

Outpatient Specialty  
Mental Health Services

---

**Certified Peer  
Support Specialists**

2023

# Clinical Documentation Guide

**CaIMHSA**

California Mental Health Services Authority

Revised 9/18/2023

Introduction to this Guide.....	3
Certified Medi-Cal Peer Support Specialist Role .....	3
Peer Support Services .....	3
Health Care Systems.....	3
Medi-Cal Programs.....	5
Mental Health Plans.....	6
Drug Medi-Cal and Drug Medi-Cal Organized Delivery System.....	6
Managed Care Plans .....	6
Definition of Medical Necessity .....	7
Access to the Specialty Mental Health Services (SMHS)System.....	7
Screening .....	8
Standardized Screening Tools .....	8
Screening Tool Administration .....	9
Assessment .....	9
Standardized Assessment Requirements (Including Timeliness).....	10
Assessment Domain Requirements.....	11
Diagnosis.....	14
The Problem List .....	16
Problem List Requirements .....	16
Treatment Plan Requirements.....	16
Example of a Problem List for a Person in Care:.....	18
Care Coordination.....	19
Treatment .....	20
Treatment Services.....	20
Treatment Team.....	23
Co-Occurring Treatment .....	23
Progress Notes.....	23
Required Progress Note Service Information .....	24
Progress Note Writing Tips.....	25
Care Transitions .....	26
Transition of Care Tool.....	26
Discharge Planning.....	27
Claiming for Services.....	27
Conclusion .....	28
Appendices.....	29
Appendix I: Acronym List.....	29
Appendix II: Medi-Cal Plans by Type.....	30
Appendix III: Scope of Practice Matrix.....	32
Appendix IV: DHCS Priority SDOH Codes .....	33
Appendix V: Sample Progress Note Narratives.....	35
Appendix VI: Commonly Used Service Codes .....	37
Appendix VII: Documentation Guide Change Log .....	38

## Introduction to this Guide

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

The intent of this documentation guide is to support the implementation of DHCS guidance concerning care coordination efforts between the Mental Health Plan (MHP) and Managed Care Plan (MCP) services delivery systems (e.g., screening, transition of care and service referrals), and the essential documentation requirements for specialty mental health services clinical documentation and claims reimbursement. Specifically, this guide provides guidance to Medi-Cal Peer Support Specialists in an MHP setting that claims outpatient Medi-Cal services. This documentation guide will cover many relevant topics and concepts that support your work with children, youth, adults, and families. The audience for this guide includes both those licensed, registered and waived practitioners who are new to documentation of services, as well as those practitioners who have experience with pre-CalAIM documentation standards. Individuals receiving treatment will be referred to as “people” or “people in care”, rather than “clients”, “patients”, or “beneficiaries”.

### Certified Medi-Cal Peer Support Specialist Role

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

### Peer Support Services

Peer support services are culturally appropriate services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports and identification of strengths. Medi-Cal Peer Support Specialist services include, but are not limited to, prevention services, support, coaching, facilitation or education that is individualized. Peer support services may be provided with the person in care or significant support persons, with or without the person in care present, and aim to prevent relapse, empower persons in care through strengths-based coaching, support linkages to community resources and educate the person in care and their significant supports about their mental health condition(s) and the process of recovery.

Services that include the person’s significant support persons remain focused on how to best support the person in care to reach their treatment goals. Case management services are also provided, including planning, finding and accessing community resources and services, coaching, mentoring, facilitation and/or psychoeducation. Services may be provided individually or in a group.

### Health Care Systems

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

We know from research that care is not always accessible, available, or responsive in an equitable way. Research further shows that access to and engagement in quality health care is affected by a number of factors, including race, ethnicity, socioeconomic status, and other social drivers. Social drivers of health (SDOH) play a huge part in people’s health and wellness. SDOH are the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are grouped into five domains (CDC)<sup>1</sup>.

<sup>1</sup> Social Determinants of Health | CDC; Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [May 2022], <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

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

SDOH contribute to health disparities and inequities simply by limiting access to fundamental resources aimed at supporting health and wellness. For example, if behavioral health services are offered in one part of town that is difficult to get to, those who live far away or have transportation challenges may not receive the services they need in a timely fashion. Or perhaps the same clinic does not employ direct service staff who speak the language or understand the culture of the person seeking care. This again impacts the ability of a person in care to access care that meets their individualized needs. Lastly, we have witnessed the harsh realities of inequities revealed by the COVID-19 pandemic, with stark differences in outcomes including mortality seen along racial/ethnic lines, socioeconomic status, and educational attainment<sup>2</sup>.

Although there are efforts aimed at addressing health disparities, there is still a lot of work to be done. As practitioners, we have a responsibility to look within our organizations and advocate for changes that help reduce or eliminate disparities within health systems. Through this diligent attention, systems can transform to best meet the needs of the people they are intended to serve. One of the monumental ways that CalAIM supports our systems in addressing health disparities is in the acknowledgment of the impact of trauma on health and wellness. We can streamline access to treatment services, especially for youth, when a substance SUD is suspected but not yet diagnosed, or due to trauma. Details on this access criteria will be addressed later in this guide, as it cues practitioners that treatment services can be initiated while assessment is occurring concurrently.

