fashion has greater accuracy and makes needed clinical information available for the best care of the client.

The intent of the five (5) business day documentation policy is to establish a trend of timely documentation. Timely documentation is not only about compliance with State expectations, but it is also about ensuring that clinically relevant and accurate information is available for the best care of the client.

## **6.3. FREQUENCY OF DOCUMENTATION**

While it has been noted that for every billing entry there must be a corresponding progress note, there are specific instances when documentation is not completed for every service contact.

Every Service Contact:	Specialty Mental Health Services (Individual Therapy, Group Therapy, etc.) Medication Support Services Crisis Intervention Case Management Services Therapeutic Behavioral Services (TBS)
Daily Notes:	Crisis Stabilization (PES) Day Treatment Intensive
Weekly Notes:	Crisis Residential Day Treatment Rehab Adult Residential Day Treatment Intensive Weekly Summary

## **6.4. PROGRESS NOTE SERVICE DEFINITION**

Title 9 Definition (Title 9 §1810.227):

Mental Health Services” means those individual or group therapies and interventions that are designed to provide reduction of mental health symptoms and improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency and that are not provided as a component of Adult Residential Services, Crisis Residential Treatment Services, Crisis Intervention, Crisis Stabilization, Day Rehabilitation, or Day Treatment Intensive Services. Mental Health Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

### **6.4.1. ASSESSMENT (331)**

The Assessment procedure code (331) is used when documenting the clinical analysis of one’s mental and behavioral health symptoms along with subsequent functionality. mental and behavioral health symptoms, functionality. This is predicated upon symptoms and behaviors of past and present in conjunction with mental status, It is informed by the histories of client’s education/work, relationships, medical, family and upbringing, substance use, trauma, hospitalization, and risk factors. Information is often gathered from a variety of sources, including past treatment providers, psychological testing, spouses, and caregivers. Appraisal of the individual’s functioning in the community, such as living situation, daily activities, social support systems, and health figure in as well. Assessment services must be provided by a licensed/license-registered and/or license-waived practitioner consistent with appropriate scope of practice.

## Sample Assessment Note

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Focus of Activity: Met with client today to discuss continued need for services. Discussed her current stressors, symptoms, and general functioning. She indicated that her anxiety symptoms (of being unable to go places because she continues to be afraid of large crowds) had increased this past month. She also stated that her mom's health had declined, and she may have to move in with her. Clinician updated annual assessment recommended continuing individual therapy and possible referrals for family therapy.

Assessment services may include:

1. Gathering information to gain a complete clinical picture.
2. Interviewing the client and/or significant support person.
3. Administering, scoring and analyzing psychological tests.
4. Formulating a diagnosis. Completing an Initial Clinical Assessment and Annual Clinical Reassessment.
5. Observing the client in a setting such as milieu or school.

It is not acceptable to simply write a note indicating an assessment was completed on a particular date. The note needs to include why the assessment is being completed and preliminary findings or observations of the client's behaviors during the assessment process. In order to obtain service authorization, CCBHS-MHP requires a completed adult or children's assessment on CCBHS-MHP approved forms.

Assessment notes contain elements which only licensed/registered or waived staff can perform, such as assigning diagnoses or performing mental status examinations. Staff should only provide and document assessment services within their scope of practice. Please refer to the Scope of Practice (Appendix D).

### **6.4.2. EVALUATION (313)**

Evaluation is an appraisal of the client's community functioning in several areas, including living situation, daily activities, social support systems, and health status. This procedure code can be claimed by all clinical staff. Evaluation services may include:

1. Gathering information from other professionals (i.e., teachers, school counselor, therapist)
2. Reviewing and/or analyzing clinical documents and other relevant documents may be justified as contributing towards an evaluation of the client's functioning
3. Observing the client in a setting such as a milieu or school, as indicated for clinical purposes or gather clinically relevant information.

**Note:** Evaluation (313) is different from Assessment (331), as it typically does not result in a written Assessment and does not involve formulating a diagnostic impression or completing a Mental Status Exam.

### **6.4.3. PLAN DEVELOPMENT (315)**

The Plan Development (315) procedure code is used to document the development of the Partnership Plan, reviewing the plan with the client, obtaining the client signature on the plan, and/or updating or revising the Partnership Plan. Plan Development is expected to be provided during the development of the initial plan and for subsequent plan updates. However, it may be used during other times than the periodic update cycle, as clinically indicated to modify the plan to make it relevant to the client's needs. For example, when the client's status changes (i.e., significant improvement or deterioration), there may be a need to update the client plan.

#### **Sample Plan Development Note**

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Focus of Activity: Met with client to discuss treatment plan and goals. Client presents as anxious and guarded. He seems to be internally preoccupied but denies auditory hallucinations. The client's anxiety prevents him from performing daily functions such as hygiene, working, and positive social interactions. Discussed with client his symptoms and current level of functional impairment. We developed goals and strategies to reduce symptoms of anxiety and his impairments in his hygiene skills, lack of regular work, and little to no positive social interactions. Completed Partnership Plan. Client was willing to engage in process. Client agreed to and signed the Partnership Plan. A copy of the plan was given to the client.

Plan development activities include:

- Development and client approval of Partnership Plan
- Negotiating plan goals with the client
- Verification of medical or service necessity for services listed on the Partnership Plan
- Evaluation and justification for modifying the Partnership Plan
- Updating, revising, renewing the Partnership Plan

Partnership Plans may be developed by non-licensed clinical staff, who can claim for this procedure. However, Partnership Plans need to be approved by licensed and/or licensed waived staff.

### **6.4.4. COLLATERAL (311)**

The Collateral (311) procedure code is used to document contact with any "significant support person" in the life of the client with the intent of improving or maintaining the mental health of the client.

Definition of Significant Support Persons (CCR, Title 9, 1810.246.1):

“Significant support person” means persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary.

**Note:** “Significant support persons” do not include speaking with other professionals, paraprofessionals, physicians, etc. who are involved in the client’s care. If these contacts are relevant to the mental health treatment and goals of the client, it would be best to bill these services as Case Management Plan Development or Case Management Linkage.

## Sample Collateral Note

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Focus of Activity: Clinician received a phone call from client’s grandmother. Clinician listened and provided emotional support to grandmother while she explained that client’s angry outbursts had increased this past week at home. Discussed strategies for handling situations when client is angry. Introduced de-escalation techniques that will assist grandmother in controlling client's behavior at home. Grandmother agreed to try the strategies and will check in next week on progress with treatment.

Collateral may include helping significant support persons understand and accept the client’s challenges/barriers and involving them in planning and provision of care. Remember, there must be a current release of information in the chart to include these supports. These services must be included in the client’s treatment plan to support the client’s recovery. This procedure code can be claimed by all clinical staff, however, if providing Family Therapy clinical staff must operate within their scope of practice (see Appendix D)

Collateral may include, but is not limited to:

- Consultation and training of the significant support person to assist in better utilization of behavioral health services by the client.
- Consultation and training of the significant support person to assist in better understanding of the client’s serious emotional disturbance (e.g., psychoeducation).
- The client may or may not be present.

### **COLLATERAL PROGRESS NOTES:**

- List people involved in the services and their role
- Training/Counseling (Family Therapy) provided to the Significant Support Person
- Describe how the client's behavioral health goals were addressed through the collateral support.
- Document the collateral support person’s response to the interventions.
- Follow-Up Plan (if needed).

## **CLAIMING FOR FAMILY THERAPY**

- In family therapy, the family is brought into the treatment process. The emphasis is on the client's care, but therapy is aimed at the environment in which the client lives and the interactions of the family.
- Family members are defined as:
  - Immediate family; husband, wife, spouse, sibling(s), child(ren), grandchild(ren), grandparent(s), mother, father
  - Includes live-in companions and significant others
- Primary caregivers who provide care on a voluntary, uncompensated, regular, sustained basis, guardian, or health care proxy
- A family therapy session does not have to include the client in the session, but documentation needs to state how the session is medically necessary for the client's mental health treatment

### **6.4.5. REHABILITATION (317)**

This procedure code is used to document services that assist the client in improving a skill, the development of a new skill set, or maintaining current functional skills. Rehabilitation service activities includes assistance in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. This procedure code may be claimed by all clinical staff.

Individual Rehabilitation may include:

- Daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication compliance (within scope of practice).
- Providing psychosocial education aimed at helping achieve the individual's goals.
- Education around medication, such as understanding benefits of medication (within scope of Practice).

### **6.4.6. INDIVIDUAL THERAPY (341)**

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

- Progress notes need to adequately document the therapeutic intervention(s) or therapy activity that was provided.
- Therapeutic interventions should focus on the reduction of mental health symptoms related to the client's diagnosis.

Only Licensed/Registered/Waivered Staff and trainees who have the training and experience necessary to provide therapy can bill for this procedure code (Scope of Practice Appendix D).

#### **6.4.7. GROUP THERAPY / FAMILY THERAPY / GROUP REHAB / GROUP COLLATERAL**

Specialty Mental Health Services may be provided to more than one individual at the same time. One or more clinicians may provide these services, and the total time for intervention and documentation may be claimed. Up to two clinicians may be claimed, and a varying amount of time may be claimed for each clinician.

**Group Therapy (351)** is a service provided simultaneously to two (2) or more clients with a primary focus of symptom reduction in order to improve social functioning and reduce interpersonal conflicts. Only Licensed/Registered/Waivered Staff and trainees who have the training and experience necessary to provide therapy may bill for this procedure code.

**Family Therapy with client present (319) or without client present (320)** are services provided simultaneously to two (2) or more family members and/or caregivers, either with or without the client present, to stabilize and/or enhance behavioral, cognitive, and/or affective well-being within the family/caregiver unit to help the client.

**Group Rehab (355)** is a service provided simultaneously to two (2) or more clients with directed at improving, restoring, or maintaining functional skills.

**Group Collateral (357)** is a service provided simultaneously to two (2) or more significant support persons of multiple clients in a group setting (e.g., First Hope or a parenting class). Focus of group is on the mental health needs of the client and not the mental health needs of the significant support persons.

Group Notes Should Document:

- The purpose/focus of the group clearly stated on each note (can be same for all group participants).
- Each note should also document the interventions/activities that are provided in the group (can be the same for all group participants).
- There must also be documentation on each progress note the need for more than 1 staff person for the group (can be the same for all group participants).
- Document on each note how client/family participated in group and client/family response to group interventions (this must be client-specific and individualized for each group participant).
- ALWAYS include the total number of clients in group, even if the clients are a mix of Medi-Cal and non Medi-Cal clients.
- If groups are run by two or more providers, each provider must write a note for every client and differentiate their own specific role in the group.

#### **Formula for Billing Total Service Time:**

Example: Billing for a group of five clients, the group was 1 hour long, and documentation time took 10 minutes for each note.

Each staff will bill:

Number of clients (5) x documentation time (10) + 60 minutes (service time) = 1 hour 50 minutes

### **6.4.8. MEDICATION SUPPORT SERVICES**

This service is used exclusively by medical staff where it is within their scope of practice to provide such services. This service type may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a

## **Sample Group Rehab Note**

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Focus of Activity:

Group Focus: Managing Anger, the focus of this group session is identifying anger triggers and how to identify signs and symptoms of anger. Staff A provided role modeling of deep breathing exercises and taking a personal “time out”. Staff B provided psychoeducation on healthy ways to set boundaries.

Client was able to identify that he tends to angry at other people when they touch him. He usually grinds his teeth and sometimes yells. Client practiced deep breathing and agreed to practice next time he starts to grind his teeth in anger.

medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate); how the use of the medication may improve the effectiveness of other services a client is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing to not take medications. Medication Support Services supports beneficiaries in taking an active role in making choices about their behavioral health care and helps them make specific, deliberate, and informed decisions about their treatment options.

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

### **TYPES OF MEDICATION SERVICES**

#### **EVALUATION/RX (361)**

Initial Assessment including medical and psychiatric history, current medication, chart review. Observation of need for medication due to acuity. Consultation with clinician, M.D., or nurse regarding medication. Prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, side effects and compliance to medication. Obtaining informed consent for medications.

#### **RN Injection (362)**

Specifically for the injection and all that an injection entails under guidelines of administration/evaluation of medication.

### **Education (363)**

Medication education (including discussing risks, benefits, and alternative with the individual or significant support persons.)

### **Plan Development (364)**

Plan development related to the delivery of this service and/or to the status of the client's community functioning.

### **Medication Group (369)**

Therapeutic interventions with two or more clients with a primary focus on medications.

## **6.4.9. CASE MANAGEMENT BROKERAGE**

Case Management Brokerage, also known as Targeted Case Management (TCM), are services that assist a client to access needed medical, educational, social, pre-vocational, 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 client access to service; monitoring of the client's progress once he/she receives access to services; and development of the plan for accessing services.

**Note:** While more than one program may deliver Case Management services, there should be different clinical roles and documentation of why more than one program is involved.

When Case Management Brokerage services will be provided to support a client to reach program goals, it must be listed as an intervention on the client treatment plan.

Types of Service Activities:

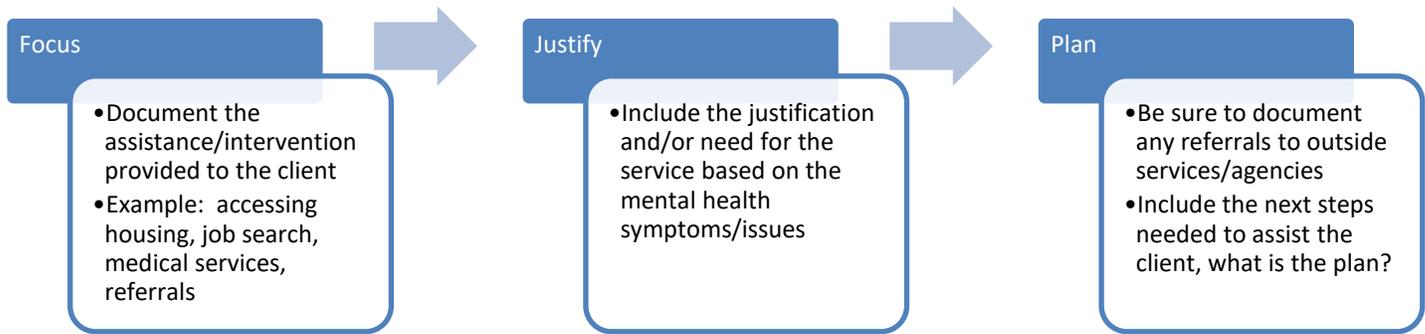
### **Linkage and Advocacy (561)**

Identification and pursuit of resources including:

- Interagency and intra-agency consultation and communication
- Monitoring service delivery to ensure a client's access to service and the service delivery system.
- Assisting the client with coordination and/or referrals to other agencies.

Linkage and Advocacy does not refer to consultation. Consultation is a conversation between one professional and another professional utilizing another professional's expertise in order to focus on the needs of the client. This dialogue between service professionals must focus on the client's treatment plan. This is a billable service since it facilitates a relationship between all service providers who are currently providing care for a client.

**Non-Billable: Consultation/Supervision is not reimbursable to the state.** The focus of the conversation is on enhancing the clinician’s skills. If a clinician receiving consultation on how to improve their therapeutic techniques, this is considered supervision and is not billable.



### **Placement Services (541)**

Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements, including:

- Monitoring of the client’s progress in regard to housing needs.
- Locating and securing an appropriate living environment.
- Locating and securing funding for housing/placement.
- Pre-placement visit(s)
- Negotiation of housing or placement contracts.
- Placement and placement follow-up.
- Accessing services necessary to secure placement.

### **Plan Development (571)**

Discussing a treatment plan (i.e., IEP, Wraparound Plan, TBS), or monitoring a client’s progress towards treatment goals. Case management plan development is similar to Plan Development but, has an emphasis on linking, coordinating, or placement\_ (i.e., focus on education, vocational, medical needs, or coordination of care).

### **6.4.10. CRISIS INTERVENTION**

Crisis Intervention is an immediate emergency response that is intended to help a client cope with a crisis (potential danger to self or others, severe reactions that is above the client’s normal baseline).

Examples of Crisis Intervention include services to clients experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves (including provision/utilization of food, clothing and shelter) due to a mental disorder. Service activities may include, but are not limited to Assessment, collateral and therapy to address the immediate crisis. Crisis Intervention activities are usually face-to-

face or by telephone with the client and/or significant support person(s) may be provided in the office or in the community.

Crisis Intervention Progress Notes Describe:

- The immediate emergency requiring crisis response
- Interventions utilized to stabilize the crisis
- Safety Plan developed
- The client's response and the outcomes
- Follow-up plan and recommendations

### **EXAMPLES OF CRISIS INTERVENTION ACTIVITIES:**

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

**Note:** Crisis Intervention progress notes may not always link to the client's treatment plan.

## **6.5. DISCHARGE SUMMARY**

Discharge summaries document the termination and/or transition of services and provide closure for a service episode and referrals as appropriate. Discharge summary must be documented using the Discharge Summary Form.

A Discharge Summary must include at a minimum, the following information:

- Discharge Diagnosis (primary DSM5 diagnosis code and Narrative and ICD10 Code)
- Dates of Treatment
- Referral Source (Reason for Admission/Presenting Problem)
- Discharge Medication (if applicable)
- Allergies
- Outcome (Summary of treatment goals/progress made towards goals)
- Post Discharge needs/plans
- Referrals made

To be a billable service (315 or 571), the discharge must be done within five (5) days of last contact or notification of planned discontinuance of services. The summary should be for documenting decision-making regarding medical necessity, or to be such that the beneficiary will benefit, e.g., to ensure continuity of care. If these requirements are not met, the services should be coded as non-billable (540).