---

<sup>2</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786466>



## Medi-Cal Programs

In California, the Department of Health Care Services (DHCS) is the state agency responsible for the administration of the state's Medicaid program. In California, we refer to Medicaid as "Medi-Cal." The Medi-Cal program is a mix of federal and state regulations serving approximately 14 million people, or 1/3 of all Californians. Medi-Cal covers 40% of children and youth and half of individuals with disabilities in California.<sup>3</sup>

Medi-Cal behavioral health services are "carved out" meaning that they are delivered through separate managed care delivery systems, each of which is responsible for delivering different sets of services to individuals depending on their care needs.

To keep it simple, we will look at these three plans: Mental Health Plans (MHP) operated by county behavioral health departments, Drug Medi-Cal Plans (DMC or DMC-ODS) administered respectively by the state or the county behavioral health departments, and Managed Care Plans (MCP), which are the physical healthcare plans. The MCPs, which are either publicly run or commercial entities, administer the Non-Specialty Mental Health Services (NSMHS) benefit, while the counties administer the Specialty Mental Health Services benefit.

<sup>3</sup> <https://www.chcf.org/publication/2021-edition-medi-cal-facts-figures/>

County				State
MCP	MCP	MHP	DMC-ODS/DMC	Dental
Physical Healthcare	Mild to Moderate Mental Health	Serious Mental Illness/Serious Emotional Disturbance	Substance Use Treatment Services	Dental

### Mental Health Plans

Specialty Mental Health Services (SMHS) are managed locally by county Mental Health Plans (MHPs). Fifty-six county MHPs are contracted with DHCS to administer the Medi-Cal SMHS benefit. In addition to managing the benefit, MHPs directly deliver and/or contract with Community-Based Organizations (CBOs) or group/individual providers to deliver an array of services designed to meet the needs of individuals with Medi-Cal who have significant and/or complex care needs. This array includes intensive services and programs, including therapy, community-based services, wraparound, and intensive case management programs. The term “case management” is used at different points since this service type is defined in federal regulation for SMHS. However, it is important to remember that each person in care is not a “case” to be managed, but rather a human being with care needs. (See [Appendix II](#) for a list of covered services.)

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

### Drug Medi-Cal and Drug Medi-Cal Organized Delivery System

California has two main types of Drug Medi-Cal Plans: A State Drug Medi-Cal Plan (DMC) and a Drug Medi-Cal Organized Delivery System (DMC-ODS). Both Plans are administered by the Counties, however, they each have a unique array of covered benefits and follow somewhat different rule sets. Further details regarding covered services for each Plan are provided in [Appendix II](#). Drug Medi-Cal State Plan services include Narcotic Treatment Program (NTP), Outpatient Drug Free (ODF) treatment services, Intensive Outpatient (IOP), Perinatal Residential and Naltrexone Treatment. To receive Drug Medi-Cal State Plan services, an individual must have Medi-Cal, and meet criteria suggesting they would benefit from substance use treatment services.

Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS.<sup>4</sup> Counties participating in the DMC-ODS program provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Drug Medi-Cal (DMC) program. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria<sup>®</sup> for SUD treatment services, increased local control over and accountability for services, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care. To receive services through the DMC-ODS, a person must be enrolled in Medi-Cal, reside in a participating county, and meet the criteria for substance use treatment services.

### Managed Care Plans

Managed Care Plans (MCPs) are responsible for the majority of the medical (physical health care) benefits and NSMHS for individuals. The MCPs provide mental health services to those with less significant or complex care needs, and therefore may provide a lower frequency/intensity of mental health services. In terms of mental health treatment, MCPs provide medication evaluation and treatment, group and individual therapy, psychological testing, as well as prescription

<sup>4</sup> BHIN 23-001 (ca.gov)

medications, including psychotropic medications (See [Appendix II](#) for a list of covered services). MCPs may operate within one county, or across an entire region, and deliver services across a managed network of providers (hospitals, Federally Qualified Health Centers [FQHCs] and other organizations). Some counties may have multiple MCPs in one county and individuals with Medi-Cal can choose which MCP they would like to belong to. In other counties, there may be a single MCP providing coverage to all individuals with Medi-Cal. To find out which MCPs provide coverage in your county, check the DHCS website, linked [here](#) for convenience.

All three plan types discussed here - MHPs, DMC State Plan/DMC-ODS and MCPs administer and/or deliver an array of services to Medi-Cal members. Given the complexity of the systems, it can be difficult for individuals seeking services to understand which plan would best treat their behavioral health care needs and where/how to access SMHS, DMC or NSMHS. To make navigating this complex system easier for people seeking services, CalAIM has provided new guidelines for accessing medically necessary care.

### Definition of Medical Necessity

All Medi-Cal services provided to persons in care need to meet the standard of being “medically necessary”. The definitions of medical necessity are somewhat different, based upon the age of the person in care. For individuals aged 21 and older, a mental health service is considered “medically necessary” when it is “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.” For individuals under age 21, the definition of whether a mental health service is considered “medically necessary” falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) Services language under a specific section of Title 42.<sup>5</sup> This section requires provision of all Medicaid (Medi-Cal) coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not the service is covered under the State Plan. These services need not be curative or restorative, and can be delivered to sustain, support, improve or make more tolerable a mental health condition.

## Access to the Specialty Mental Health Services (SMHS) System

In a previous section, we described covered services under the MHP Medi-Cal benefit. Next, we will discuss the criteria for accessing specialty mental health services (SMHS) through the MHP. While we will be discussing the technical criteria, we encourage practitioners to continue to review the information from the perspective of the person in care with empathy and centering the person’s voice regarding their health care decisions.