## **6.6. NON-BILLABLE SERVICES**

Some services are not claimable to Medi-Cal. Non-Reimbursable procedures and certain service locations block the service from being claimed. Unclaimable services may include a wide variety of services which may be useful and beneficial to the client but are not reimbursable as a Specialty Mental Health service. Even though these are not claimable, these services should be documented by all staff working with clients.

The following services are not Medi-Cal reimbursable:

1. Any service after the client is deceased. Includes “collateral” services to family members of deceased.
2. Preparing documents for court testimony for the purpose of fulfilling a requirement; whereas when the preparation of documents is directly related and reflects how the intervention impacts the client’s behavioral health treatment and/or progress in treatment, then the service may be billable.
3. Completing the reports for mandated reporting such as a CPS or APS.
4. No service provided: Missed visit. Waiting for a “no show” or documenting that a client missed an appointment.
5. Services under 5 minutes.
6. Traveling to a site when no service is provided due to a “no show”. Leaving a note on the door of a client or leaving a message on an answering machine or with another individual about the missed visit.
7. Personal care services provided to individuals including grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals.
8. Purely clerical activities (faxing, copying, calling to reschedule, appointment, etc.).
9. Recreation or general play.
10. Socialization-generalized social activities which do not provide individualized feedback.
11. Childcare/babysitting.
12. Academic/Educational services, i.e., actually teaching an academic subject such as math or reading.
13. Vocational services which have, as a purpose, actual work or work training.
14. Multiple Practitioners in Case Conference or meeting: Only practitioners directly contributing (involved) in the client’s care may claim for their services, and each practitioner’s unique contribution to the meeting must be clearly noted.
15. Supervision of clinical staff or trainees is not reimbursable because it does not center on client care (i.e., development of personal insight that may be impacting clinician’s work with the client).
16. Utilization management, peer review, or other quality improvement activities.

17. Interpretation/Translation; however, an *intervention* in another language may be claimed.
18. Money Management services (i.e., cashing checks, bringing money, buying clothes for the client).
19. Providing transportation ONLY:
  - a. **NOTE:** “Travel” is not “Transportation.”
    - i) **Travel** involves the provider going from his/her “home office”, to the location where a service will be provided.
    - ii) **Transportation** involves the provider taking the client/family from one location to another.
    - iii) If a “behavioral health service” is provided during the time a provider is transporting the client/family, then the time spent providing the service is not “transportation” and that portion of service time can be claimed.

Examples of non-billable services versus billable services:

### **Academic/Educational Situations:**

1. **Reimbursable:** Sitting with the client during class and redirecting client’s focus when client is unable sit still.
2. **Not Reimbursable:** Assisting the consumer with his/her homework.
3. **Not Reimbursable:** Teaching the client how to type.

### **Recreational Situations:**

1. **Reimbursable:** Assisted client in creating a list of activities which decrease stress/anxiety.
2. **Not Reimbursable:** Teaching the individual how to lift weights in order to destress.

### **Vocational Situations:**

1. **Reimbursable:** Assisting the client in learning how to apply for jobs.
2. **Not Reimbursable:** Visiting the consumer’s job site to teach him/her how to use a cash register.

### **Travel/Transportation Situations:**

1. **Reimbursable:** Driving to a client’s home to provide a service – travel time is added to the service time if the client is there and the service is provided.
2. **Reimbursable:** Providing supportive interaction with a client while accompanying the client from one place to another in a vehicle. Claimable time is limited to time spent interacting.
3. **Not Reimbursable:** Taking a client to a doctor’s appointment and not providing any service other than driving or sitting and waiting with the client.

### **Money Management/Budgeting Situations:**

1. **Reimbursable:** Assisting the client with budgeting her money at the grocery store so client could purchase all needed personal care items for the week.
2. **Reimbursable:** Brought client weekly check and helped teach the client how to budget his/her money, discussed client’s anxiety levels during this process.
3. **Not reimbursable:** Dropped off weekly funds to client so she/he could purchase clothes.

## **6.7. LOCKOUTS AND LIMITATIONS**

### **LOCKOUTS**

A “lockout” means that a service activity is not reimbursable to Medi-Cal because the client resides in and/or receives mental health services in one of the settings listed below. Clinical staff may provide the service but need to bill the Non-Billable Lockout procedure code (580).

<p><b>Jail</b></p> <p><b>Juvenile Hall (not adjudicated)</b></p> <p><b>Institutes for Mental Disease (IMD)</b></p> <p><b>Mental Health Rehab Center (MHRC)</b></p>	<p>No service activities are reimbursable if the client resides in one of these settings (except for the day of admission and discharge).</p>
<p><b>Psychiatric Inpatient</b></p>	<p>No service activities are reimbursable if the client resides in one of these settings (except for the day of admission and discharge).</p> <p>Exception: Case Management Placement (541) for placement related services provided 30 days prior to discharge.</p>
<p><b>Crisis Residential Treatment</b></p> <ul style="list-style-type: none"> <li>• <b>Nierika</b></li> <li>• <b>Hope House</b></li> </ul>	<p>No service activities are reimbursable if the client resides in one of these settings (except for the day of admission and discharge).</p> <p>Exception: Medication Support Services (if within scope of practice) and Case Management services are billable.</p>

<p><b>Katie A: ICC Services</b></p> <ul style="list-style-type: none"> <li>• Hospital</li> <li>• Psychiatric Health Facilities</li> <li>• Psychiatric Nursing Facilities</li> <li>•</li> </ul>	<p>No service activities are reimbursable if the client resides in one of these settings</p> <p>Exception: Can bill for ICC services for placement related services provided 30 days prior to discharge.</p>
<p><b>Katie A: IHBS Services</b></p> <ul style="list-style-type: none"> <li>• Group Homes / STRTP limitations</li> </ul>	<p>IHBS may be provided to youth placed in a group home or STRTP facility.</p> <p>IHBS may be provided in the community (homes, schools, recreational settings, etc.)</p> <p>Limitation: IHBS services are not permitted during the same hours of the same day as day treatment, group therapy, TBS, or Targeted Case Management (TCM).</p>
<p><b>Limits for Medication Support Services</b></p>	<p>The maximum amount claimable for Medication Support Services for a client in a 24-hour period is 4 hours and is based on staff time and is not program specific.</p>
<p><b>Limits for Crisis Intervention</b></p>	<p>The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours and is based on staff time and is not program specific.</p>
<p><b>Limits for Day Treatment</b></p>	<p>Mental Health services are not reimbursable if provided by the same Day Treatment staff during the same time period that Day Treatment services are being provided.</p>

## **6.8. SERVICE TYPE COMPARISON**

Sometimes the same intervention activity can be described differently, making it look like either one service type or another.

The following common service activities are matched with the best procedure code.

<b>To Document</b>	<b>Use</b>
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<ul style="list-style-type: none"> <li>• Coordinating</li> <li>• Linking</li> <li>• Checking on whether s/he has followed through with a referral</li> <li>• Relaying information from consumer/therapist/case manager/psychiatrist to another clinician</li> </ul>	<p><b>Case Management Linkage</b></p>
<ul style="list-style-type: none"> <li>• Placement</li> <li>• Discharge planning</li> </ul>	<p><b>Case Management Placement</b></p>
<ul style="list-style-type: none"> <li>• Assisting with a specific problem area</li> <li>• Assisting a client overcome an obstacle</li> <li>• Helping strategize with consumer about how they can accomplish....</li> <li>• Figuring out what obstacles are</li> <li>• Educating regarding how symptoms/problem behaviors are getting in the way</li> <li>• Educating about how symptoms/problem behaviors might be managed</li> </ul> <p>And the focus is <u>functioning skills</u> (improving, maintaining, restoring)</p>	<p><b>Rehab/Group Rehab [317, 355]</b></p>
<ul style="list-style-type: none"> <li>• Assisting with a specific problem area</li> <li>• Showing consumer how some obstacle might be overcome</li> <li>• Helping strategize with consumer about how they can accomplish....</li> <li>• Figuring out what obstacles are</li> <li>• Educating regarding how symptoms/problem behaviors are getting in the way</li> <li>• Educating about how symptoms/problem behaviors might be managed</li> </ul> <p>And the focus is on <u>symptom reduction and stability</u>, with the goal of improving functioning</p>	<p><b>Individual/Group [341, 351] (If within scope of practice.)</b></p>

<ul style="list-style-type: none"> <li>• Getting information from a significant support person in a client's life</li> <li>• Discussing (assuming with permission) with a significant support person in a client's life how to collaborate in overcoming obstacles, or how they might support (and not hinder) some area of improvement in functioning.</li> </ul> <p>Note: Do not use collateral for coordinating or collaborating with other providers - may be linkage, or plan development, depending on service.</p>	<p align="center"><b>Collateral/Group Collateral [311, 357]</b></p>
<ul style="list-style-type: none"> <li>• Gathering information from the client</li> <li>• Gathering information about the client from another source</li> <li>• Analyzing information from sources to make a complete (and documented) picture of how the client is functioning, what are obstacles, etc.</li> </ul>	<p align="center"><b>Evaluation [313]</b></p>
<ul style="list-style-type: none"> <li>• Gathering information from the consumer</li> <li>• Gathering information about the consumer from another source</li> <li>• Analyzing information from sources to make a complete picture of how the consumer is functioning, what are obstacles, etc.</li> <li>• Do a Mental Status Exam</li> <li>• Formulate a diagnosis</li> </ul>	<p align="center"><b>Assessment [331] (If within scope of practice).</b></p>
<ul style="list-style-type: none"> <li>• Taking information from evaluation/assessment and developing a written plan.</li> <li>• Discussing, negotiating, getting approval of a written plan.</li> </ul>	<p align="center"><b>Plan Development [315]</b></p>
<ul style="list-style-type: none"> <li>• If doing Plan Development activities, but the goals are limited to linking, placement, and coordination, Checking on progress toward a previously planned goal.</li> </ul>	<p align="center"><b>Case Management Plan development [571]</b></p>
<ul style="list-style-type: none"> <li>• An immediate response to an acute situation</li> <li>• An intervention to prevent an escalation that may include violence or self-destructive behavior or would cause loss of housing</li> <li>• Facilitating a 5150</li> </ul>	<p align="center"><b>Crisis Intervention [371]</b></p>

- Must serve to diminish the client's mental health symptoms and functional impairments
- Creates behavioral, cognitive, and/or affective change in the group of family / caregivers
- Therapeutic interventions may facilitate one or more of the following:
  - Understanding the client's mental health symptoms, impairments, and their impact on family / caregiver group dynamics
  - Learning strategies to support the client
  - Improving family / caregiver group communication and conflict
  - Developing attachment between the client and family / caregiver group

**Family Therapy  
With Client Present [319]  
Without Client Present [320]**

**Below are a few examples.**

<b>Issue</b>	<b>Case Management Service</b>	<b>Mental Health Services</b>
Client wants a job	Assist client in researching job opportunities and helping client practice job interviews due to extreme anxiety. (561)	Individual or Rehab: Staff works with client to try/develop coping skills to manage anxiety when client applies for jobs.
Rep-payee or Budget problems	Assist client with resources to low cost food options. Provided information on Food Banks in the area and filling out forms for Food Stamps. (561)	Rehab: Helping the client to develop skills to make a realistic budget Individual: identifying past barriers to maintaining budget.
School Problems	Consulting with education staff regarding client's school behavior and any areas of need. (561 or 571)	Collateral: Working with client and parent to practice behavioral interventions that help client to focus while working on homework.
Risk of losing placement	Consulting with care providers regarding client's changing needs and possible referrals to housing. (541)	Individual: Meeting with client to discuss triggers to acting-out behaviors which make client's current placement at risk. Rehab: Assisting in developing interpersonal skills to increase prosocial interactions with housemates.
Access to treatment client needs help applying for benefits	Advocating for client during Social Security appointment in order apply for benefits. (561)	Individual: Working with client to identify how anxiety impacts ability to apply for benefits. Rehab: Help client develop skills around time management and focusing in order to complete application for benefits.

## **CHAPTER 7. SCOPE OF PRACTICE/COMPETENCE/WORK**

Staff must only provide services that are within their scope of practice and scope of competency. Scope of practice refers to how the law defines what members of a licensed profession may do in their licensed practice. It applies to the profession as a whole. Scope of competence refers to those practices for which an individual member of the profession has been adequately trained. Scope of work refers to limitations imposed by CCBHS-MHP to ensure optimal utilization of staff resources.

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

A "Waivered Professional" is defined as: A psychologist candidate, an individual employed or under contract to provide services as a psychologist who is gaining the experience required for licensure and who has been granted a professional licensing waiver to the extent authorized under State law; or

A "Registered Professional" (AMFT or ASW) is defined as: A marriage and family therapist candidate or a licensed clinical social worker candidate, who has registered with the corresponding state licensing authority for marriage and family therapists or clinical social workers to obtain supervised clinical hours for marriage and family therapist or clinical social worker or professional clinical counselor licensure, to the extent authorized under state law.

A "Licensed Practitioner of the Healing Arts (LPHA)" is defined as: Any health practitioner who possesses a valid California clinical licensure in one of the following professional categories:

- Physician/Nurse Practitioner
- Licensed Clinical Psychologist (PhD/PsyD)
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Registered Nurse\*

Can conduct comprehensive assessments and provide a diagnosis without co-signature (\*except for RN staff, as providing a mental health diagnosis is out of their scope of practice).

A "Clinician/Therapist" is defined as: A mental health care professional that diagnoses, provides treatment and holds a valid license (MD, NP, MFT, LCSW, PhD/PsyD) or valid internship number (AMFT or ASW) or has been granted trainee/waivered status.

## **7.1. CCBHS-MHP PROFESSIONAL CLASSIFICATIONS AND LICENSES**

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

<b>AA, Bachelor's, and/or Accrued Experience</b>	
<b>Title</b>	<b>Definitions/Characteristics</b>
MHRS (Mental Health Rehabilitation Specialist)	<ul style="list-style-type: none"> <li>• Possesses a bachelor's degree (BS or BA) in a mental health related field <i>and</i> a minimum of four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.</li> <li>• <i>Or</i>, an associate arts degree <i>and</i> a minimum of six (6) years of experience in a mental health setting.</li> <li>• <i>Or</i>, graduate education may be substituted for the experience on a year-for-year basis. For example, someone with a bachelor's degree, 2 years of graduate school, and 2 years of experience in a mental health setting can qualify to be an MHRS.</li> </ul>
Designated Mental Health Worker (DMHW)	<ul style="list-style-type: none"> <li>• Any other direct service staff providing client support services that does not meet any of the other specified licensure or classification definitions or characteristics, i.e., Staff without BA/BS and 4 years' experience, or with an AA &amp; and 6 years' experience.</li> </ul>
<b>Graduate School (pre-Masters or pre-Doctoral)</b>	
<b>Title</b>	<b>Definitions/Characteristics</b>
Psychologist Intern (pre-Doctoral)	<ul style="list-style-type: none"> <li>• Completed academic courses but have not been awarded their doctoral degree.</li> <li>• Completing one of the final steps of clinical training, which is one year of full-time work in a clinical setting supervised by a licensed psychologist.</li> <li>• Intern status requires a formal agreement between the student's school and the licensed psychologist that is providing supervision.</li> </ul>

Psychologist Trainee (pre-Doctoral)	<ul style="list-style-type: none"> <li>• In the process of completing a qualifying doctoral degree.</li> <li>• Often called “Practicum Students.”</li> <li>• Receiving academic credit while acquiring “hands-on” experience in psychology by working within a variety of community agencies, institutions, businesses, and industrial settings.</li> <li>• Supervised by a licensed psychologist.</li> </ul>
MSW Trainees	<ul style="list-style-type: none"> <li>• In the process of completing an accredited Masters of Social Work program.</li> <li>• Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number.</li> <li>• Completing clinical hours as part of their graduate school internship field placement.</li> </ul>
MFT Trainee	<ul style="list-style-type: none"> <li>• In the process of completing a qualifying doctorate or master’s program.</li> <li>• Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number.</li> <li>• Completing clinical hours as part of their graduate school trainee practicum course.</li> </ul>
<b>Post-Master’s, Pre-License (Interns), Post-Doctorate (Waivered)</b>	
<b>Title</b>	<b>Definitions/Characteristics</b>
ASW (Associate Social Worker)	<ul style="list-style-type: none"> <li>• Completed an accredited Masters of Social Work (MSW) program.</li> <li>• In the process of obtaining clinical hours towards a LCSW license</li> <li>• Registered with the CA Board of Behavioral Sciences (BBS) as an ASW</li> <li>• Possesses a current BBS <i>registration</i> certificate (which contains a valid BBS <i>registration</i> number)</li> </ul>
AAMFT (Associate Marriage and Family Therapist)	<ul style="list-style-type: none"> <li>• Completed a qualifying Doctorate or Master’s degree.</li> <li>• In the process of obtaining clinical hours towards an MFT license</li> <li>• Registered with the CA Board of Behavioral Sciences (BBS) as an IMF (this is the official BBS title, but it is interchangeable with AAMFT)</li> <li>• Possesses a current BBS <i>registration</i> certificate (which contains a valid BBS <i>registration</i> number)</li> </ul>
Psychologist (Waivered)	<ul style="list-style-type: none"> <li>• Issued a waiver by the State of CA Department of Mental Health to practice psychology in CA. Possess valid waiver.</li> <li>• Waiver is limited to 5 years.</li> </ul>

Licensed	
Title	Definitions/Characteristics
Psychologist (Licensed)	<ul style="list-style-type: none"> <li>• Licensed by the CA Board of Psychology</li> <li>• Possesses a current CA Board of Psychology <i>license</i> certificate (which contains a valid <i>license</i> number)</li> </ul>
LCSW (Licensed Clinical Social Worker)	<ul style="list-style-type: none"> <li>• Licensed by the CA Board of Behavioral Sciences (BBS)</li> <li>• Possesses a current BBS <i>license</i> certificate (which contains a valid BBS <i>license</i> number)</li> </ul>
MFT (Licensed Marriage and Family Therapist)	<ul style="list-style-type: none"> <li>• Licensed by the CA Board of Behavioral Sciences (BBS)</li> <li>• Possesses a current BBS <i>license</i> certificate (which contains a valid BBS <i>license</i> number)</li> </ul>
LPCC (Licensed Professional Clinical Counselor)	<ul style="list-style-type: none"> <li>• Licensed by the CA Board of Behavioral Sciences (BBS)</li> <li>• Possesses a current BBS <i>license</i> certificate (which contains a valid BBS <i>license</i> number)</li> </ul>
LPCC with Restricted license	<ul style="list-style-type: none"> <li>• <b><i>Please see Appendix D for complete definition.</i></b></li> <li>• Licensed by the CA Board of Behavioral Sciences (BBS)</li> <li>• Possesses a current BBS <i>license</i> certificate (which contains a valid BBS <i>license</i> number)</li> <li>• <b><i>Has not met the required hours to assess and treat couples and families.</i></b></li> </ul>

Scope of Practice is defined by Title 9, CCR, Section 1810.227, and further clarified by DMH Letter No. 02-09, The grid above provides an outline but does not authorize individual practitioners to work outside their own scope of competence.

Some staffing classifications require a co-signature where the clinical supervisor provides clinical supervision using the co-signature as a supervision tool. State laws and regulations specify that a co-signature does not enable someone to provide services beyond his/her scope of practice.

Medical	
Title	Definitions/Characteristics
Registered Nurse (RN)	Registered with the California Board of Registered Nursing (BRN)
Clinical Nurse Specialist (CNS/MSN)	An RN with a Masters Degree in an area of specialization and certification by BRN.
Psychiatric /Mental Health Nurse	A CNS with a specialization in Psychiatry/Mental Health, certified by BRN.

Nurse Practitioner (NP)	An RN who has completed a Nurse Practitioner program, certified by BRN.
Licensed Psychiatric Technician (LPT)	Licensed by California Board of Vocational Nursing and Psychiatric Technicians
Physician (MD)	Licensed by the Medical Board of California

## CHAPTER 9. MEDICATION CONSENTS

### 9.1. MEDICATION CONSENTS

A Medication Consent must be obtained for every new medication and should be specific to each medication prescribed. Medication consents are and can be valid every two (2) years. A note indicating discussion about medications and side effects and the accompanying written information/materials provided to the beneficiary does not replace the signed form. It shall include the documentation of a discussion about risks of not taking as prescribed, what side effects for client to be aware of, and other education about risks and benefits of taking or not taking the recommended medication. A parent or guardian must sign a consent for a minor for psychotropic medications. The MD/NP is also responsible for providing information to client about the specific medication, preferably in written form, at minimum verbally. This provision of information should be documented in the note.

#### **Medication Consent Requirements:**

1. Consent must be signed/dated by beneficiary agreeing to each prescribed medication.
2. Consent must include the following:
  - a. Signature and Licensure/Date of Prescriber
  - b. Reason for taking medication
  - c. Reasonable for alternative treatments, if any
  - d. Type of medication
  - e. Range of frequency
  - f. Dosage
  - g. Method of administration
  - h. Duration of taking the medication
  - i. Probable side effects
  - j. Possible side effects, if taken for longer than three months
3. Consents can be withdrawn at any time

**NOTE:** A JV220 is not considered a complete medication consent until a Medication Consent Form is completed stating that the therapeutic benefits and side effects have been discussed with the family/caregiver/provider and signature was obtained.

### 9.2. MEDICATION DOCUMENTATION GUIDELINES

**Client Plan:** As with other planned services, Title 9 Regulations require an annual plan and evidence of client's participation in the plan.

**Assessments:** CCBHS-MHP currently requires an Initial Psychiatric Assessment upon episode opening. Psychiatrist must complete re-assessments every two years, before the second and subsequent authorization period expires. The completed assessment of a licensed or license-eligible clinician or Nurse Practitioner with specialty certification in Psychiatry may be substituted for the psychiatric assessment. (Please refer to CCBHS-MHP Policy and Procedure 706-MH and 709-MH)

**Medication Support Services:** Medication Support Services include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness.

**CAUTION:** Physician services that are not psychiatric services are not the responsibility of the MHP. These would include services that are to address or ameliorate a physical condition that is not related to a mental health condition. Referral to and collaboration with primary care is encouraged. Services to ameliorate physical conditions related to psychotropic medications should be documented in a way that the link to the psychiatric condition is clear.

Time Claiming Limitations for Medication Support: The maximum amount claimable for a client for Medication Support Services in a 24-Hour period is four (4) hours. Note that time spent by multiple medication support service staff is combined toward this maximum.

## **CHAPTER 10. SPECIAL POPULATIONS**

### **10.1. KATIE A. SUBCLASS**

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

In 2016, the provision of Katie A. services was expanded to include all Early and Periodic Screening Diagnostic and Treatment (EPSDT) eligible children/youth who meet criteria as established in the core practice model regardless of CFS involvement.

The Katie A. Subclass is a group of children/youth:

- Are full scope Medi-Cal (Title 9) eligible.
- Have an open child welfare services case {means any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made}; and
- Meet the Medical Necessity criteria for Specialty Mental Health Services (SMHS) as set forth in CCR, Title 9, Section 1830.205 or section 1830.210
- One of the two items below:
  - Currently being considered for: Wraparound, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to therapeutic behavioral services or crisis stabilization/intervention (see definitions listed in glossary)
  - Currently in or being considered for group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs.

#### **10.1.1. KATIE A. SERVICE PROCEDURES**

##### ***INTENSIVE CARE COORDINATION (ICC)***

Intensive Care Coordination (ICC) is similar to the activities that are routinely provided to our clients as Case Management. ICC must be delivered using a Child/Youth/Client and Family Team (CFT) to develop and guide the planning and service delivery process. The difference between this service and traditional

Case Management is that ICC must be used to facilitate implementation of the cross-system/multi-agency collaborative services approach. ICC also differs from Case Management in that it typically requires more frequent and active participation by the ICC Coordinator to ensure that the needs of the child/youth are being met.

### **INTENSIVE HOME-BASED SERVICES (IHBS)**

Intensive Home Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the Child/Youth/Client and their significant support persons to help the child/youth develop skills and achieve the goals and objective of the plan. These are not traditional therapeutic services.

This service differs from rehabilitation services in that it is expected to be of significant intensity to address the intensive mental health needs of the child/youth and are predominantly delivered outside of the office setting such as at the client's home, school or another community location.

#### **10.1.2. KATIE-A RESTRICTIONS FOR ICC & IHBS PROCEDURE**

- ICC services are locked out for youth in hospitals, group homes, psychiatric health facilities, or psychiatric nursing facilities except for the purposes of coordinating placement of the youth transitioning from those facilities for a maximum of thirty (30) days and for no more than 3 non-consecutive thirty (30)-day periods.
- IHBS may be provided to youth in a group home facility; IHBS can be provided in the community (homes, schools, recreational settings, etc.) IHBS services are not permitted during the same hours of the same day as: day treatment, group therapy, or TBS.

### **10.2. THERAPEUTIC BEHAVIORAL SERVICES (TBS) CLASS**

As stated in the *Emily Q* Settlement document, children and youth under the age of 21 who, in addition to having full scope Medi-Cal and meeting Medical Necessity criteria, also meet the class criteria for TBS if:

- Child/Youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs; or
- Child/Youth is being considered by the county for placement in a facility described above; or
- Child/Youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months; or
- Child/Youth has previously received TBS while a member of the certified class; or
- Child/Youth is at risk of psychiatric hospitalization.

#### **10.2.1. TBS SERVICES**

Therapeutic behavioral service (TBS) is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health service. TBS is an intensive one-to-one, short-term outpatient treatment intervention. TBS is used to prevent placement in a group home at Rate

Classification Level (RCL) 12 through 14 or a locked facility, or to enable a transition from any of those levels to a lower level of residential care.

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

### **10.2.2. TBS SERVICE PROCEDURES**

**TBS INTERVENTION:** A TBS intervention is defined as an individualized *one-to-one* behavioral assistance intervention to accomplish outcomes specifically outlined in the written TBS treatment plan.

A TBS intervention can be provided either through face-to-face interaction or by telephone; however, a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time.

**TBS COLLATERAL:** A TBS collateral service activity is an activity provided to significant support persons in the child/youth's life, rather than to the child/youth. The documentation of collateral service activities must indicate clearly that the overall goal of collateral service activities is to help improve, maintain, and restore the child/youth's mental health status through interaction with the significant support person.

**TBS ASSESSMENT:** A TBS assessment service activity is an activity conducted by a provider to assess a child/youth's current problem presentation, maladaptive at-risk behaviors that require TBS, member class inclusion criteria, and clinical need for TBS services. Periodic re-assessments for continued medical necessity and clinical need for TBS should also be recorded under this service function.

**TBS PLANS:** TBS Plans of Care/Client Plan service activities include the preparation and development of a TBS care plan. Activities that would qualify under this service function code include, but are not limited to:

- Preparing Client Plans
- Reviewing Client Plan (Reimbursable only if review results in documented modifications to the Client Plan)
- Updating Client Plan
- Discussion with others to coordinate development of a child/youth's Client Plan (excludes supervision). (Reimbursable only if discussion results in documented modifications to the Client Plan.)

## CHAPTER 11. WORDING SAMPLES

### 11.1. SAMPLE STRENGTHS

Strengths refer to individual and environmental factors that increase the likelihood of success. Therefore, it is not only important to recognize individual and family strengths, but to *use* these strengths to help them reach their full potential and life goals.

- Motivated to change
- Has a support system –friends, family, etc.
- Employed/does volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Acknowledges mental health diagnosis or symptoms
- Sees value in taking medications
- Has a spiritual program/connected to church
- Good physical health
- Adaptive coping skills
- Capable of independent living
- Interested in restoring relationships

### 11.2. SAMPLE INTERVENTION WORDS

Analyze	Arrange	Assess	Clarify
Connect	Develop	Discuss	Educate
Encourage	Evaluate	Explore	Facilitate
Identify	Interpret	List	Modelled
Practice	Refer	Reframe	Reinforce
Support	Utilize		

### 11.3. SAMPLE INTERVENTION PHRASES FOR SPECIFIC PSYCHIATRIC SYMPTOMS and CONDITIONS

#### ANXIETY

- Assess reasons for symptoms of anxiety
- Refer for medication evaluation to address
- Encourage reading on subject of anxiety
- Explore triggers/situations
- Discuss benefits of taking medication
- Discuss how medication is helping

- Explore benefits/changes in symptoms
- Utilize relaxation homework to reinforced skills learned
- Develop insight into worry/avoidance
- Encourage use of self-talk exercises
- Identify situations that are anxiety provoking
- Encourage routine use of strategies
- Validate/reinforce use of coping skills
- Teach relaxation skills
- Analyze fears, in logical manner
- Identify source of distorted thoughts
- Teach thought stopping techniques
- Teach/practice problem-solving strategies
- Identify coping skills that have helped in the past
- Identify unresolved conflicts and how they play out

### **BORDERLINE PERSONALITY**

- Assess behaviors and thoughts
- Explore trauma/abuse
- Explore how DBT may be helpful
- Explore risky behaviors
- Improve insight into self-injurious behaviors
- Encourage and practice use of coping skills
- Discuss benefits/effectiveness of medication
- Encourage use of skills training skills
- Reinforce use of positive self-talk
- Review homework
- Reinforce completion of homework/diary card
- Encourage/reinforce trust in own responses
- Explore interpersonal skills
- Validate distress and difficulties
- Encourage outside reading on BPD
- Explore self-injurious behaviors
- Assess suicidal behaviors
- Identify and work through therapy interfering behaviors
- Educate on skills training
- Explore all self-talk
- Explore and identify triggers
- Review Diary Card
- Reinforce use of DBT skills

### **SUBSTANCE USE/ABUSE (impulsivity, poor judgment, mood disorder)**

- Explore how mental health symptoms lead to drugs/alcohol
- Encourage follow up with physician
- Discuss benefits/effectiveness of medication
- List/identify negative consequences of substance use/abuse and establish replacement behavior
- Encourage to remain open to discussion around denial/acceptance
- Facilitate/explore understanding of risk factors
- Reinforce development of substance free relationships
- Refer for physical exam to primary care physician
- Support and encourage evaluation for psychotropic medication
- Encourage participation in appointments with psychiatrist
- Educate on consequences of substance use on mental health
- Refer to inpatient/outpatient program
- List positive aspects of using adaptive replacement behavior (to maintain sobriety)
- Review effects of negative peer influences

- Encourage exercise and social activities that do not include substances
- Identify positive aspects of sobriety on family unit/social support system
- Reframe negative self-talk
- Teach stress management skills
- Explore effective after-Client Plan
- Encourage positive change in living situation
- Explore effects of self-talk
- Assess stress management skills
- Reinforce use of stress management skills

## **TRAUMA**

- Work together on building trust
- Teach/explore trust in others
- Explore effects of childhood experiences
- Encourage use of journaling
- Explore how trauma impacts parenting patterns
- Explore history of dissociative experiences
- Utilize empty-chair exercise to work through trauma
- Explore roles of victim and survivor and how they are playing out
- Explore issues around trust
- Research family dynamics and how they play out
- Encourage healthy expression of feelings
- Encourage outside reading on trauma
- Educate on dissociation as a coping response
- Support confronting of perpetrator
- Explore/identify benefits of forgiveness

## **DEPENDENCY**

- Explore history of dependency on others
- List positive aspects of self
- Identify how distorted thoughts affect understanding
- Identify ways to increase independence
- Explore effects of sensitivity to criticism
- Explore issues around co-dependency
- Teach/practice assertiveness skills
- Encourage use of “No”
- Identify ways of giving without receiving
- Practice/reinforce/model use of healthy boundaries
- Identify how fear of disappointing others affects functioning
- Assign positive affirmations
- Explore fears of independence
- Teach and reinforce positive self-talk
- Educate on co-dependency
- Educate on benefits of assertiveness skills
- Reinforce/encourage assertiveness
- Identify and list steps toward independence
- Teach about healthy boundaries
- Encourage decision making

## **DEPRESSION**

- Assess history of depressed mood
- Identify what behaviors associated with depression
- Assess/monitor suicide potential and risk
- Identify symptoms of depression
- Explore/assess level of risk
- Teach and identify coping skills to decrease suicide risks

- Identify patterns of depression
- Identify support system
- Encourage use of WRAP plan
- Explore issues of unresolved grief/loss
- Reinforce/recommend physical activity
- Normalize feelings of sadness and responses
- Connect anger/guilt with depression
- Encourage journaling feelings as coping skill
- Develop WRAP plan
- Encourage/reinforce positive self-talk
- Teach/identify coping skills to manage interpersonal problems
- Monitor and encourage self-care (hygiene/grooming)
- Explore potential reasons for sadness/pain

## **FAMILY CONFLICT**

- Explore patterns of conflict within the family
- Explore familial communication patterns
- Identify how family patterns of conflict and communication are played out
- Reinforce use of healthy expression of feelings
- List ways family may participate in healthy activities in community
- Identify areas of strength that may be used to parent
- Identify patterns of dependency on family members
- Explore/identify patterns of dependency within family unit
- Teach conflict resolution
- Facilitate family communication
- Facilitate healthy expression of feelings/concerns
- Identify/reinforce family strengths
- Define roles in the family
- Teach/practice/model parenting techniques
- Identify feelings of fear/guilt/disappointment

## **BIPOLAR DISORDER**

- Explore symptoms concerning bipolar disorder
- Use reflection to identify mania/depression behaviors
- Explore behaviors associated with mania
- Identify early warning signs and energy levels
- Encourage/discuss effectiveness of medication
- Identify effects of stress on psychiatric symptoms
- Discuss consequences of impulsivity
- Utilize cognitive reframe
- Educate on mania and depression
- Educate on risky behaviors associated with mania
- Identify coping skills
- Explore grandiosity
- Encourage participation in appointments with psychiatrist
- Identify/discuss issues of impulsivity
- Model/reinforce effective communication
- Encourage education on bipolar disorder

## **MEDICAL ISSUES**

- Gather information regarding medical history
- Identify who is primary care physician

- Encourage follow through with medical recommendations
- Educate on grief/loss issues and impact on openness to medical treatment
- Process feelings of fear/ambivalence/anxiety
- Teach relaxation exercises
- Reinforce use of coping skills during medical appointments
- Reinforce assertiveness skills
- Identify/explore negative consequences of no following through
- Explore denial around recommended medical treatment/follow up
- Normalize feelings of fear/ambivalence/anxiety
- Monitor/encourage compliance with medical recommendations
- Reinforce communication skills to ask for clarity
- Encourage use of social support system

## **11.4. SAMPLE PROGRESS NOTES**

Format for each sample: 1. Current Situation, 2. Focus Activity, 3. Plan

### **SAMPLE ASSESSMENT (331)**

1. Client came in to update annual assessment.
2. Met with client today to discuss continued need for services. Discussed her current stressors, symptoms, and general functioning. She indicated that her anxiety symptoms of being unable to go places because she continues to be afraid of large crowds had been increased this past month. She also stated that her mom's health had declined, and she may have to move in with her.
3. Clinician updated annual assessment recommended continuing individual therapy and possible referrals for family therapy.