The criteria we will discuss in this section are for two distinct age cohorts: individuals aged 21 years and older and individuals under 21 years of age. Each of these cohorts have distinct criteria due to their developmental needs.<sup>6</sup> It is important to point out early that a person may begin to receive clinically appropriate services, so long as the person would benefit from the SMHS services, even before a diagnosis has been fully articulated and a final determination has been made.

### Overview of criteria for adults aged 21 year and older

- The person has significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in an important area of life functioning.
- AND the significant impairments listed above are due to a mental health disorder diagnosed from the current version of the Diagnostic Statistical Manual, Fifth Edition (DSM-5), or a suspected disorder that has not yet been diagnosed.

<sup>5</sup> Section 1396d(r) of Title 42 of the United States Code

<sup>6</sup> DHCS Behavioral Health Information Notice (BHIN) No: 21-073

### Overview of criteria for persons under 21 years of age

- The person is experiencing homelessness, and/or is interacting with the child welfare or criminal justice system.
- OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder.<sup>7</sup>
- OR, the person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment.
- AND the significant impairments listed above are due to a mental health disorder diagnosed from the current version of the Diagnostic Statistical Manual, Fifth Edition (DSM-5), or a suspected disorder that has not yet been diagnosed.

Screening

Assessment

Problem Lists

Care Coordination

Treatment

Care  
Transitions

Discharge

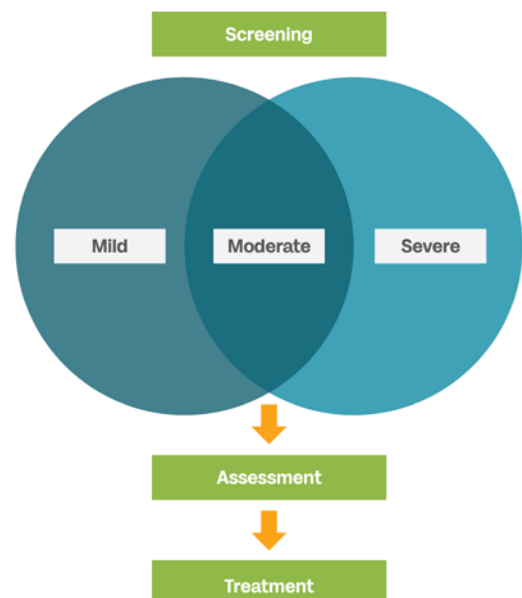
## Screening

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

### Standardized Screening Tools

The Department of Health Care Services (DHCS) has created standardized screening tools – one for adults aged 21 and over, and one for youth under age 21. The purpose of these screening tools is to determine the appropriate Medi-Cal mental health delivery system to refer an individual to when they are not already receiving mental health services. Medi-Cal Managed Care Plans (MCPs) and county Mental Health Plan (MHPs) are both required to use the tools when contacted by an individual who is seeking treatment, or when a person is reaching out on behalf of someone under age 21 to obtain mental health services.

If a person seeking care contacts a community-based or county contracted provider directly, the provider may begin the assessment process and provide services during the assessment period without using the screening tools (consistent with the No Wrong Door for Mental Health Services Policy.) If a provider (e.g., a primary care physician or school nurse) refers an individual to an MCP for non-specialty mental health services or to an MHP for specialty mental



<sup>7</sup> Specific information on the trauma screening tools, scoring and thresholds for access criteria will be provided by DHCS at a later date.



health services based on an understanding of the individual's needs, the MCP/MHP is not required to use the screening tools. In these scenarios, MCPs and MHPs should follow existing protocols for provider referrals and begin the assessment process. Alternatively, if a third party (including but not limited to a health care provider) simply connects the individual to the MCP/MHP as a resource (e.g., gives them the MCP/MHP phone number for more information about what services may be available to them) without having conducted a screening or brief assessment to determine the appropriate delivery system for referral, the screening tool must be used.

### Screening Tool Administration

The screening tools are designed to be administered by both non-clinicians and clinicians and do not require clinical judgment to complete. They may be administered in person, over the phone, or in a community setting. The specific wording and ordering of the questions / fields in the tools must remain intact and the scoring methodology for the screening tools may not be altered. Deviation from the specific wording of screening questions is allowable as part of translation into another language if DHCS has not yet provided translated versions of the screening questions in that language. There may be instances where the person administering the screening is asked to clarify a question so that the individual being screened is able to respond. MCPs and MHPs are expected to train staff on approaches to respond to requests for clarification that are aligned with the intent of the question(s) and existing internal policies.

The adult tool contains 14 questions, and the youth tool contains 23 questions. If a provider is conducting a screening with a person on behalf of a youth under age 21, the provider must use the "Respondent on Behalf of Youth" version of the tool. If a person responds affirmatively to certain questions (e.g., emergency, suicidality, homicidality, already receiving mental health services from the MCP or MHP, certain youth access criteria), the screening must be discontinued, and the provider must complete appropriate next steps as indicated in the tool.

The screening tools include questions related to substance use disorder (SUD) that do not impact the screening score. If an individual responds affirmatively to an SUD question, the MCP or MHP must offer them a referral to the county behavioral health plan for an SUD assessment in addition to completing the screening tool and making an appropriate mental health delivery system referral. The person seeking care may decline the referral for an SUD assessment without any impact to their mental health delivery system referral.