### **SAMPLE EVALUATION (313)**

1. Met with Client and family to gather information for the 6-month CANS update.
2. Met at client's home and spoke with parents to discuss the CANS Assessment update. This clinician reviewed the client's current level of functioning at home and school. Identified progress in treatment and current service needs. Please see attached CANS Assessment update.
3. Clinician will continue to provide Individual Therapy, Family Therapy, and as needed Case Management. Will review CANS scores and update Treatment Plan if necessary.

### **SAMPLE PLAN DEVELOPMENT (315)**

1. Met with Client to discuss treatment plan goals.
2. Client presents as anxious and guarded. He seems to be internally preoccupied but denies auditory hallucinations. The client's anxiety prevents him from performing daily functions such as hygiene, working, and positive social interactions. Discussed with client his symptoms and current level of functional impairment. We developed goals and strategies to reduce symptoms of anxiety and his impairments in his hygiene skills, lack of regular work, and little to no positive social interactions.

Completed Partnership Plan. Client was willing to engage in process. Client agreed to and signed the Partnership Plan. A copy of the plan was given to the client.

3. Clinician will begin providing Individual Therapy and provide referrals as discussed.

### **SAMPLE COLLATERAL (311)**

1. Clinician received a phone call from client's grandmother. Client's grandmother was upset about client's recent behavior and provided clinician with an update regarding client's current functioning.
2. Clinician listened and provided emotional support to grandmother while she explained that client's angry outbursts had increased this past week at home. Discussed strategies for handling situations when client is angry. Introduced de-escalation techniques that will assist grandmother in controlling client's behavior at home. Grandmother agreed to try the strategies and will check in next week on progress with treatment.
3. Clinician will follow up with a call to client's school counselor regarding recent increase in behaviors. Will also follow up with Grandmother to see if client has made any further progress at home.

### **SAMPLE COLLATERAL (Family Therapy 311)**

1. Met with mom and client to facilitate a family session. Provided a safe place for mom and client to express their concerns and emotions.
2. Mom requested to meet with clinician and client because she is having a difficult time with client at home. Provided a safe place for mom and client to express their concerns at home. Mom was able to express her emotions and client used his listening skills, however, disagreed with mom. Clinician guided mom and client to express their concerns in a positive way and helped them reframe their negative words to help clarify their feelings. Discussed client's increased aggression and disrespectful behaviors. Client was able to listen and share his frustrations with mom. Client was able to share he is being bullied at school. Discussed ways client and mom can support each other at home and created a safety plan due to the client's increased violent behaviors. Discussed possible referral for a psychiatric evaluation for client.
3. Clinician will follow up with an individual session with client and also possible medication evaluation referral.

### **SAMPLE INDIVIDUAL REHAB (317)**

1. Rehab Specialist met with client in in the community. Client continues to exhibit impaired judgment, low frustration tolerance, and highly reactive when faced with frustrating situations. Appeared somewhat subdued, although anxious.
2. Rehab Specialist encouraged the client to utilize coping skills such as deep breathing and relaxation exercises such as taking quick time-outs instead of reacting to situations which trigger his anxiety. Rehab Specialist and client role-played a recent situation where client's anxiety was triggered. Client practiced different responses he could have had other than anxiety, i.e., deep breathing, walking away, etc. Client was encouraged to use his coping skills when his anxiety is

triggered over the next week. Client was engaged in role play and reported that he would try to use deep breathing when he is anxious.

3. Rehab Specialist will meet with client in next week and follow up on progress of treatment goals. Discuss if possible referral to psychiatry is necessary at next session.

### **SAMPLE INDIVIDUAL THERAPY (341)**

1. Client continues to suffer from PTSD symptoms which make it difficult for her to work and sleep at night. She reports she can't focus on her day-to-day tasks and is easily startled. She also continues to be scared at night.
2. Client came in stating that she continues to have nightmares of her husband being murdered in their home. She has difficulty getting to work and focusing on tasks. Client stated she is afraid of leaving the house at night or when it is dark outside. Clinician brainstormed with client how to increase her social support. Client stated she could connect with her church for emotional support. Problem solved with client on how to increase her amount of sleep. Discussed having her children visit her at night and to sleep with soothing music. Client agreed to work on finding more ways to socialize with her friends and leave the house to visit with her family during the day. She continues to decline referral to psychiatrist.
3. Clinician will continue to meet with client weekly for Individual Therapy. Will continue to encourage referrals to resources to increase client's support network.

### **SAMPLE GROUP REHABILITATION (355)**

1. Client is a 12-year-old male living with his parents and struggling in school. Client isolates himself and has very few friends. Client was referred to group to help him develop social skills and learn coping skills to assist him with his symptoms of depression and anxiety.
2. The purpose of this group is to assist clients in decreasing isolative behaviors, increasing proactive positive social skills, improve communication, improve the decision-making process, encourage community involvement, and reinforce interpersonal skills.

Facilitator provided psychoeducation to clients about the value of learning various coping skills when anxious, upset, angry, or just bored. Facilitator taught the following techniques: deep breathing, self-soothing, and positive self-talk to overcome feelings of frustration. Facilitator actively engaged clients as they practiced these coping strategies. Facilitator provided encouragement and praise to the group. Facilitator provided a verbal check out regarding each member's group experience. Encouraged clients to practice coping skills until the group meeting.

Client attentively listened during group and participated in the deep breathing exercise. Client responded well to encouragement from his peers and Facilitator. Client stated that he enjoyed the group and will try to practice new coping skills at home.

3. Client will continue to attend group rehab. Facilitator will continue to coordinate with Individual Therapist and School Counselor regarding progress in treatment.

### **EXAMPLE CASE MANAGEMENT PLAN DEVELOPMENT (571)**

1. Parents have reached out to family partner in order to assist in advocating for their son during the Individualized Education Plan (IEP) at the school. The parents would like more services but feel that they have not been heard at the previous IEP meetings. The client is a 6-year-old boy who is struggling in school because he is unable to sit for long periods of time, has a hard time focusing, is quick to anger, and will lash out at teachers or peers when he is upset.
2. The worker encouraged the parents to read the list of items that they would like to see provided to their son. The parents stated that they would like to have additional support at school so that their son is able to better manage his behaviors of hurting others or threatening to hurt others. They would also like to see that their son receives academic support since his grades have suffered this school year. This worker supported the parents by paraphrasing the requests to the team and posing questions to see if there were other services that could be provided for the client. This worker updated the team that the client is doing well in individual play therapy with county mental health and seems to have decrease his defiant behaviors (hitting, pushing, or kicking others) at home, to only 4 times per week. He is now able to comply with the parent's requests and rules at home more frequently. The parents have made adjustments to their reward system and have learned that their son responds more favorably to positive reinforcement (adding time outs) rather than negative reinforcement (taking away TV time or video games). The IEP team will look into additional supports for the client while at school in order to assist in decreasing his emotional outbursts at school, as it seems the WRAP meetings have helped decrease the emotional outbursts at home. Having the additional supports will help the client cope with his anger and learn new mechanisms in which to display his frustrations, which will hopefully help create a more constructive learning environment for him to focus on his academic assignments.
3. WRAP meeting is scheduled for tomorrow. Family partner will follow up on the IEP meeting with a collateral contact with the parents on the phone to check on and see their perception of the IEP and possibly create a list of any issues that were not discussed or any areas that need further discussion. Family Partner will coordinate with individual therapist to update her on the supports that the school district will provide so that she is aware of the changes at school.

### **EXAMPLE CASE MANAGEMENT LINKAGE (561)**

1. Therapist spoke with Client's TBS worker to coordinate services and plan a team meeting and to plan a team meeting with all service providers.
2. Therapist provided an update on client's short-term and long-term goals. Therapist spoke of how client was doing in therapy with new therapist. Therapist discussed client's general presentation and content during individual therapy sessions. Therapist inquired about client's behavior with TBS worker and at school. TBS worker stated client has been doing really well and has accomplished many of his treatment goals. TBS worker stated client has been doing a great job of processing anger in a healthy manner and behaving in school. TBS worker stated client may be discharged this summer from the TBS program. This therapist stated client and therapist are continuing to establish rapport and client is able to communicate his needs effectively.
3. Therapist will continue to communicate regularly with TBS worker when appropriate.

### **SAMPLE CRISIS INTERVENTION**

1. Received a call from manager of client's residence. Manager reported that client was yelling repeatedly, although not at any particular person. Manager stated that client's behavior is frightening other residents, although she was unsure whether there was any direct threat. Client has a history of stopping meds and substance use, which have resulted in decompensation and hospitalization due to similar behavior in the past.
2. Visited client at his residence. Client was extremely agitated, with considerable delusional content expressed. Appeared to be responding to internal stimuli. Client admitted that he has not been taking meds – states that they are poison. Was only able to redirect to coherent interaction from brief periods before client would return to somewhat incoherent rambling speech, containing ideas of reference and delusional material. Manager stated that she can't keep him in the residence in his current state, although said that she would accept him back if he gets back on his medication and his behavior stabilizes. Called for police for a 5150 to PES for evaluation and stabilization. Provided reassurance to client while waiting for police and transport, and after their arrival. Client became slightly more subdued when officers arrived and when told that he was going to hospital. Was reassured that he was not being arrested, only being taken to hospital on a hold to help him get re-stabilized.
3. Will check with PES after they have evaluated to see whether they will admit to inpatient, or restart meds and discharge back to residence. Will inform PES that unless client clears considerably, residence will not accept back. Will keep residence manager informed of client's state in terms of discharge.

### **SAMPLE IHBS SERVICE**

1. Staff met with the client at his home in order to assist the client with continuing to learn and utilize coping skills to effectively manage feelings related to his anger outbursts and impulse control.
2. Staff encouraged the client to process what coping skills have and have not worked with for him this past week. He stated that remaining calm helped him stay safe at school. Client shared that some kids at school tried to bully him, but he was able to avoid the fight and stay safe. Staff and client discussed and reinforced the use of his positive coping skills: taking space, deep breathing, and listening to music. Staff encouraged client to continue to use his coping skills when triggered.
3. Staff will continue to work with client's ICC coordinator in order to update client's progress towards goals.

### **SAMPLE ICC SERVICE (564)**

1. ICC coordinator (ICC) contacted CFS worker regarding housing issues for biological mother. Social worker (SW) stated the client continues to display concerning behaviors such as struggles with direction and aggressive behavior towards peers.
2. ICC spoke with the child's CFS social worker regarding the support the SW feels the mother needs in order to successfully reunify with her child. SW states that the mother needs the support with finding housing. SW states that she is going to send ICC some links in regard to possible housing options for biological mom. ICC discussed how the mother's visits with her child have been going. SW stated that the child and mother continue to have good visits with no behavioral concerns. ICC

discussed the importance of the mother gaining the skills to handle concerning behavior when the child is reunified. Biological mother at this time does not see many of the concerning behaviors because she only sees client once a week. ICC discussed possible referral to parenting skills class for mom.

3. ICC will continue to provide ICC services to help coordinate client's care and provide case management during possible family reunification. Referral to Wraparound may be discussed in the future.

## **11.5. SAMPLE PARTNERSHIP PLAN GOALS**

### **SAMPLE CHILDREN'S CASE MANAGEMENT PLAN**

#### **Clinical Treatment Goals:**

Improve ability to maintain safe behavior while living at home with mom, which includes identifying triggers of self-harm behavior and suicidal ideation, so that client can remain at home with mom.

#### **Strategies to Achieve Goals:**

1. Case manager will provide coordination of care with school staff, psychiatrist, and therapist in order to maintain current placement at least 1 time per month.
2. Consult with child protective services as needed.
3. Link to additional supportive services to help client maintain home and school placement as needed.
4. Explore possible referral to Transitional Age Youth (TAY) program.

### **SAMPLE CLINICAL PLAN 1**

#### **Clinical Treatment Goals:**

Client will work on decreasing her behavior of isolation, by participating in social activities at least 1 time per week as reported by client.

The client will work on replacing her negative self-talk (low self-esteem & poor body image) with a more positive self-image as reflected in her individual therapy progress at least 1 time per week as reported by client.

#### **Strategies to Achieve Goals:**

1. Client will participate in individual therapy sessions weekly in order to decrease negative self-talk and work on positive self-image that will decrease depressive symptoms.
2. Client will take her medications as prescribed and attend all scheduled psychiatric appointments.
3. Case manager and clinician will work with client on increasing her social activities so that she can work on her isolation at least 1 time per month.

### **SAMPLE CLINICAL PLAN 2**

### **Clinical Treatment Goals:**

Client will decrease symptoms of Post-Traumatic Stress Disorder, including hyper-arousal, anxiety, fear and impulsive behavior that interfere with social and emotional development as reported by client.

### **Strategies to Achieve Goals:**

1. Client will participate in individual therapy sessions weekly in order to address mental health symptoms related to PTSD and increase coping skills.
2. Cognitive Behavioral Therapy will be utilized to assist client with fear and impulsive behaviors at least 1 time per week.
3. Client will take her medications as prescribed and attend all scheduled psychiatric appointments.
4. Case manager and clinician will work with client on increasing her social activities at least monthly.
5. Possible referral to group therapy.

## **SAMPLE ADULT CASE MANAGEMENT PLAN**

### **Clinical Treatment Goals:**

Identify, coordinate, and monitor services that address the mental health symptoms - reduce depressive and anxiety symptoms, decrease distress, irritability, anger outbursts, develop and implement effective coping skills that will assist the client in stabilization of housing.

Client will reduce angry outbursts, swift and harsh statements towards others and use of abusive language towards others from 10 instances to 6 per week. She will do this by learning appropriate ways to express her anger, direct communication with the person she is angry with or expressing her feelings to a trusted adult. By doing this she will have appropriate boundaries with her family.

### **Strategies to Achieve Goals:**

1. Case manager on a weekly basis will assist client in addressing issues that interfere with client's ability to maintain stable housing and help client develop new ways to cope with impulsivity.
2. Client will work with client on a weekly basis to increase independent skills related to finding and maintaining stable housing
3. Case manager will assist client in accessing psychiatric services and providing referrals as needed.
4. Provide assistance with linkages to housing support and other services as needed.

## ***APPENDICES***

## **APPENDIX A. MEDI-CAL DIAGNOSIS LISTS**

### **MEDI-CAL INCLUDED DIAGNOSIS GROUPS**

- A. Pervasive Developmental Disorders (PDD), except Autistic Disorder excluded (Currently, DSM IV-TR diagnostic criteria must be used for PDD Disorders, per MHSUDS Information Notice No: 16-051)
- B. Neurodevelopmental Disorders
- C. Schizophrenia Spectrum and Other Psychotic Disorders
- D. Bipolar and Related Disorders
- E. Depressive Disorders
- F. Anxiety Disorders
- G. Obsessive-Compulsive Disorders
- H. Trauma- and Stressor-Related Disorders
- I. Dissociative Disorders
- J. Somatic Symptom and Related Disorders
- K. Feeding and Eating Disorders
- L. Elimination Disorders
- M. Sleep-Wake Disorders
- N. Sexual Dysfunction Disorders
- O. Gender Dysphoria
- P. Disruptive, Impulse-Control, and Conduct Disorders
- Q. Substance-Related and Addictive Disorders
- R. Neurocognitive Disorders
- S. Personality Disorders
- T. Paraphilic Disorders
- U. Other Mental Disorders
- V. Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- W. Other Conditions That May Be a Focus of Clinical Attention
- X. No Diagnosis - *The Z03.89 code can **only** be used when claiming for services provided during the **assessment period** when a diagnosis has not yet been established.*

To continue claiming the diagnosing clinician must complete one of the following before the assessment period (e.g., 30/60 days) expires:

*(See also detail below)*

**MEDI-CAL EXCLUDED DIAGNOSIS GROUPS**

A client may receive services for an included diagnosis even though an excluded diagnosis may also be present. Excluded diagnosis shall be a secondary diagnosis, services shall focus on mental health treatment.

## **APPENDIX B. CCBHS-MHP OUTPATIENT INCLUDED DIAGNOSIS LIST**

A copy of the most recent version of this list is available at  
<https://cchealth.org/mentalhealth/clinical-documentation/#Documents>

## CCMHP Outpatient Included Diagnosis List

**Effective 02/09/21**

**Note:** All diagnoses that are ~~lined-out-in-red~~ have been removed from the Included Diagnosis list. Please refer to the DHCS MHSUDS Information Notice specified.

ICD-10: Required for ShareCare Billing	DSM-5	DSM-5 Narrative Description
<b>F20.0</b>	295.3	Schizophrenia, paranoid type (narrative from DSM-IV-TR manual)
<b>F20.1</b>	295.1	Schizophrenia, disorganized type (narrative from DSM-IV-TR manual)
<b>F20.2</b>	295.2	Schizophrenia, catatonic type (narrative from DSM-IV-TR manual)
<b>F20.3</b>	295.9	Schizophrenia, undifferentiated type (narrative from DSM-IV-TR manual)
<b>F20.5</b>	295.6	Schizophrenia, residual type (narrative from DSM-IV-TR manual)
<b>F20.81</b>	295.4	Schizophreniform disorder
<b>F20.89</b>	298.9	Unspecified schizophrenia spectrum and other psychotic disorder
<b>F20.9</b>	295.9	Schizophrenia
<b>F21</b>	301.22	Schizotypal personality disorder
<b>F22</b>	297.1	Delusional disorder
<b>F23</b>	298.8	Brief psychotic disorder
<b>F24</b>	297.3	Shared psychotic disorder (narrative from DSM-IV-TR manual)
<b>F25.0</b>	295.7	Schizoaffective disorder, bipolar type
<b>F25.1</b>	295.7	Schizoaffective disorder, depressive type
<b>F25.8</b>	295.7	Schizoaffective disorder, unspecified (for reference, ICD-10: Other Schizoaffective disorders)
<b>F25.9</b>	295.7	Schizoaffective disorder, unspecified (for reference, ICD-10: Schizoaffective disorder, unspecified)
<b>F28</b>	298.8	Other specified schizophrenia spectrum and other psychotic disorder
<b>F29</b>	298.9	Unspecified schizophrenia spectrum and other psychotic disorder
<b>F30.10</b>	296.4	Bipolar I disorder, current or most recent episode manic, unspecified (for reference, ICD-10: Manic episode without psychotic symptoms, unspecified)
<b>F30.11</b>	296.41	Bipolar I disorder, current or most recent episode manic, manic (for reference, ICD-10: manic episode without psychotic symptoms, mild)

<b>ICD-10: Required for ShareCare Billing</b>	<b>DSM-5</b>	<b>DSM-5 Narrative Description</b>
<b>F30.12</b>	296.42	Bipolar I disorder, current or most recent episode manic, moderate (for reference, ICD-10: Manic episode without psychotic symptoms, moderate)
<b>F30.13</b>	296.43	Bipolar I disorder, current or most recent episode manic, severe (for reference, ICD-10: Manic episode without psychotic symptoms, severe)
<b>F30.2</b>	296.44	Bipolar I disorder, current or most recent episode manic, with psychotic features (for reference, ICD-10: Manic episode, severe, with psychotic symptoms)
<b>F30.3</b>	296.45	Bipolar I disorder, current or most recent episode manic, in partial remission (for reference, ICD-10: Manic episode in partial remission)
<b>F30.4</b>	296.46	Bipolar I disorder, current or most recent episode manic, in full remission (for reference, ICD-10: Manic episode in full remission)
<b>F30.8</b>	296.4	Bipolar I disorder, current or most recent episode manic, unspecified (for reference, ICD-10: Other manic episodes)
<b>F30.9</b>	296.4	Bipolar I disorder, current or most recent episode manic, unspecified (for reference, ICD-10: Manic episode, unspecified)
<b>F31.0</b>	296.4	Bipolar I disorder, current or most recent episode hypomanic
<b>F31.10</b>	296.4	Bipolar I disorder, current or most recent episode manic, unspecified
<b>F31.11</b>	296.41	Bipolar I disorder, current or most recent episode manic, mild
<b>F31.12</b>	296.42	Bipolar I disorder, current or most recent episode manic, moderate
<b>F31.13</b>	296.43	Bipolar I disorder, current or most recent episode manic, severe
<b>F31.2</b>	296.44	Bipolar I disorder, Current or most recent episode manic, With psychotic features
<b>F31.30</b>	296.5	Bipolar I disorder, current or most recent episode depressed, unspecified
<b>F31.31</b>	296.51	Bipolar I disorder, current or most recent episode depressed, mild
<b>F31.32</b>	296.52	Bipolar I disorder, current or most recent episode depressed, moderate
<b>F31.4</b>	296.53	Bipolar I disorder, current or most recent episode depressed, severe
<b>F31.5</b>	296.54	Bipolar I disorder, Current or most recent episode depressed, with psychotic features
<b>F31.60</b>	296.7	Bipolar I disorder, current or most recent episode unspecified (for reference, ICD-10: Bipolar disorder, current episode mixed, unspecified)
<b>F31.61</b>	296.89	Bipolar II disorder, with mixed features

<b>ICD-10: Required for ShareCare Billing</b>	<b>DSM-5</b>	<b>DSM-5 Narrative Description</b>
<b>F31.63</b>	296.7	Bipolar I disorder, current or most recent episode unspecified (for reference, ICD-10: Bipolar disorder, current episode mixed, moderate)
<b>F31.63</b>	296.7	Bipolar I disorder, current or most recent episode unspecified (for reference, ICD-10: Bipolar disorder, current episode mixed, severe, without psychotic features)
<b>F31.63</b>	296.7	Bipolar I disorder, current or most recent episode unspecified (for reference, ICD-10: Bipolar disorder, current episode mixed, severe, with psychotic features)
<b>F31.7</b>	296.56	Bipolar I disorder, current or most recent episode depressed, in full remission (for reference, ICD-10: Bipolar disorder, currently in remission, most recent episode unspecified)
<b>F31.71</b>	296.45	Bipolar I disorder, current or most recent episode hypomanic, in partial remission
<b>F31.72</b>	296.46	Bipolar I disorder, current or most recent episode hypomanic, in full remission
<b>F31.73</b>	296.45	Bipolar I disorder, current or most recent episode manic, in partial remission
<b>F31.74</b>	296.46	Bipolar I disorder, current or most recent episode manic, in full remission
<b>F31.75</b>	296.55	Bipolar I disorder, current or most recent episode depressed, in partial remission
<b>F31.76</b>	296.56	Bipolar I disorder, current or most recent episode depressed, in full remission
<b>F31.77</b>	296.55	Bipolar I disorder, current of most recent episode depressed, in partial remission, with mixed features
<b>F31.78</b>	296.56	Bipolar I disorder, current or most recent episode depressed, in full remission, with mixed features.
<b>F31.81</b>	296.89	Bipolar II disorder
<b>F31.89</b>	296.89	Other specified bipolar and related disorder
<b>F31.9</b>	296.4	Bipolar I disorder, current or most recent episode hypomanic, unspecified
<b>F31.9</b>	296.4	Bipolar I disorder, current or most recent episode manic, unspecified
<b>F31.9</b>	296.5	Bipolar I disorder, current or most recent episode depressed, unspecified
<b>F31.9</b>	296.7	Bipolar I disorder, current or most recent episode unspecified
<b>F31.9</b>	296.8	Unspecified bipolar and related disorder
<b>F32.0</b>	296.21	Major depressive disorder, single episode, mild
<b>F32.1</b>	296.22	Major depressive disorder, single episode, moderate
<b>F32.2</b>	296.23	Major depressive disorder, single episode, severe

<b>ICD-10: Required for ShareCare Billing</b>		
<b>ICD-10</b>	<b>DSM-5</b>	<b>DSM-5 Narrative Description</b>
<b>F32.3</b>	296.24	Major depressive disorder, single episode, with psychotic features
<b>F32.4</b>	296.25	Major depressive disorder, single episode, in partial remission
<b>F32.5</b>	296.26	Major depressive disorder, single episode, in full remission
<b>F32.81</b>	635.4	Premenstrual dysphoric disorder
<b>F32.89</b>	311	Other specified depressive disorder
<b>F32.9</b>	296.2	Major depressive disorder, single episode, unspecified
<b>F32.9</b>	311	Unspecified depressive disorder
<b>F33.0</b>	296.31	Major depressive disorder, recurrent episode, mild
<b>F33.1</b>	296.32	Major depressive disorder, recurrent episode, moderate
<b>F33.2</b>	296.33	Major depressive disorder, recurrent episode, severe
<b>F33.3</b>	296.34	Major depressive disorder, recurrent episode, with psychotic features
<b>F33.40</b>	296.36	Major depressive disorder, recurrent episode, in full remission
<b>F33.41</b>	296.35	Major depressive disorder, recurrent episode, in partial remission
<b>F33.42</b>	296.36	Major depressive disorder, recurrent episode, in full remission
<b>F33.8</b>	296.3	Major depressive disorder, recurrent episode, unspecified
<b>F33.9</b>	296.3	Major depressive disorder, recurrent episode, unspecified
<b>F34.0</b>	301.13	Cyclothymic disorder
<b>F34.1</b>	300.4	Persistent depressive disorder (dysthymia)
<b>F34.81</b>	296.99	Disruptive mood dysregulation disorder
<b>F34.89</b>	311	Other specified depressive disorder (for reference, ICD-10: Other specified persistent mood disorder)
<b>F34.9</b>	300.4	Persistent depressive disorder (dysthymia) (for reference, ICD-10: Persistent mood [affective] disorder)
<b>F39</b>	311	Unspecified depressive disorder (for reference, ICD-10: Unspecified mood [affective] disorder)
<b>F40.00</b>	300.22	Agoraphobia
<b>F40.01</b>	300.21	Agoraphobia with panic disorder (narrative from DSM-IV-TR manual)
<b>F40.02</b>	300.01	Agoraphobia without panic disorder (narrative from DSM-IV-TR manual)
<b>F40.10</b>	300.23	Social anxiety disorder (social phobia)
<b>F40.11</b>	300.23	Social anxiety disorder (for reference, ICD-10: Social phobia, Generalized)
<b>F40.210</b>	300.29	Specific phobia, animal (for reference, ICD-10: arachnophobia)
<b>F40.218</b>	300.29	Specific phobia, animal
<b>F40.220</b>	300.29	Specific phobia, natural environment (for reference, ICD-10: Fear of thunderstorms)
<b>F40.228</b>	300.29	Specific phobia, natural environment
<b>F40.230</b>	300.29	Specific phobia, fear of blood
<b>F40.231</b>	300.29	Specific phobia, fear of injections and transfusions

<b>ICD-10: Required for ShareCare Billing</b>		
<b>ICD-10</b>	<b>DSM-5</b>	<b>DSM-5 Narrative Description</b>
<b>F40.232</b>	300.29	Specific phobia, fear of other medical care
<b>F40.233</b>	300.29	Specific phobia, fear of injury
<b>F40.240</b>	300.29	Specific phobia, situational (for reference, ICD-10: Claustrophobia)
<b>F40.241</b>	300.29	Specific phobia, natural environment (for reference, ICD-10: Acrophobia)
<b>F40.242</b>	300.29	Specific phobia, situational (for reference, ICD-10: Fear of bridges)
<b>F40.243</b>	300.29	Specific phobia, situational (for reference, ICD-10: Fear of flying)
<b>F40.248</b>	300.29	Specific phobia, situational
<b>F40.290</b>	300.29	Specific phobia, other (for reference, ICD-10: Androphobia)
<b>F40.291</b>	300.29	Specific phobia, other (for reference, ICD-10: Gynophobia)
<b>F40.298</b>	300.29	Specific phobia, other
<b>F40.8</b>	300.00	Unspecified anxiety disorder
<b>F40.9</b>	300.29	Specific phobia, other
<b>F41.0</b>	300.01	Panic disorder
<b>F41.1</b>	300.02	Generalized anxiety disorder
<b>F41.3</b>	300	Unspecified anxiety disorder (for reference, ICD-10: Other mixed anxiety disorders)
<b>F41.8</b>	300.09	Other specified anxiety disorder
<b>F41.9</b>	300	Unspecified anxiety disorder
<b>F42.2</b>	300.3	Obsessive-compulsive disorder
<b>F42.3</b>	300.3	Hoarding disorder
<b>F42.4</b>	698.4	Excoriation (skin-picking) disorder
<b>F42.8</b>	300.3	Other specified obsessive-compulsive and related disorder
<b>F42.9</b>	300.3	Unspecified obsessive-compulsive and related disorder
<b>F43.0</b>	308.3	Acute stress disorder
<b>F43.10</b>	309.81	Posttraumatic stress disorder
<b>F43.11</b>	308.3	Acute stress disorder
<b>F43.12</b>	309.81	Posttraumatic stress disorder
<b>F43.20</b>	309.9	Adjustment disorder, unspecified
<b>F43.21</b>	309	Adjustment disorder, with depressed mood
<b>F43.22</b>	309.24	Adjustment disorder, with anxiety
<b>F43.23</b>	309.28	Adjustment disorder, with mixed anxiety and depressed mood
<b>F43.24</b>	309.3	Adjustment disorder, with disturbance of conduct
<b>F43.25</b>	309.4	Adjustment disorder, with mixed disturbance of emotions and conduct
<b>F43.29</b>	309.9	Adjustment disorder unspecified
<b>F43.8</b>	309.89	Other specified trauma and stressor related disorder
<b>F43.9</b>	309.9	Unspecified trauma and stressor related disorder
<b>F44.0</b>	300.12	Dissociative amnesia
<b>F44.1</b>	300.13	Dissociative amnesia, with dissociative fugue
<b>F44.2</b>	300.15	Other specified dissociative disorder

<b>ICD-10: Required for ShareCare Billing</b>	<b>DSM-5</b>	<b>DSM-5 Narrative Description</b>
<b>F44.4</b>	300.11	Conversion disorder (functional neurological symptom disorder), with abnormal movement
<b>F44.4</b>	300.11	Conversion disorder (functional neurological symptom disorder), with speech symptoms
<b>F44.4</b>	300.11	Conversion disorder (functional neurological symptom disorder), with swallowing symptoms
<b>F44.4</b>	300.11	Conversion disorder (functional neurological symptom disorder), with weakness/paralysis
<b>F44.5</b>	300.11	Conversion disorder (functional neurological symptom disorder), with attacks or seizures
<b>F44.6</b>	300.11	Conversion disorder (functional neurological symptom disorder), with anesthesia or sensory loss
<b>F44.6</b>	300.11	Conversion disorder (functional neurological symptom disorder), with special sensory symptoms
<b>F44.7</b>	300.11	Conversion disorder (functional neurological symptom disorder), with mixed symptoms
<b>F44.81</b>	300.14	Dissociative identity disorder
<b>F44.89</b>	300.15	Other specified dissociative disorder
<b>F44.9</b>	300.15	Unspecified dissociative disorder
<b>F45.0</b>	300.81	Somatization disorder (narrative from DSM-IV-TR manual)
<b>F45.1</b>	300.82	Somatic symptom disorder
<b>F45.20</b>	300.7	Illness anxiety disorder (for reference, ICD-10: Hypochondriacal disorder, Unspecified)
<b>F45.21</b>	300.7	Illness anxiety disorder
<b>F45.22</b>	300.7	Body dysmorphic disorder
<b>F45.29</b>	300.7	Illness anxiety disorder (for reference, ICD-10: Other hypochondriacal disorders)
<b>F45.42</b>	307.8	Unspecified somatic symptom and related disorder
<b>F45.51</b>	307.8	Unspecified somatic symptom and related disorder
<b>F45.8</b>	300.89	Other specified somatic symptom and related disorder
<b>F45.9</b>	300.82	Unspecified somatic symptom and related disorder
<b>F48.1</b>	300.6	Depersonalization/derealization disorder
<b>F50.00</b>	307.5	Unspecified feeding or eating disorder
<b>F50.01</b>	307.1	Anorexia nervosa, restricting type
<b>F50.02</b>	307.1	Anorexia nervosa, binge-eating/purging type
<b>F50.2</b>	307.51	Bulimia nervosa
<b>F50.8</b>	307.59	Avoidant/restrictive food intake disorder
<b>F50.81</b>	307.51	Binge-eating disorder
<b>F50.82</b>	307.59	Avoidant/restrictive food intake disorder
<b>F50.89</b>	307.52	Pica, in adults
<b>F50.89</b>	307.59	Other specified feeding or eating disorder

<b>ICD-10: Required for ShareCare Billing</b>		
<b>ICD-10</b>	<b>DSM-5</b>	<b>DSM-5 Narrative Description</b>
<b>F50.9</b>	307.5	Unspecified feeding or eating disorder
<b>F53.0</b>	296.23	Major depressive disorder, severe, single episode with peripartum onset
<b>F53.1</b>	298.8	Brief psychotic disorder with peripartum onset
<b>F60.0</b>	301	Paranoid personality disorder
<b>F60.1</b>	301.2	Schizoid personality disorder
<b>F60.3</b>	301.83	Borderline personality disorder
<b>F60.4</b>	301.5	Histrionic personality disorder
<b>F60.5</b>	301.4	Obsessive-compulsive personality disorder
<b>F60.6</b>	301.82	Avoidant personality disorder
<b>F60.7</b>	301.6	Dependent personality disorder
<b>F60.81</b>	301.81	Narcissistic personality disorder
<b>F60.9</b>	301.9	Unspecified personality disorder
<b>F63.0</b>	312.31	Gambling disorder
<b>F63.1</b>	312.33	Pyromania
<b>F63.2</b>	312.32	Kleptomania
<b>F63.3</b>	312.39	Trichotillomania (hair-pulling disorder)
<b>F63.81</b>	312.34	Intermittent explosive disorder
<b>F63.89</b>	312.89	Other specified disruptive impulsive control and conduct disorder (for reference, ICD-10: Other impulse disorders)
<b>F63.89</b>	312.34	Intermittent explosive disorder (for reference, ICD-10: Other impulse disorder)
<b>F64.0</b>	302.85	Gender dysphoria in adolescents and adults (transsexualism)
<b>F64.2</b>	302.6	Gender dysphoria in children
<b>F64.8</b>	302.6	Other specified gender dysphoria
<b>F64.9</b>	302.6	Unspecified gender dysphoria
<b>F65.0</b>	302.81	Fetishistic disorder
<b>F65.1</b>	302.3	Transvestic disorder
<b>F65.2</b>	302.4	Exhibitionistic disorder
<b>F65.3</b>	302.82	Voyeuristic disorder
<b>F65.4</b>	302.2	Pedophilic disorder
<b>F65.50</b>	302.84	Sexual sadism disorder (for reference, ICD-10: Sadomasochism, unspecified)
<b>F65.51</b>	302.83	Sexual masochism disorder
<b>F65.52</b>	302.84	Sexual sadism disorder
<b>F65.81</b>	302.89	Frotteuristic disorder
<b>F65.89</b>	302.89	other specified paraphilic disorder
<b>F65.9</b>	302.9	Unspecified paraphilic disorder
<b>F68.10</b>	300.19	Factitious disorder imposed on self
<b>F68.11</b>	300.19	Factitious disorder imposed on self, with predominantly psychological signs and symptoms