The screening tools are not assessments and do not replace assessments. Once the screening tool has been administered, the individual will be referred to the appropriate Medi-Cal mental health delivery system for a clinical assessment that will determine the level of care and medically necessary services. The clinical assessment captures additional information (refer to Assessment section), and there may be instances when the assessment reveals that the individual should receive services in the other delivery system. In these cases, the provider would use the Transition of Care Tool to facilitate a transition of care to the other mental health delivery system (refer to Care Transitions section).

Screening

Assessment

Problem Lists

Care Coordination

Treatment

Care  
Transitions

Discharge

## Assessment

Once the screening tool has been administered, a person seeking care may receive a referral for an assessment by an LPHA. DHCS requires the use of a standard assessment that includes seven domains that are discussed below. Additional assessments may also be done based on the age of the individual seeking care and/or current treatment needs. During an assessment, an LPHA develops a clinical understanding regarding the person's care needs, determines an accurate diagnosis, confirms the appropriate treating system, and what services are medically necessary<sup>8</sup> to support the person in their goals so they can thrive in their community. Because human beings are complex, an assessment may take more than one session to fully determine the overall care needs. For some individuals completing an assessment may include collecting information from collateral sources including, but not limited to, family members and other natural support persons, prior service providers and/or external system partners. While the assessment is in process, the person in care may simultaneously receive additional clinically appropriate treatment services such as therapy, rehabilitation, case

<sup>8</sup> California Code of Regulations, Title 9, Chapter 11, Section 1810.204

management, medication support, etc). These services are reimbursable under Medi-Cal even when<sup>9</sup> :

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

- Remember that while a mental health diagnosis is not a prerequisite for access to covered services and while a person may access necessary services prior to determining a diagnosis, an ICD-10<sup>10</sup> code must be assigned to submit a service claim for reimbursement. More information on appropriate ICD-10 codes prior to the determination of a mental health diagnosis can be found in the next section.

2. The person in care has a co-occurring mental health condition and substance use disorder (SUD); or

3. Non-specialty mental health services (NSMHS) and specialty mental health services (SMHS) are provided concurrently, if those services are coordinated and not duplicative.

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

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

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

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

### **Standardized Assessment Requirements (Including Timeliness)**

#### **A. SMHS**

- a. MHPs require providers to conduct a uniform assessment that includes the seven domains identified below. For persons in care between the ages of six and 20, the Child and Adolescent Needs and Strengths (CANS) Assessment tool and for persons aged three through 18 the Pediatric Symptom Checklist (PSC-35) are required in addition to the Standardized Assessment. Assessments for substance use disorders for persons of all ages should include the American Society of Addiction Medicine (ASAM) criteria when an assessment is made to determine the appropriate treatment level of care. Findings gathered while using these additional tools may be included as part of the standard assessment domain requirements.
- b. Findings gathered while using these additional tools may be included as part of the standard assessment domain requirements.
- c. The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

<sup>9</sup> Welfare & Institutions Code 14184.402(f)

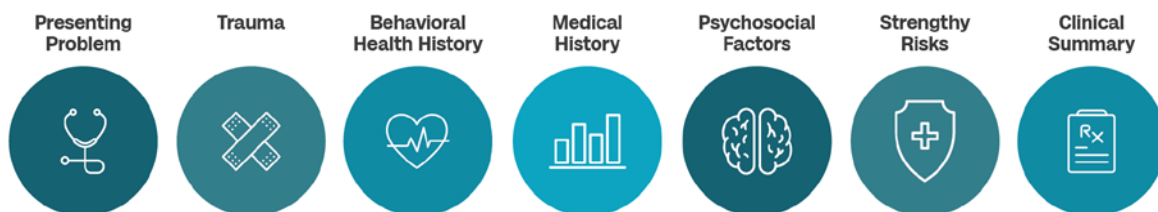
<sup>10</sup> BHIN 22-013 (ca.gov) and <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

- d. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the person does not meet criteria for SMHS.
- e. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Please note that providers using an electronic health record (EHR) will likely find that the EHR captures their signature and the signature date when the provider finalizes a service note.
- f. The assessment shall include the provider's recommendation – and determination of medical necessity for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided
- g. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the person's physical and mental health must be completed by a provider, operating in their scope of practice under California State law, who is licensed, registered, waived, and/or under the direction of a licensed mental health professional as defined in the State Plan.<sup>11</sup>
- h. The Mental Health Plan (MHP) may designate certain other qualified providers to contribute to the assessment, including gathering the person's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals<sup>12</sup>.

### Assessment Domain Requirements<sup>13</sup>

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

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



<sup>11</sup> [https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supp1toAtt3.1-A98-16%20\(10-012B\).pdf](https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supp1toAtt3.1-A98-16%20(10-012B).pdf)

<sup>12</sup> <https://www.dhcs.ca.gov/Documents/Att-3-1-A-Supp-3-5-5-22.pdf>; <https://www.dhcs.ca.gov/Documents/Supplement-2-to-Attachment-3-1-B-2-4-22.pdf>

<sup>13</sup> WIC 14184.402(c) and 402(d)

## Presenting Problem/Chief Complaint (Domain 1)

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

- **Presenting Problem (Current and History of)** – The person’s and collateral sources’ descriptions of problem(s), history of the presenting problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.
- **Current Mental Status Exam** – The person’s mental state at the time of the assessment.
- **Impairments in Functioning** – The person and collateral sources identify the impact/ impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning. Functioning should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.

## Trauma (Domain 2)

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

- **Trauma Exposures** – A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.)
- **Trauma Reactions** – The person’s reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.
- **Trauma Screening** – The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}), indicating elevated risk for development of a mental health condition.
- **Systems Involvement** – The person’s experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.

### Behavioral Health History: (Domain 3)

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

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

### Medical History and Medications: (Domain 4)

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

- **Physical Health Conditions** – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.
- **Medications** – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.
- **Developmental History** – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger).

### Psychosocial Factors (Domain 5)

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

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

## Strengths, Risk and Protective Factors (Domain 6)

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

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

## Clinical Summary and Treatment Recommendations (Domain 7)

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

- **Clinical Impression** – Summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/ protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below)
- **Diagnostic Impression** – Clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified diagnoses)
- **Treatment Recommendations** – Recommendations for detailed and specific interventions and service types based on clinical impression and overall goals for care<sup>14 15</sup>

## Diagnosis

Information used to determine a diagnosis is obtained through a clinical assessment and may include a series of structured tools. Information may come directly from the person in care or through other means, such as collateral information or health records. A diagnosis captures clinical information about the person's mental health needs and other conditions based on the DSM-5. Diagnoses are determined by an LPHA commensurate with their scope of practice (see [Appendix III](#) for scope of practice grid). Diagnoses are used to communicate with other team members about the person's mental health symptoms and other conditions and may document the level of distress/impairment. Diagnoses also help guide practitioners in their advisement about treatment options to the person in care.

Diagnoses should not remain static. For example, the person's clinical presentation may change over time and/or the practitioner may receive additional information about the person's symptoms and how the person experiences their symptoms(s) and conditions. As a practitioner, it is your responsibility to document all diagnoses, including preliminary diagnostic impressions and differential diagnoses as well as to update the health record of the person in care whenever a diagnostic change occurs. Additionally, Peer Support Specialists should collaborate with the clinician when they believe the symptoms of a person in care have changed so that the health record may be updated accordingly.

While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SMHS, the

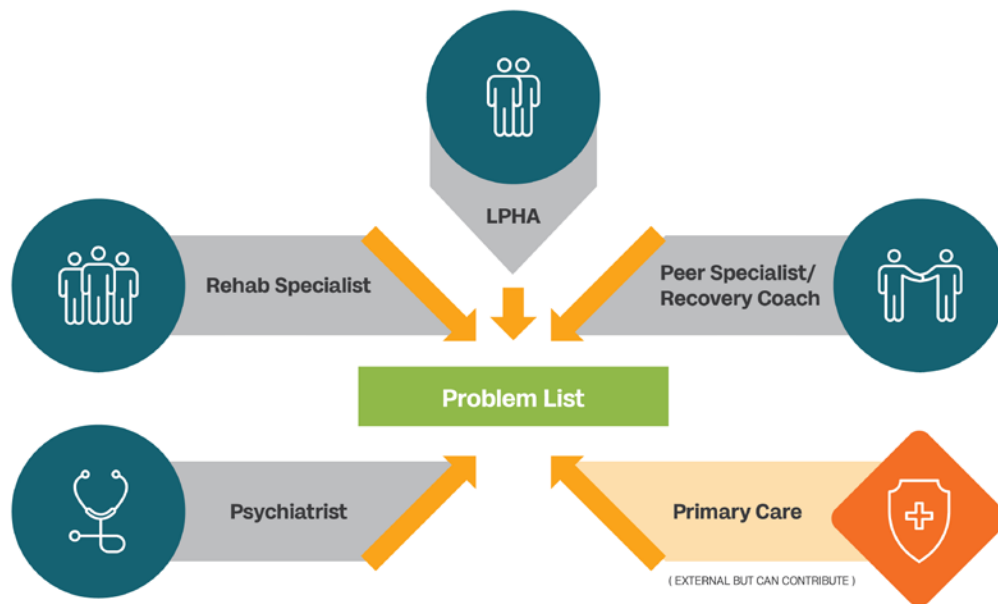
<sup>14</sup> BHIN 21-071 (ca.gov)

<sup>15</sup> BHIN21-073 (ca.gov)

covered benefits and services responsibilities of the MHPs and MCPs remain unchanged. For example, MHPs are not required to provide Applied Behavior Analysis (ABA), a key intervention in the treatment of autism spectrum disorder (ASD), as the responsibility for providing that service remains with the MCP. However, a person in care who has ASD is able to additionally receive treatment from the MHP if their service needs require it and services are not duplicative with the other care they are receiving.

Providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established<sup>16</sup>:

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



any clinically appropriate ICD-10<sup>17</sup> code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

<sup>16</sup> BHIN 22-013 (ca.gov)

<sup>17</sup> BHIN 22-013 and <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

Screening

Assessment

Problem Lists

Care Coordination

Treatment

Care  
Transitions

Discharge

## The Problem List

In the previous section we explored the assessment and how it informs care recommendations. Next, we will explore how the diagnosis and problem list intersect. Below you can see how different members of the care team can add to the list to fully capture the issues needing attention.

The use of a Problem List has largely replaced the use of treatment plans<sup>18</sup>, except where federal requirements mandate a treatment plan be maintained. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list. The providers responsible for the person's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by Mental Health Rehabilitation Specialists, Peer Support Specialists, and other treatment team members. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues.