<b>ICD-10: Required for ShareCare Billing</b>		
<b>ICD-10</b>	<b>DSM-5</b>	<b>DSM-5 Narrative Description</b>
<b>F68.12</b>	300.19	Factitious disorder imposed on self, with predominantly physical signs and symptoms
<b>F68.13</b>	300.19	Factitious disorder imposed on self, with combined psychological and physical signs and symptoms
<b>F68.A</b>	300.19	Factitious disorder imposed on another
<b>F80.82</b>	315.39	Social pragmatic communication disorder
<b>F80.9</b>	307.9	Unspecified communication disorder
<b>F84.0</b>	299.00	Autism spectrum disorder
<b>F84.2</b>	299.8	Rett's syndrome (narrative from DSM-IV-TR manual)
<b>F84.3</b>	299.1	Other childhood disintegrative disorder (narrative from DSM-IV-TR manual)
<b>F84.5</b>	299.8	Asperger's syndrome (must use DSM-IV-TR manual)
<b>F84.8</b>	299.8	Other pervasive developmental disorders (narrative from DSM-IV-TR manual)
<b>F84.9</b>	299.8	Pervasive developmental disorder, unspecified (narrative from DSM-IV-TR manual)
<b>F90.0</b>	314	Attention-deficit/hyperactivity disorder, predominantly inattentive presentation
<b>F90.1</b>	314.01	Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation
<b>F90.2</b>	314.01	Attention-deficit/hyperactivity disorder, combined presentation
<b>F90.8</b>	314.01	Other specified attention-deficit/hyperactivity disorder
<b>F90.9</b>	314.01	Unspecified attention-deficit/hyperactivity disorder
<b>F91.0</b>	312.89	Other specified disruptive impulsive control and conduct disorder (for reference, ICD-10: Conduct disorder confined to family context)
<b>F91.1</b>	312.81	Conduct disorder, childhood-onset type
<b>F91.2</b>	312.82	Conduct disorder, adolescent-onset type
<b>F91.3</b>	313.81	Oppositional defiant disorder
<b>F91.8</b>	312.89	Other specified disruptive, impulse-control, and conduct disorder
<b>F91.9</b>	312.89	Conduct disorder, unspecified onset
<b>F91.9</b>	312.9	Unspecified disruptive, impulse-control, and conduct disorder
<b>F93.0</b>	309.21	Separation anxiety disorder
<b>F93.8</b>	313.9	Disorder of infancy, childhood or adolescence NOS (must use DSM-IV-TR manual) (for reference, ICD-10: Other childhood emotional disorders, unspecified)
<b>F93.9</b>	313.9	Disorder of infancy, childhood or adolescence NOS (must use DSM-IV-TR manual) (for reference, ICD-10: Childhood emotional disorder, unspecified)
<b>F94.0</b>	313.23	Selective mutism
<b>F94.1</b>	313.89	Reactive attachment disorder
<b>F94.2</b>	313.89	Disinhibited social engagement disorder

ICD-10: Required for ShareCare Billing		
ICD-10	DSM-5	DSM-5 Narrative Description
F94.8	315.39	Social pragmatic communication disorder (for reference, ICD-10: Other childhood disorders of social functioning)
F94.9	315.39	Social pragmatic communication disorder (for reference, ICD-10: Other childhood disorders of social functioning)
F95.0	307.21	Provisional tic disorder
F95.1	307.22	Persistent (chronic) motor or vocal tic disorder
F95.2	307.23	Tourette disorder
F95.8	307.2	Other specified tic disorder
F95.9	307.2	Unspecified tic disorder
F98.0	307.6	Enuresis
F98.1	307.7	Encopresis
F98.21	307.53	Rumination disorder
F98.29	307.59	Other specified feeding or eating disorder
F98.3	307.52	Pica, in children
F98.4	307.3	Stereotypic movement disorder
F98.8	313.9	Must use ICD-10 narrative: Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. Use DSM-IV-TR criteria for Disorder of infancy, childhood, or adolescence Not otherwise specified
F98.9	313.9	Must use ICD-10 narrative: Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. Use DSM-IV-TR criteria for Disorder of infancy, childhood, or adolescence, not otherwise specified
G21.0	333.92	Neuroleptic malignant syndrome **
G21.11	332.1	Neuroleptic-induced parkinsonism **
G24.4		Idiopathic orofacial dystonia (ICD-10 narrative) **
G25.1	333.1	Medication-induced postural tremor **
G25.70		Drug-induced movement disorder, unspecified (ICD-10 narrative) **
G25.71	333.99	Medication-induced acute akathisia **
G25.9		Extrapyramidal and movement disorder, unspecified (ICD-10 narrative) **
R15.0	787.6	Other specified elimination disorder with fecal symptoms
R15.9	787.6	Unspecified elimination disorder with fecal symptoms
<b>R69</b>		<b>Diagnosis Deferred (Illness, unspecified) Code removed per Info Notice 20-043.</b>
Z03.89		No Diagnosis

## **APPENDIX C. TITLE 9 SERVICE DEFINITIONS**

### **TITLE 9. CALIFORNIA CODE OF REGULATIONS Chapter 11. Medi-Cal Specialty Mental Health Services**

#### **Assessment (§1810.204)**

“Assessment” means a service activity which may include a clinical analysis of the history and current status of a beneficiary’s mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

#### **Plan Development (§1810.232)**

“Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.

#### **Mental Health Services (§1810.227)**

“Mental Health Services” means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

#### **Therapy (1810.250)**

“Therapy” means a service activity which is a therapeutic intervention that focuses 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.

#### **Rehabilitation (§1810.243)**

“Rehabilitation” means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

#### **Collateral (§1810.206)**

“Collateral” means a service activity to a significant support person in a beneficiary’s life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.

### **Medication Support Services (§1810.225)**

“Medication Support Services” means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

### **Crisis Intervention (§1810.209)**

“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by the department or a Mental Health Plan to provide crisis stabilization.

### **Case Management (§1810.249)**

“Targeted Case Management” (Case Management/ Brokerage/Linkage/Placement) 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.

### **TITLE 9 DEFINITION (§1810.227) ~ SPECIALTY MENTAL HEALTH SERVICE**

“Mental Health Services” mean those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of Adult Residential Services, Crisis Residential Treatment Services, Crisis Intervention, Crisis Stabilization, Day Rehabilitation, or Day Treatment Intensive Services. Mental Health Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: For seriously emotionally disturbed children and adolescents, Mental Health Services provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration.

## **APPENDIX D. SCOPE OF PRACTICE DEFINITIONS**

This document is also available at  
<https://cchealth.org/mentalhealth/provider/>



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

The establishment of provider selection criteria is a required activity of County MHPs.<sup>1</sup> MHPs are authorized to establish additional requirements “as part of a credentialing or other evaluation process”.<sup>2</sup> This Scope of Practice specifies the required credentials, supervision and approved activities for Psychiatrists, Nurse Practitioners, Registered Nurses, Psychiatric Technicians, Licensed Mental Health Professionals (LMHPs), Interns, Trainees, Mental Health Rehabilitation Specialists (MHRs), and Designated Mental Health Workers (DMHWs).

### MEDICAL

#### PSYCHIATRIST (MD, DO)

A Psychiatrist shall have a license to practice as a physician and surgeon granted by the California Medical Board or by the Board of Osteopathic Examiners.<sup>3</sup> A Psychiatrist must possess a valid, unrestricted DEA registration and a NPI number with a valid taxonomy.

### NURSING

#### FAMILY NURSE PRACTITIONER (FNP)/PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER (PMHNP)

A FNP/PMHNP is a registered nurse who possesses additional preparation and skill in physical diagnosis, psycho-social assessment and management of episodic and chronic mental illness. FNP/PMHNP are certified by the State of California, Board of Registered Nursing to practice under standardized procedure<sup>4</sup> and to furnish drugs and devices.<sup>5</sup> FNP/PMHNP must possess a valid, unrestricted DEA registration and a NPI number with a valid taxonomy.

FNP/PMHNPs must also possess a master’s degree in nursing from an accredited college or university with a Family Nurse Practitioner or Mental Health Family Nurse Practitioner specialty. In addition, they must have either one (1) year of full-time or its equivalent experience as a Registered Nurse in a hospital, clinic or other medical facility or one (1) year of full-time or its equivalent experience as a Public Health Nurse or one (1) year of experience as a Registered Nurse in a mental health clinic, psychiatric clinic, or private practice.

#### REGISTERED NURSE (RN)

A registered nurse shall have a license as a registered nurse by the State of California, Board of Registered Nursing.<sup>6</sup> RNs must possess a NPI number with a valid taxonomy.

<sup>1</sup> CCR, Title 9, §1810.435

<sup>2</sup> CCR, Title 9, §1810.435(b)(6)

<sup>3</sup> Title 9, §782.39

<sup>4</sup> CCR, Title 16, §14.74

<sup>5</sup> BPC Section 4076

<sup>6</sup> Title 9, §782.44



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**PSYCHIATRIC TECHNICIAN (PT)**

A licensed psychiatric technician shall have a license as a psychiatric technician by the State of California, Board of Vocational Nurses and Psychiatric Technician Examiners.<sup>7</sup> LPTs must possess a NPI number with a valid taxonomy.

RNs and PTs cannot conduct assessments and individual or group psychotherapy but are able to provide group rehab; PTs can only facilitate with Licensed Mental Health Professionals (LMHP).

**LICENSED MENTAL HEALTH PROFESSIONALS (LMHP)**

**LICENSED PSYCHOLOGIST (PhD, PsyD)**

A Licensed Psychologist shall have obtained a license to practice as a psychologist granted by the State of California Board of Psychology.<sup>8</sup> Psychologists must possess a NPI number with a valid taxonomy.

**LICENSED CLINICAL SOCIAL WORKER (LCSW)**

A Licensed Clinical Social Worker is licensed as a clinical social worker by the State of California, Board of Behavioral Sciences.<sup>9</sup> LCSWs must possess a NPI number with a valid taxonomy.

**LICENSED MARRIAGE & FAMILY THERAPIST (LMFT)**

A Licensed Marriage & Family Therapist shall have obtained a license to practice as marriage, family and child therapist by the State of California, Board of Behavioral Sciences.<sup>10</sup> LMFTs must possess a NPI number with a valid taxonomy.

**LICENSED PROFESSIONAL CLINICAL COUNSELOR (LPCC)**

A Licensed Professional Clinical Counselor shall have obtained a license to practice as a licensed professional clinical counselor by the California Board of Behavioral Sciences.<sup>11</sup> LPCCs must possess a NPI number with a valid taxonomy. This group of LPCCs will have a secondary status on Breeze – State of California to confirm they can provide assessment and treatment to couples and families.

<sup>7</sup> Title 9 §782.28

<sup>8</sup> Title 9, §782.42

<sup>9</sup> Title 9, §782.48

<sup>10</sup> Title 9, §782.32

<sup>11</sup> CA Bus & Prof Code §4999.20 and CCR, Title 16 §1820.5

<sup>12</sup> Refer to Contra Costa County Scope of Practice Grid



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**LICENSED PROFESSIONAL CLINICAL COUNSELOR (LPCC) - Restricted**

A Licensed Professional Clinical Counselor shall have obtained a license to practice as a licensed professional clinical counselor by the California Board of Behavioral Sciences.<sup>11</sup> LPCCs must possess a NPI number with a valid taxonomy. The scope of practice for Licensed Professional Clinical Counselors (LPCCs) does not include the assessment or treatment of couples or families. For a LPCC to provide assessment and treatment to couples or families, they are required to complete the following requirements:

**Scope of Practice Qualifications to Assess and Treat Couples and Families (must meet all 3)**

1. Six (6) semester units or nine (9) quarter units specifically focused on the theory and application of marriage and family therapy **OR** a named specialization or emphasis area on the qualifying degree in marriage and family therapy; marital and family therapy; marriage, family, and child counseling; or couple and family therapy.
2. No less than 500 hours of documented supervised experience working directly with couples, families, or children.
3. A minimum of six (6) hours of continuing education (CE) specific to marriage and family therapy during each license renewal cycle. The six (6) hours will count toward the required overall 36 hours of CE.

With the requirement listed above the LPCCs must submit proof that they have been approved by the Board.

Licensed Mental Health Professionals can authorize services as directed by the MHP; can conduct comprehensive assessments and provide a diagnosis without co-signature; can co-sign the work of other staff members within their scope of practice.<sup>11</sup> Not required but recommend weekly supervision with clinical supervisor/manager.

**INTERN**

**PSYCHOLOGIST INTERN (PhD and PsyD Waivered)**

**Post-Doctoral Interns**

A Post-Doctoral intern must possess an earned doctorate degree in psychology, in education psychology, or in education with the field of specialization in counseling psychology or educational psychology in order to obtain supervised post-doctoral hours towards licensure as a



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

psychologist.<sup>12</sup> The Post-Doctoral Intern can be registered with the State of California, Board of Psychology as a Registered Psychologist/Registered Psychological Assistant or sign an official Supervision Agreement in a formal internship placement or as an employee of an exempt setting. Post-doctoral interns must earn a minimum of 1500 supervised hours of experience within 30 consecutive months.<sup>13</sup> A Post-Doctoral Intern must possess a NPI number with a valid taxonomy.

### **Pre-Doctoral Interns**

A Pre-Doctoral Intern is one who is in the process of earning a doctoral degree with a formal internship. A Pre-Doctoral Intern is not required to be registered with the State of California, Board of Psychology if working in a governmental agency. Pre-doctoral Interns may earn a maximum of 1500 supervised hours of experience within 30 consecutive months.<sup>14</sup> A Pre-Doctoral Intern must possess a NPI number with a valid taxonomy.

### **Waiver Requirements**

All qualifying Pre- and Post-Doctoral Interns are required to obtain a waiver from the Department of Health Care Services (DHCS). The Waiver is granted up to five consecutive years from the initial date of approval with DHCS. The waiver allows the intern to provide services equivalent to those of a licensed mental health professional while acquiring experience towards clinical licensure. DMH Letter 10-03 provides the following guidelines:

- Each psychologist candidate must obtain a waiver – even if he/she is registered with his/her licensing board.
- In order to be eligible for such a waiver, the psychologist candidate must have successfully completed 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship, or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.
- There is no statutory provision for extension of psychologist candidate waivers beyond the five-year limit.

### **Supervision Requirements**

An Intern must accrue 3000 hours of supervised professional experience. At least 1500 hours of supervised professional experience must be accrued post-doctorally. A minimum of one hour of face-to-face supervision per week is required. The total weekly supervision required must account for 10% of total hours worked to a maximum of forty (44) hours per week including supervision time.<sup>15</sup>

<sup>12</sup> CA Bus & Prof Code § 2914 (2016)

<sup>13</sup> CCR, Title 16, §1367(a)(1)(A)-(D)

<sup>14</sup> CCR, Title 16, §1387(a)(1)(A)-(E)

<sup>15</sup> CCR, Title 16, §1387(b)(4)-(5)



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**Qualifications and Responsibilities of a Primary Supervisor**

All primary supervisors shall be licensed psychologists while the psychologist candidate is accruing Supervised Professional Experience hours toward licensure. Primary supervisors must possess and maintain a valid, active license free of any formal disciplinary action. Primary supervisors who are licensed by the board shall complete a minimum of six (6) hours of supervision coursework every two years.<sup>16</sup>

Primary supervisors are responsible for ensuring compliance and monitoring the welfare of the Intern's clients, as well as for monitoring the performance and professional development of the interns.<sup>17</sup>

The primary supervisor must be employed in the same work setting at least half the time as the Intern and be available to the Intern 100% of the time he/she is accruing supervised professional experience.<sup>18</sup> Primary supervisors shall ensure that each client or patient is informed prior to the rendering of services by the Intern (1) that the Intern is unlicensed and is functioning under the direction and supervision of the supervisor; (2) that the primary supervisor shall have full access to the treatment records in order to perform supervision responsibilities and (3) that any fees paid for the services of the Intern must be paid directly to the primary supervisor or employer.<sup>19</sup>

**Qualifications and Responsibilities of a Delegated Supervisor**

Primary supervisors may delegate supervision to other qualified psychologists or to other qualified mental health professionals including licensed marriage and family therapists, licensed educational psychologists, licensed clinical social workers and board certified psychiatrists.<sup>20</sup> However, the primary supervisor remains responsible for the minimum one hour per week of direct, individual face-to-face supervision.<sup>21</sup> Once the collection of Supervised Professional Experience hours has been completed, supervision by a licensed mental health professional is required until the psychologist candidate obtains a license to practice.