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

Problem lists will have ICD-10 codes and or Systematized Nomenclature of Medicine (SNOMED) codes, including Z codes, as well as SDOH codes<sup>19</sup>. DHCS has identified a list of priority SDOH codes to facilitate the collection of reliable SDOH information for the Medi-Cal population. These codes are found in [Appendix IV](#).

### Problem List Requirements

The problem list shall be updated on an ongoing basis to reflect the current presentation of the person in care. Providers shall add to or remove problems from the problem list when there is a relevant change to a person's condition.

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

- Diagnoses identified by a provider acting within their scope of practice.
  - Include diagnostic specifiers from the ICD-10 if applicable.
- Problems identified by a provider acting within their scope of practice.
- Problems or illnesses identified by the person in care and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

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

Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a person, and to support claiming for services. Inconsistencies in either can lead to poor coordination of care across teams and treatment as well as inadequate documentation of the medical necessity of services, which can lead to rejected claims.

### Treatment Plan Requirements

In the past, treatment plans were static and complicated documents with strict start and end dates. If services were provided that were not documented on the treatment plan, they could not be claimed. Persons in care had to sign the treatment plans or they were not considered valid. Over time it has become clear that effective treatment

<sup>18</sup> Treatment or Care Plans remain in place for some specialty programs, per BHIN 22-019, Attachment 1

<sup>19</sup> <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf>



planning involves a more dynamic process since the person's needs can evolve and change rapidly. As part of CalAIM, treatment plans for many types of services are moving from standalone documents to being embedded in the "plan section" of progress notes. Exceptions to these changes can be found in Attachment 1 of BHIN 22-019<sup>20</sup>.

#### **A. Targeted Case Management (TCM)**

Targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan:

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

These required elements shall be provided in a narrative format in the person's progress notes.

#### **B. Peer Support Services**

Peer support services must be based on an approved plan of care.<sup>21</sup> The plan of care shall be documented within the progress notes in the person's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

#### **C. Additional Treatment and Care Plan Requirements**

Requirements for treatment/care planning for additional service types are found in Attachment 1 of BHIN 22-019<sup>22</sup>.

<sup>20</sup> <https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf>

<sup>21</sup> State Medicaid Director Letter #07-011; California State Plan, Supp. 3 to Att. 3.1-A, pp. 4, 5, 6h, 6i (substance use disorder); p. 2m.1 (SMHS)

<sup>22</sup> BHIN 22-019 (ca.gov)

## Example of a Problem List for a Person in Care:

Code	Description	Date Added	Date Removed	Added or Removed by	Provider Title*
Z65.9	Problem related to unspecified psychosocial circumstances	07/01/2022	07/19/2022	Name	Mental Health Rehabilitation Specialist
Z59.02	Unsheltered homelessness	07/01/2022	Current	Name	AOD Counselor
Z59.41	Food insecurity	07/01/2022	Current	Name	Peer Support Specialist
Z59.7	Insufficient social insurance and welfare support	07/01/2022	Current	Name	Peer Support Specialist
F33.3	Major Depressive Disorder recurrent, severe with psychotic features	07/19/2022	Current	Name	Psychiatrist
F10.99	Alcohol Use Disorder, unspecified	07/19/2022	Current	Name	Clinical Social Worker
I10.	Hypertension	07/25/2022	Current	Name	Primary Care Physician
Z62.819	Personal history of unspecified abuse in childhood	08/16/2022	Current	Name	Clinical Social Worker

\*Name and provider title may be automatically populated by your Electronic Health Record.

Screening

Assessment

Problem Lists

Care Coordination

Treatment

Care  
Transitions

Discharge

## Care Coordination

In previous sections we explored social drivers of health and how access to resources contributes meaningfully to quality of life. Access to health care is an important driver of quality of life and health outcomes, and one that we can directly impact. We know far too well that accessing and navigating healthcare systems can be a challenge for anyone. This may be especially true in behavioral health because care can involve treatment providers across multiple disciplines and organizations. Appropriate access to healthcare requires not only that services be available and accessible at the time the person needs the services, but also that care is coordinated, streamlined, and non-duplicative, even when it is provided by multiple entities. Care that is not coordinated runs the risk of being ineffective, wasteful of healthcare resources, and onerous for the individuals it is designed to help. As a whole, the disparate practitioners that are providing care can benefit from coordination so they can act in concert, as a team, with the person in care having a central voice and role.

Care coordination necessitates that a point person is identified who is accountable for coordination, bringing the person in care, natural supports/family, other service providers and system partners to the table. To ensure smooth coordination of care, practitioners should request authorization to share information (also known as releases of information) for all others involved in the care of the person in treatment during the intake process and throughout the course of treatment.