Delegated supervisors are responsible for monitoring the welfare of the intern's clients while under their delegated supervision and abide by the all provisions of the California Code of Regulations §1387.2.

<sup>16</sup> CCR, Title 16, §1387.1(b)

<sup>17</sup> CCR, Title 16, §1387.1

<sup>18</sup> CCR, Title 16, §1387(b)(6)

<sup>19</sup> CCR, Title 16, §1387.1(g) and 1392.6(b)

<sup>20</sup> CCR, Title 16, §1387(c)(1)

<sup>21</sup> CCR, Title 16, §1387(c)(2)



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

**Approved Activities:** Psychologist Interns can conduct comprehensive assessments and provide a diagnosis. They can claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), Crisis Intervention (15/70), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice.<sup>22</sup>

### **ASSOCIATE MARRIAGE AND FAMILY THERAPIST (AMFT)**

An Associate Marriage and Family Therapist (AMFT) must possess a Master's in Marriage and Family Therapy from an accredited graduate school program that prepares the student for licensure as a marriage and family therapist. AMFTs must be registered with the State of California, Board of Behavioral Sciences and must possess a NPI number with a valid taxonomy.

**Required Supervision:** The State of California, Board of Behavioral Sciences requires 3000 hours of supervised professional experience and 104 weeks of supervision to qualify for MFT licensure. Of the 104 weeks required, 52 weeks must be weeks in which the AMFT received at least one hour of one-on-one, individual face-to-face supervision. Any week in which an AMFT participates in one hour of individual, face-to-face supervision or two hours of group face-to-face supervision, counts as one supervised week. Group supervision sessions shall include no more than eight (8) persons receiving supervision, even if there are two or more supervisors present. Group supervision can be broken into one-hour sessions, as long as both increments (full two hours) are provided in the same week as the experience being claimed.<sup>23</sup>

**Supervision ratio for AMFTs:** AMFTs are required to obtain a minimum of one unit<sup>24</sup> of supervision per week to count work experience toward licensure in a work setting. AMFTs must receive an additional unit of supervision in any week during which more than 10 hours of direct counseling/psychotherapy are performed. An AMFT providing direct counseling/psychotherapy services in more than one work setting must meet the minimum supervision requirements for each setting.

**Qualifications and Responsibilities of Supervisor:** The qualifications differ depending on the license type of the potential supervisor. Listed below are the licensed mental health professionals authorized to supervise AMFTs and some of the general qualifications needed to provide supervision to an AMFT.

<sup>22</sup> Refer to Contra Costa County Scope of Practice Grid

<sup>23</sup> Source: Board of Behavioral Sciences *Important Answers to Frequently Asked Questions for Marriage & Family Therapist Trainees and Interns*

<sup>24</sup> One unit of supervision is equivalent to one hour of individual supervision; one unit of supervision is equivalent to two hours of group supervision.

*Licensed Marriage and Family Therapist (LMFT) – LMFTs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

*Licensed Clinical Social Worker (LCSW) – LCSWs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

*Licensed Professional Clinical Counselor (LPCC)-LPCCs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.
- An LPCC who supervises an MFT Trainee or an AMFT must provide the supervisee, prior to the commencement of supervision, with written confirmation from the Board verifying that they are qualified to assess and treat couples and families,

*Licensed Psychologist (licensed through the Board of Psychology) – Psychologists must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

*Licensed Physicians certified in psychiatry by the American Board of Psychiatry and Neurology – Psychiatrists must:*

- possess a current and valid license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

**Approved Activities:** AMFTs can conduct comprehensive assessments and provide a diagnosis. They can claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), Crisis Intervention (15/70), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice.<sup>25</sup> AMFTs may count a maximum of 40 hours of experience in any seven consecutive day period.<sup>26</sup>

### ASSOCIATE SOCIAL WORKER (ASW)

An Associate Social Worker (ASW) must possess a Master's in Social Work from an accredited graduate school program that prepares the student for licensure as a social worker. ASWs must be registered with the State of California, Board of Behavioral Sciences and possess a NPI number with a valid taxonomy.

**Required Supervision:** The State of California, Board of Behavioral Sciences requires 3200 hours of supervised work experience and 104 weeks of supervision. A total of 1700 hours must be gained under the supervision of a LCSW. Of the 104 supervised weeks required, 52 weeks must be weeks in which the ASW met with an individual supervisor for at least 1 hour. Of the 52 required weeks of individual supervision, 13 weeks must be with a LCSW supervisor.

ASWs are required to obtain one hour of individual supervision or two hours of group supervision during any week in which supervised experience is gained. If the ASW provides more than 10 hours of direct psychotherapy during a given week, he or she will need to obtain one additional hour of individual supervision or two additional hours of group supervision to cover the additional direct psychotherapy hours for that week.

**Qualifications and Responsibilities of Supervisor:** The qualifications differ depending on the license type of the potential supervisor. Listed below are the licensed mental health professionals authorized to supervise Associate Social workers and some of the general qualifications needed to provide supervision to an ASW.

*Licensed Marriage and Family Therapist (LMFT) – LMFTs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and

<sup>25</sup> Refer to Contra Costa County Guidelines for Scope of Practice

<sup>26</sup> 4980.43 BBS Statutes and Regulations



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- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Clinical Social Worker (LCSW) – LCSWs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Professional Clinical Counselor (LPCC)-LPCCs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Psychologist (licensed through the Board of Psychology) – Psychologists must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Physicians certified in psychiatry by the American Board of Psychiatry and Neurology – Psychiatrists must:*

- possess a current and valid license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.



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**Approved Activities:** ASWs can conduct comprehensive assessments and provide a diagnosis. They can claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), Crisis Intervention (15/70), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice.<sup>27</sup>

### ASSOCIATE PROFESSIONAL CLINICAL COUNSELOR (APCC)

An Associate Professional Clinical Counselor (APCC) must possess a Master's in Clinical Counseling or Psychotherapy from an accredited graduate school program that prepares the student for licensure as a professional clinical counselor. APCCs must be registered with the State of California, Board of Behavioral Sciences and possess a NPI number with a valid taxonomy.

**Required Supervision:** The state of California, Board of Behavioral Sciences requires 3,000 hours of post degree supervised professional experience over a period of at least two years (104 weeks) to qualify for LPCC licensure. Of the 104 weeks required, 52 weeks must be weeks in which the applicant received at least one hour of one on one individual face to face supervision, otherwise 2 hours of group supervision counts as one unit of supervision. One unit of supervision is required for each week in each setting in which experience is gained. Additional units of supervision must be received during any week in which more than 10 hours of face to face psychotherapy is provided. The maximum amount of work experience that an intern may count in a given week is 40 hours.

**Qualification and Responsibilities of Supervisor:** The qualifications differ depending on the license type of the potential supervisor. Listed below are the licensed mental health professionals authorized to supervise Associate Professional Clinical Counselors and some of the general qualifications needed to provide supervision to an APCC.

*Licensed Marriage and Family Therapist (LMFT) – LMFTs must:*

- possess a current and valid California license for at least two years out of the last 5 years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

*Licensed Clinical Social Worker (LCSW) – LCSWs must:*

- possess a current and valid California license for at least two years out of the last 5 years prior to the commencement of supervision;

<sup>27</sup> Refer to Contra Costa County Guidelines for Scope of Practice

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- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

**Licensed Professional Clinical Counselors (LPCC)- LPCCs must:**

- possess a current and valid California license for at least two years out of the last 5 years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

**Licensed Psychologist (licensed through the [Board of Psychology](#)) – Psychologists must:**

- possess a current and valid California license for at least two years out of the last 5 years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

**Licensed Physicians certified in [psychiatry](#) by the [American Board of Psychiatry and Neurology](#) – Psychiatrists must:**

- possess a current and valid license for at least two years out of the last 5 years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

**Supervisors of Experience with Couples, Families or Children:** In order to be allowed to assess and treat couples or families once licensed as an LPCC, certain requirements must be met. One of those requirements is 500 hours of supervised experience with couples, families, or children. This experience may be gained while you are an Associate or after you become licensed, and must be supervised by a licensee who, in addition to meeting the qualifications listed in the above section, meets the following:



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- LPPCs: Must have already met the qualifications to assess and treat couples and families and have obtained written confirmation from the Board of meeting the qualifications. LPPC supervisors must provide the supervisee with a copy of their “confirmation of qualifications to assess and treat couples and families” from the Board.
- LCSWs, Licensed Clinical Psychologists, or Licensed Physicians certified in psychiatry by the American Board of Psychiatry and Neurology: Must have sufficient education and experience in treating couples and families to competently practice couples and family therapy in California.
- LMFTs: No additional requirements.

**Approved Activities:** APCCs can conduct comprehensive assessments and provide treatment and diagnosis. They can claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice. An APCC is not allowed to assess or treat couples or families unless they have completed six (6) semester units or nine (9) quarter units specifically focused on the theory and application of marriage and family therapy **OR** a named specialization or emphasis area on the qualifying degree in marriage and family therapy; marital and family therapy; marriage, family, and child counseling; or couple and family therapy **AND** is receiving the required supervision that is listed above.

### TRAINEES

#### PSYCHOLOGIST TRAINEE

A psychologist trainee is a pre-degree practicum student participating in a field placement while enrolled in an accredited Doctoral (PhD or PsyD) program that prepares the student for licensure as a Psychologist.

In order to gain experience as a Psychologist Trainee, the student must have a field placement agreement with their graduate school. There must be an individual contract signed by the student, individual supervisor and/or training coordinator and school field placement liaison that specifies the duration of the contract. There is no minimum experience level required and the hours worked cannot be counted toward licensure. Students are provided with a minimum of one hour of individual supervision by a licensed psychologist and weekly group supervision.<sup>28</sup>

**Approved Activities:** Psychologist Trainees can conduct comprehensive assessments and provide a diagnosis with co-signature by a licensed mental health provider. They can claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), Crisis Intervention (15/70), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice.<sup>29</sup>

<sup>28</sup> Refer to Wright Institute and California School of Professional Psychology Office of Professional Training description of clinical practice.

<sup>29</sup> Refer to Contra Costa County Guidelines for Scope of Practice



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

### MARRIAGE AND FAMILY THERAPIST (MFT) TRAINEE

A Marriage and Family Therapist (MFT) Trainee is a pre-masters practicum student participating in a field placement while enrolled in an accredited Master's degree program in marriage and family therapy that prepares the student for licensure as a marriage and family therapist.

In order to gain experience as a MFT Trainee, the practicum student must have completed a minimum of 12 semester or 18 quarter units of coursework in a qualifying MFT degree program. In addition, there must be 1) a school agreement with the school and 2) a field placement agreement which is an individual contract signed by the student, individual supervisor and/or training coordinator and school field placement liaison that specifies the duration of the contract. There is no minimum experience required and no BBS registration is required; however, MFT Trainees must be enrolled in a practicum course in order to provide counseling services. The only condition under which a MFT trainee may provide counseling services while *not* enrolled in a practicum course is if the period of time is less than 90 calendar days AND the 90-day or shorter period is immediately preceded by enrollment in practicum and immediately followed by enrollment in practicum or completion of the degree program.<sup>29</sup> MFT Trainees must possess a NPI number with a valid taxonomy.

**Required Supervision:** The State of California, Board of Behavioral Sciences requires 3000 hours of supervised professional experience and 104 weeks of supervision to qualify for MFT licensure. Of the 104 weeks required, 52 weeks must be weeks in which the MFT Trainee received at least one hour of one-on-one, individual face-to-face supervision. Any week in which an MFT Trainee participates in one hour of individual, face-to-face supervision or two hours of group face-to-face supervision, counts as one supervised week. Group supervision sessions shall include no more than eight (8) persons receiving supervision, even if there are two or more supervisors present. Group supervision can be broken into one-hour sessions, as long as both increments (full two hours) are provided in the same week as the experience being claimed.<sup>30</sup>

**Supervision ratio:** MFT Trainees must receive a minimum of one unit of supervision per week to count work experience in a work setting. Trainees are required to obtain one unit of supervision for every five hours of direct counseling experience earned in each setting.

**Qualifications and Responsibilities of Supervisor:** The qualifications differ depending on the license type of the potential supervisor. Listed below are the licensed mental health professionals authorized to supervise Associate Marriage & Family Therapists and some of the general qualifications needed to provide supervision to an MFT Trainee.

<sup>30</sup> Source: Board of Behavioral Sciences Important Answers to Frequently Asked Questions for Marriage & Family Therapist Trainees and Interns)



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### *Licensed Marriage and Family Therapist (LMFT) – LMFTs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, **NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;** and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Clinical Social Worker (LCSW) – LCSWs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, **NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;** and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Psychologist (licensed through the [Board of Psychology](#)) – Psychologists must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Physicians certified in psychiatry by the [American Board of Psychiatry and Neurology](#) – Psychiatrists must:*

- possess a current and valid license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

**Approved Activities:** MFT Trainees can conduct comprehensive assessments and provide a diagnosis with co-signature by a licensed mental health professional. They can claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), Crisis Intervention (15/70), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice.<sup>31</sup> MFT Trainees may count a maximum of 40 hours of experience in any seven consecutive day period.<sup>32</sup>

<sup>31</sup> Refer to Contra Costa County Guidelines for Scope of Practice

<sup>32</sup> 4980.43 BBS Statutes and Regulations



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

### **SOCIAL WORK TRAINEES**

A Social Work trainee is a pre-master's student participating in a field placement while enrolled in an accredited master's level social work program that prepares the student for licensure as a social worker.<sup>33</sup>

Community organizations providing field experience for Social Work trainees must have a school agreement with the school. In addition, a field placement agreement which is an individual contract signed by the student, individual supervisor and/or training coordinator, and school field placement liaison that specifies the duration of the contract is required. There is no minimum experience required and no BBS registration is required. Social Work trainees must possess a NPI number with a valid taxonomy.

**Required Supervision:** <sup>34</sup> Non-licensed trainees must be under the immediate supervision of a licensed mental health professional (LMHP) who shall be responsible for ensuring that the extent, kind, and quality of services performed are consistent with his or her training and experience and be responsible for the trainee's compliance with applicable state law.<sup>35</sup>

Social Work trainees must receive a minimum of one hour of individual supervision or two hours of group supervision in any week that direct services are provided. Trainees are required to obtain one hour of individual supervision or two hours of group supervision for every five hours of direct counseling experience earned in each setting.<sup>36</sup>

**Qualifications and Responsibilities of Supervisor:** The qualifications differ depending on the license type of the potential supervisor. Listed below are the licensed mental health professionals authorized to supervise Social Work trainees and some of the general qualifications needed to provide supervision to a Social Work trainee.

<sup>33</sup> Accredited master's level social work programs prepare the student for licensure; however, hours of experience earned pre-degree do not accrue toward licensure as a LCSW.

<sup>34</sup> The Board of Behavioral Sciences mandates licensing and supervision requirements for LCSW's and ASW's; however, hours of professional experience earned by students enrolled in an accredited MSW program are not accrued toward licensure and supervision requirements are not specified by the Board. Generally, hours of experience and supervision requirements for pre-master's social work students are school-specific and based upon Council on Social Work Education (CSWE) standards. CSWE requires that pre-master's students perform a minimum of 900 hours of field experience under the supervision of a person who holds a master's degree in social work from a CSWE-accredited program and have 2 years post master's social work practice experience; clinical licensure of the supervisor is preferred but not required. It should be noted that the CSWE's primary concern is that the master's degree program provides students with educational field opportunities to demonstrate core social work competencies which include but are not limited to clinical work.

<sup>35</sup> Department of Health Care Services, MHDUDS Information Notice 17-040, August 24, 2017

<sup>36</sup> Supervision requirements are based on BBS supervision requirements for comparable master's level students enrolled in an accredited Marriage and Family Therapy program.



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

### *Licensed Clinical Social Worker (LCSW) – LCSWs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Marriage and Family Therapist (LMFT) – LMFTs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, *NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Psychologist (licensed through the [Board of Psychology](#)) – Psychologists must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

### *Licensed Physicians certified in psychiatry by the [American Board of Psychiatry and Neurology](#) – Psychiatrists must:*

- possess a current and valid license for at least two years prior to the commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

**Approved Activities:** Social work trainees can conduct comprehensive assessments and provide a diagnosis with co-signature by a licensed mental health professional. They can also claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), Crisis Intervention (15/70), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice.<sup>37</sup>

<sup>37</sup> Refer to Contra Costa County Guidelines for Scope of Practice



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

### PROFESSIONAL CLINICAL COUNSELOR TRAINEE

A Professional Clinical Counselor trainee is a pre-master's student participating in a field placement while enrolled in an accredited master's level professional clinical counseling program that prepares the student for licensure as a professional clinical counselor.<sup>38</sup>

Community organizations providing field experience for Professional Clinical Counselor trainees must have a school agreement with the graduate school. In addition, a field placement agreement which is an individual contract signed by the student, individual supervisor and/or training coordinator, and school field placement liaison that specifies the duration of the contract is required. There is no minimum experience required and no BBS registration is required. Professional Clinical Counselor trainees must possess a NPI number with a valid taxonomy.