Care coordination also meets federal requirements designed to ensure that each person in care has an ongoing source of care appropriate to their needs. One person or entity must be formally designated as primarily responsible for coordinating the services accessed by the person in care, and the person in care must be provided information on how to contact their designated person or entity<sup>23</sup>. The Care Coordinator may be you, a treatment team member from your organization, or a treatment provider from another organization or delivery system. This role may have different names within various organizations, such as case manager, care manager, team facilitator, or the function of care coordination may be incorporated into the role of a clinician or other staff. The main goal of the Care Coordinator is to meet the person's care needs by using treatment information in a deliberate way and sharing necessary information with providers and the person in care, to guide the delivery of appropriate and effective care. Care Coordinators work to build teams and facilitate partnerships, creating formal and informal networks of support that enhance treatment for persons in care and allow for sustainable support long after treatment ends. Care coordination serves as a key element of service planning, ensuring that treatment across the team is meeting the needs of the person in care, that plans are updated as needed and that barriers to success are overcome. Within the team, communication is a key element of success, along with empowering the person in care to guide the team to meet their own needs. When referring or transitioning a person in care, the practitioner should discuss the reason for referral or transition and ensure the person understands, not only the reason for referral or transition, but also the expected outcome of the referral or transition. When transitioning care between MHP and MCP providers, be aware that DHCS has launched a Transition of Care tool to assist with care coordination and communication during transitions.

<sup>23</sup> 42 CFR §438.208

Screening

Assessment

Problem Lists

Care Coordination

Treatment

Care  
Transitions

Dischar

## Treatment

Treatment in behavioral health refers to a range of interventions designed to address and improve the mental health of a person in care. Treatment can involve a variety of evidence-based practices, such as motivational interviewing or Seeking Safety. Treatment approaches should be tailored to meet the unique needs of the person in care to alleviate mental health symptoms, enhance coping skills, and foster overall mental wellness. Treatment involves the use of a variety of Medi-Cal services, such as individual or group therapy, individual or group rehabilitation, medication services, or targeted case management to provide supportive interventions. By taking a comprehensive and holistic approach to the treatment needs of the person in care, providers can help individuals navigate their challenges, develop resilience, and work towards achieving optimal mental wellness and quality of life.

### Treatment Services

Medi-Cal SMHS are comprised of a variety of treatment services provided to individuals, groups and/or families. Definitions of the primary service types are below:

**Assessment:** A service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnoses and the use of testing procedures.

**Collateral:** A service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity. Effective with the transition to CalAIM claiming on 7/1/2023, collateral services cannot be claimed as a stand-alone service. Claiming for collateral contacts will be dependent on the provision of a covered service. A collateral claim must be submitted together with the claim for the covered service or it will be denied. Counties can claim for collateral-type services and are advised to identify codes that best describe the activity performed by the non-clinical staff when billing for those services. HCPCS codes that that may be used for collateral-type contacts are available in every category except Therapy.

**Crisis Intervention:** Service, lasting less than 24 hours, for a condition which requires more timely response than a regularly scheduled visit. Crisis intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Crisis intervention may be provided face-to-face, by telephone or by telemedicine with the beneficiary and/or significant support persons and may be provided in a clinic setting or anywhere in the community.

Service activities may include but are not limited to assessment, collateral, and therapy. Note that billing for crisis intervention services is limited to 8 hours per instance.

**Intensive Care Coordination (ICC):** ICC is a targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure

facilitation of a collaborative relationship among a child, their family, and involved child-serving systems<sup>24</sup>.

**Intensive Home-Based Services (IHBS):** IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the Child and Family Team (CFT) in coordination with the family's overall service plan. They may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria<sup>25</sup>.

**Medication Support Services:** Services provided by medical staff which include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.

**Mobile Crisis Services:** Community-based mobile crisis intervention services provide rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques that reduce the immediate risk and subsequent harm and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restore the beneficiary to the highest possible functional level. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate, and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary a behavioral health crisis. Locations may include, but are not limited to the beneficiary's home, school or workplace, on the street, or where a beneficiary socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours per day, seven days per week, 365 days per year.

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

Peer support services may be provided face-to-face, by telephone or by telehealth with the beneficiary or significant support person(s) and may be provided anywhere in the community. Peer support services are based on an approved plan of care. This service includes one or more of the following service components:

- **Therapeutic Activity:** A structured non-clinical activity provided by a certified Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include but are not limited to,

<sup>24</sup> See Exhibit E – Attachment 2, Section J of the Mental Health Contract Template.

<sup>25</sup> See Exhibit E – Attachment 2, Section K of the Mental Health Contract Template.

advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiary and others providing care or support to the beneficiary, family members, or significant support persons.

- **Engagement:** Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- **Educational Groups:** Providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiary achieve desired outcomes. These groups should promote skill building for the beneficiary in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- **Collateral:** A service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary must be present for this service activity.

Peer support services may be provided by a Peer Support Specialist.

**Plan Development:** Service activity which consists of one or more of the following: development of client plans, approval of plans, and/or monitoring of a person in care's progress.

**Rehabilitation:** A recovery or resiliency-focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary'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 beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

**Targeted Case Management (Case Management/Brokerage/Linkage):** Services that assist a person in care 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 access to service and the service delivery system; monitoring of individual progress.

**Therapeutic Behavioral Services (TBS):** Specialty mental health services covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services<sup>26</sup>. TBS are intensive, one-to-one, short-term outpatient services for beneficiaries up to age 21 designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish specified outcomes<sup>27</sup>.

**Therapeutic Foster Care (TFC):** This model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services (SMHS) activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain

<sup>26</sup> For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT services.

<sup>27</sup> See Exhibit E-Attachment 2, Section L of the Mental Health Contract Template.

SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs)<sup>28</sup>.