**Required Supervision:** Non-licensed trainees must be under the immediate supervision of a licensed mental health professional (LMHP) who shall be responsible for ensuring that the extent, kind, and quality of services performed are consistent with his or her training and experience and be responsible for the trainee's compliance with applicable state law.<sup>39</sup>

Professional Clinical Counseling trainees must receive a minimum of one hour of individual supervision or two hours of group supervision in any week that direct services are provided. Trainees are required to obtain one hour of individual supervision or two hours of group supervision for every five hours of direct counseling experience earned in each setting.<sup>40</sup>

**Qualifications and Responsibilities of Supervisor:** The qualifications differ depending on the license type of the potential supervisor. Listed below are the licensed mental health professionals authorized to supervise Professional Clinical Counselor trainees and some of the general qualifications needed to provide supervision to a Professional Clinical Counselor trainee.

*Licensed Clinical Social Worker (LCSW) – LCSWs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising. *NOTE: if the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision;* and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

<sup>38</sup> Accredited master's level social work programs prepare the student for licensure; however, hours of experience earned pre-degree do not accrue toward licensure as a LCSW.

<sup>39</sup> Department of Health Care Services, MHDUDS Information Notice 17-040, August 24, 2017

<sup>40</sup> Supervision requirements are based on BBS supervision requirements for comparable master's level students enrolled in an accredited Marriage and Family Therapy program.

*Licensed Marriage and Family Therapist (LMFT) – LMFTs must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: if the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

*Licensed Professional Clinical Counselors (LPCC)- LPCCs must:*

- possess a current and valid California license for at least two years out of the last 5 years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: if the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.
- if the PCC Trainee is providing couple and/or families therapy, the LPCC supervisor must have already met the qualifications to assess and treat couples and families and have obtained written confirmation from the Board of meeting the qualifications. LPCC supervisors must provide the supervisee with a copy of their "confirmation of qualifications to assess and treat couples and families" from the Board.

*Licensed Psychologist (licensed through the Board of Psychology) – Psychologists must:*

- possess a current and valid California license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: if the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

*Licensed Physicians certified in psychiatry by the American Board of Psychiatry and Neurology – Psychiatrists must:*

- possess a current and valid license for at least two years prior to the commencement of supervision;
- complete a 6-hour supervision training within the two-year period immediately preceding supervision and every renewal period when supervising, NOTE: if the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision; and
- have practiced psychotherapy or directly supervised trainees, interns, or associate professional clinical counselors who perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the commencement of supervision.

**Approved Activities:** Professional Clinical Counselor trainees can conduct comprehensive assessments and provide a diagnosis with co-signature by a licensed mental health professional. They can also claim for all Mental Health Services (15/30), Case Management/Brokerage (15/01), Crisis



## Contra Costa Mental Health Plan SCOPE OF PRACTICE DEFINITIONS

Intervention (15/70), and Therapeutic Behavioral Services (TBS) (15/58) within their scope of practice.<sup>41</sup> A Professional Clinical Counselor trainee is permitted to treat couples or families as part of their supervised practicum experience, but may not count that experience toward the 500 hours required to assess and treat couples or families.

### MENTAL HEALTH REHABILITATION SPECIALIST (MHRSS)

A Mental Health Rehabilitation Specialist (MHRSS) is an individual who meets one of the following requirements:

- An Associate's degree in the field of psychology or closely related field and six years of experience in a mental health setting as a specialist. Two years of the experience must have been accrued after obtaining the Associate's degree. Two years of post-associate arts clinical experience requires a sequence where first, an Associate degree is obtained and second, clinical experience is obtained.<sup>42</sup>
- A Baccalaureate degree in the field of psychology or closely related field and four years of experience in a mental health setting as a specialist.
- A Master's degree in the field of psychology or closely related field and two years of experience<sup>43</sup> in a mental health setting as a specialist<sup>44</sup>.

MHRSSs must possess a NPI number with a valid taxonomy.

**Required Supervision:** MHRSSs must receive ongoing oversight through a minimum of 1 hour of weekly individual or group supervision.

**Approved Activities:** MHRSSs can claim for Mental Health Services (15/30) except Assessment, Individual Psychotherapy and Group Psychotherapy.<sup>45</sup> They can also claim for Case Management/Brokerage (15/01) and Crisis Intervention (15/70). MHRSSs who have completed the CCMHP Therapeutic Behavioral Services (TBS) training program may provide TBS.<sup>46</sup>

<sup>41</sup> Refer to Contra Costa County Guidelines for Scope of Practice

<sup>42</sup> CCR, Title 9, §630

<sup>43</sup> "Experience" is defined as verifiable experience, either paid/unpaid, full-time or full-time equivalence, including practicum experiences gained in professional training programs;

<sup>44</sup> "Specialist" is defined as a role primarily working with/providing services to clients

<sup>45</sup> Refer to Contra Costa County Scope of Practice Grid

<sup>46</sup> DMH Information Notice 08-38; California State Plan Amendment (SPA) 12-025

**DESIGNATED MENTAL HEALTH WORKER (DMHW)**

Designated Mental Health Worker (DMHW) is staff that does not meet the MHS educational and experience requirements. DMHWs must be at least 18 years of age with a high school diploma or equivalent degree. The MHP has the prerogative and program flexibility to integrate and define other staff that can provide direct or supportive specialty mental health services as determined by the Mental Health Director. DMHWs must possess a NPI number with a valid taxonomy.

**Required Supervision:** DMHWs must receive ongoing oversight through a minimum of 1 hour of weekly individual or group supervision.

**Approved Activities:** All approved activities are per the MHP and all documentation requires a co-signature by a licensed mental health professional. DMHWs can claim for Mental Health Services (15/30) except Assessment, Individual Psychotherapy, and Group Psychotherapy with evidence of on-going supervision, within the scope of the staff member's ability.<sup>47</sup> They can also claim for Case Management/Brokerage (15/01) and Crisis Intervention (15/70). DMHWs who have completed the CCMHP Therapeutic Behavioral Services (TBS) training program may provide TBS under the direction of a licensed mental health professional.<sup>48</sup>

**THERAPEUTIC FOSTER CARE (TFC) PARENT**

A Therapeutic Foster Care (TFC) parent is an individual who meets all of the following requirements:

- Must be at least 21 years of age with a high school diploma or equivalent degree;
- Must be an approved resource parent; and
- Must complete forty (40) hours of initial TFC parent training and twenty-four (24) hours of annual/ongoing training.

TFC Parents must possess a NPI number with a valid taxonomy.

**Required Supervision:** TFC parents must receive ongoing oversight through a minimum of 1 hour of weekly face-to-face supervision in the TFC parent's home.

**Approved Activities:** All approved activities are per the MHP and all documentation requires a co-signature by a licensed mental health professional. TFC parents can only claim for Therapeutic Foster Care services –billing code 380.

<sup>47</sup> Refer to Contra Costa County Scope of Practice Grid

<sup>48</sup> DMH Information Notice 08-38; California State Plan Amendment (SPA) 12-025

## **APPENDIX E. GUIDELINES FOR SCOPE OF PRACTICE**

This document is also available at  
<https://cchealth.org/mentalhealth/provider/>



## **APPENDIX F. ABBREVIATIONS**

<b>Number</b>	
1:1	One to one
1 <sup>o</sup>	Primary
2 <sup>o</sup>	Due to; Secondary to
24/7	24 hours a day/7 days a week
5150	WIC 72-hour hold for mental health evaluation
5250	WIC 14-day hold
<b>A</b>	
Ā	before
@	At
A/H	Auditory Hallucinations
A/O	Alert & Oriented
AA	Alcoholics Anonymous
ACBH	Antioch Children’s Behavioral Health
ADD	Attention Deficit Disorder
ADHD	Attention Hyperactive Disorder
ADL	Activities of Daily Living
ADOL	Adolescent
AFS	Alternative Family Services
AM	Morning
AMA	Against Medical Advice
AOD	Alcohol and Other Drugs
AOT	Assisted Outpatient Treatment
APPT	Appointment
APPROX	Approximately
APS	Adult Protective Services
ASAP	As soon as possible
ASSMT	Assessment
ASW	Associate of Social Work
ATOD	Alcohol, Tobacco, and other drugs
ATTN	Attention
AVG	Average
AWOL	Absence With Out Leave
<b>B</b>	
BA	Bachelor of Arts
BACR	Bay Area Community Resource
BARM	Bay Area Rescue Mission
B&C	Board & Care
BDI	Beck Depression Inventory
BF	Boyfriend

BIB	Brought in by
Bid	Twice a day
Bio	Biological
BPD	Borderline Personality Disorder
Bro	Brother
b/t	Between
Bx	Behavior
<b>C</b>	
C	with
C/O	Complains of
CALOCUS	Child and Adolescent Level of Care Utilization System
CANS	Children and Adolescent Needs and Strengths Assessment
CBO	Community Based Organization
CBT	Cognitive Behavioral Therapy
CCAMH	Central County Adult Mental Health
CCBHS	Contra Costa Behavioral Health Services
CCBHS-MHP	Contra Costa Mental Health Plan
CCC	Contra Costa County
CCCMH	Central County Children's Mental Health
CCRMC	Contra Costa Regional Medical Center
CD	Chemical Dependency
CFS	Child and Family Services
CFT	Child and Family Team
CHAA	Community Health for Asian Americans
CLT	Client
CM	Case Management
COFY	Community Options for Family and Youth
COLL	Collateral
CON REP	Conditional Release Program
cont.	Continuously
CPS	Child Protective Services
Crisis Res.	Crisis Residential
CSW	Community Support Worker
CTI	Child Therapy Institute
CWAT	County Wide Assessment Team
<b>D</b>	
D	Divorced
DAU	Daughter
Day Tx	Day Treatment
DBT	Dialectical Behavior Treatment

D/C	Discharge
DC	Discontinue
DHCS	California Department of Health Care Services
DD	Developmentally Disabled
DMH	Department of Mental Health
DMV	Department of Motor Vehicles
DOB	Date of Birth
DOS	Date of Service
Dr	Doctor
DSM	Diagnostic & Statistical Manual
DTN	Detention
DTO	Danger to Others
DTS	Danger to Self
DUI	Driving Under the Influence
DV	Domestic Violence
DVR	Diablo Valley Ranch
Dx	Diagnosis
Dz	Disease
<b>E</b>	
EBP	Evidence Based Practice
ECAMH	East County Adult Mental Health
EFC	Emergency Foster Care
EMDR	Eye Movement Desensitization Reintegration
EPSDT	Early & Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ERMHS	Educationally Related Mental Health Service
EtOH	Alcohol
EVAL	Evaluation
<b>F</b>	
F/U	Follow Up
Fa	Father
FAS	Fetal Alcohol Syndrome
FOI	Flight of Ideas
FFT	Functional Family Therapy
FSP	Full-Service Partnership
<b>G</b>	
GAD	General Anxiety Disorder
GAF	Global Assessment of Functioning
GD	Gravely Disabled
Gfa	Grandfather

G/F	Girlfriend
GLBTQQ	Gay, Lesbian, Bisexual, Transgendered, Queer, Questioning
GM	Grandmother
Group Tx	Group Therapy
<b>H</b>	
H	Heroin
H&P	History and Physical
H&R	Hospital and Residential
Hal	Hallucinations
H/I	Homicidal Ideation
HIPAA	Health Insurance Portability & Accountability Act
Hosp	Hospitalized
HS	High School
HUD	Housing and Urban Development
HUSB	Husband
HV	Home Visit
Hx	History
<b>I</b>	
ICC	Intensive Care Coordination
ICCCo	Intensive Care Coordinator
ICU	Intensive Care Unit
IEP	Individual Education Plan
IHBS	Intensive Home-Based Service
IMD	Institute of Mental Disease
IN-PT	Inpatient
IHSS	In Home Support Services
<b>J</b>	
JACS	Juvenile Assessment and Consultation Services (Juvenile Hall)
JMBH	John Muir Behavioral Health
JUV	Juvenile
<b>K</b>	
KTA	Katie A.
<b>L</b>	
LCSW	Licensed Clinical Social Worker
LD	Learning Disability
LOCUS	Level of Care Utilization System
LMFT	Licensed Marriage and Family Therapist
LPT	Licensed Psychiatric Technician
LPS	Lanterman-Petris-Short

LVN	Licensed Vocational Nurse
<b>M</b>	
M	Male
Ma	Married
MD	Medical Doctor/Physician
MDD	Major Depressive Disorder
Med Hx	Medical History
Meds	Medications
MFT	Marriage & Family Therapist
AMFT	Marriage & Family Therapist Intern
MH	Mental Health
MHCS	Mental Health Clinical Specialist
MHP	Mental Health Plan
MHRC	Mental Health Rehabilitation Center
MHRS	Mental Health Rehab Specialist
MHSA	Mental Health Services Act or Prop 63
MHTC	Mental Health Treatment Center
MHW	Mental Health Worker
MI	Motivational Interviewing
MJ	Marijuana
MMPI	Minnesota Multiphasic Personality Inventory
Mo	Mother
MRN	Medical Record Number
MRT	Mobile Response Team
MSE	Mental Status Exam
MSG	Message
MST	Multisystemic Therapy
MSW	Masters of Social Worker (not registered with the board)
Mt. D	Mount Diablo Unified School District
MTG	Meeting
MWC	Miller Wellness Center
<b>N</b>	
N/A	Not Applicable
NA	Narcotics Anonymous
NAMI	National Alliance for the Mentally Ill
NARC	Narcotic
N/C	No Complaints
NEG	Negative
NKA	No Known Allergies
NKDA	No Known Drug Allergies

NOA	Notice of Action
NOC	Night
NOS	Not Otherwise Specified
NPI	National Provider Identifier
NS	No Show
<b>O</b>	
OCC	Occasionally
OCD	Obsessive Compulsive Disorder
OCE	Office of Consumer Empowerment
Od	Overdose
OD	Officer of the Day
OFF	Oppositional Defiant Disorder
OT	Occupational Therapy
Outpt	Outpatient
<b>P</b>	
p.c.	After meals
Prn	As needed
P/C	Phone Call
PCP	Primary Care Physician
PD	Plan Development
PDD	Pervasive Developmental Disorder
PDR	Physician's Desk Reference
PEI	Prevention and Early Intervention
PES	Psychiatric Emergency Services
PhD	Doctor of Philosophy
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHN	Public Health Nurse
PHQ	Patient Health Questionnaire
Pm	Afternoon
PN	Psychiatric Nurse
PO	Probation Officer
Po	By mouth
PREG	Pregnant
PROB	Problem
PROG	Progress
PST	Problem Solving Therapy
PsyD	Doctor of Psychology
Pt	Patient
P/T	Part Time

PTSD	Post-Traumatic Stress Disorder
P/U	Pick Up
<b>Q</b>	
Q	Every
q2h	Every 2 hours
QA	Quality Assurance
Qam	Every morning
Qh	Every hour
Qhs	At night
Qid	Four times a day
<b>R</b>	
R/O	Rule Out
R&B	Room and Board
REC'D	Received
Re	Regarding
REC	Recommend
REG	Regular
REHAB	Rehabilitation
REL	Relationship
ROI	Release of Information
REV	Review
RI	Recovery Innovations
RN	Registered Nurse
Rx	Prescription
Rxn	Reaction
<b>S</b>	
S	Single
SA	Substance Abuse
s/b	Should be
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIZ	Schizophrenia
SED	Severely Emotionally Disturbed
S/S	Signs and Symptoms
S/A	Suicide Attempt
S/I	Suicide Ideation
SIB	Self-Injurious Behavior
Sib	Sibling
Sis	Sister
SOC	System of Care
S/O	Significant Other

SPIRIT	Service Provider Individualized Recovery Intensive Training
SSRI	Selective Serotonin Reuptake Inhibitor
START	Short Term Assessment of Resources and Treatment
SW	Social Worker
Sx	Symptoms
<b>T</b>	
TAY	Transitional Age Youth
T/C	Telephone Call
TV	Television
TBI	Traumatic Brain Injury
TBS	Therapeutic Behavioral Service
TCM	Targeted Case Management
Tid	Three times a day
TAR	Treatment Authorization Request
TRO	Temporary Restraining Order
Tox	Toxicology
TT	Transition Team
Tx	Treatment
<b>U</b>	
UNK	Unknown
UON	Unusual Occurrence Notice
UR	Utilization Review
<b>V</b>	
VA	Veteran's Administration
V/H	Visual Hallucinations
VM	Voicemail
<b>W</b>	
W	Widowed
W&I	California Welfare and Institutions Code
w/o	Without
w/	With
WCAMH	West County Adult Mental Health
WCCMH	West County Children's Mental Health
WCCUSD	West Contra Costa County Unified School District
W/D	Withdrawal
WNL	Within Normal Limits
WRAP	Wellness Recovery Action Plan
Wt.	Weight
<b>X</b>	

X	Multiplied by/times
<b>Y</b>	
Y/O	Years Old
YSB	Youth Service Bureau
YR	Year
<b>Symbols</b>	
Ψ	Psychiatric/ Psychiatrist/Psychology
≤	Less Than or Equal To
≥	Greater Than or Equal To
↑	Increase
↓	Decrease
♀	Female
♂	Male
#	Number
%	Percent
+	Plus, positive, yes
-	Minus, negative, no
”	Inches
‘	Feet
?	Unknown
&	And
@	At
=	Equal

## **APPENDIX G. FORMS**

A copy of CCBHS-MHP clinical forms is available here:

<http://cchealth.org/mentalhealth/clinical-documentation/>