**Therapy:** A therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

### Treatment Team

SMHS services are often provided through a team-based approach. While the precise composition of teams varies in each individual situation, it is not uncommon to have treatment teams with some combination of LPHAs, MHRs, Peer Support Specialists, medical providers and other qualified staff who work with the person in care. It is critical that treatment teams include the person in care and center their voice and priorities as the treatment team collaborates to support the person in care in meeting their goals. Teaming is ideally a seamless part of treatment, allowing all members to work collaboratively to ensure that care is highly coordinated and aligned across providers. Successful teaming takes intentional partnership, information-sharing, and focus. Treatment teams are encouraged to use consensus building decision making techniques and to solicit and explore viewpoints across the team.

## Co-Occurring Treatment

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

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

Under CalAIM, the No Wrong Door policy aims to ensure that beneficiaries have access to the right care at the right time<sup>29</sup>. No Wrong Door specifies that clinically appropriate SMHS are covered and reimbursable even when the person in care has a co-occurring substance use disorder. Similarly, clinically appropriate and covered DMC and DMC-ODS services are covered by DMC and DMC-ODS plans even when the person in care has a co-occurring mental health disorder. Co-occurring diagnoses can interact and influence each other, leading to more complex treatment. By recognizing and understanding the interplay between co-occurring diagnoses, providers can provide more effective treatment tailored to the person in care's needs.

## Progress Notes

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

Progress notes have multiple functions. First and foremost, progress notes are used to document the treatment that has occurred (the intervention), and the intended next steps (the plan). Progress notes can also serve as communication tools to alert other practitioners (or the person in care themselves) of the status of treatment. For these reasons, each

<sup>28</sup> See Exhibit E-Attachment 2, Section M of the Mental Health Contract Template.

<sup>29</sup> BHIN 22-011

progress note should be understandable when read independently of other progress notes, providing an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided. To facilitate clear and accurate communication, abbreviations should be avoided, unless universally recognized, so that they will be accessible to a range of practitioners with whom you may wish to coordinate care. Keep in mind that progress notes can be used in legal proceedings and may also be accessed by the person in care themselves. People in care should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

Given the communication aspect of progress notes, they should be completed as soon as reasonable after a service has occurred – generally within 24 hours for a crisis service, and within three days for most other services (more below).

[Appendix V](#) provides sample note narratives demonstrating sufficient documentation of the intervention.

**The following list are characteristics of a progress note that supports quality documentation. Consider the following characteristics when documenting<sup>30</sup>:**

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Clear       | <input type="checkbox"/> Reliable         |
| <input type="checkbox"/> Consistent  | <input type="checkbox"/> Accurate/Precise |
| <input type="checkbox"/> Descriptive | <input type="checkbox"/> Timely           |

### Required Progress Note Service Information

- The type of service rendered
- A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time, which should be documented separately<sup>31</sup>.
- Location of the person in care at the time of receiving the service<sup>32</sup>.
- A typed or legibly printed name, signature for the service provided and date of signature.
- ICD 10 code.<sup>33</sup>
- Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- The plan, or next steps, including but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate.

### Group Progress Notes

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

- For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners can be used to document the group service provided.  
Progress notes need to contain the information as noted above and modifications and additional information as noted below:
- Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity. Travel and documentation time should be captured separately<sup>34</sup>.
- A list of group participant names needs to be maintained. Please note, due to confidentiality standards, the full

<sup>30</sup> Hess, Pamela Carroll. Clinical Documentation Improvement: Principles and Practice. Chicago: AHIMA Press, 2017.

<sup>31</sup> Under Payment reform, rates include the costs of travel and documentation time which supports streamlined claims processing. However, travel time and documentation time should still be documented separately in progress notes to support future rate setting efforts.

<sup>32</sup> Per BHIN 22-019 the location of the beneficiary at the time of the service shall be identified, regardless of whether the beneficiary was present for the service.

<sup>33</sup> ICD-10 Tabular: <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

<sup>34</sup> Under Payment reform, rates include the costs of travel and documentation time which supports streamlined claims processing. However, travel time and documentation time should still be documented separately in progress notes to support future rate setting efforts.



list of group participants must **not** be kept in any single participant's personal health records: instead the MHP or practitioner must maintain the full participant list outside of any participant's health records.

### Progress Note Writing Tips

Learning to write progress notes is a skill that takes time for individuals who are new to billing Medi-Cal services. While MHP rules vary regarding specific note content expectations, in general the below tips can assist in writing high-quality progress notes.

- Focus on the interventions and the services provided.
- Use active verbs to describe interventions rather than passive verbs.
- Highlight the themes and topics of a service rather than documenting a “play by play” of the service.
- Use simple, concise and professional language with clear and specific examples.
- Avoid jargon or abbreviations to keep the notes person-friendly.
- Check the problem list and add to it to reflect the topics of the sessions as needed.
- If multiple services of the same service type (e.g., individual rehabilitation) were provided to the same person on the same day, consider writing one note for a cumulative duration of time rather than separate notes.
- Be precise in service minutes – rounding is not permitted.
- Schedule time to complete note writing each day and limit interruptions during those times.

### Progress Notes Timeliness

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

- **Routine outpatient services:** Documentation should be completed within three (3) business days. If a note is submitted outside of the 3 business days, it is good practice to document the reason the note is delayed. Late notes remain billable and should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations<sup>35</sup>), stricter note completion timelines may be required by state regulation.
- **Crisis services:** Documentation should be completed within 24 hours.
- **A daily note** is required for documentation of some residential services, day treatment, and other similar settings that use a daily rate for billing. In these programs, weekly summaries are no longer required.

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse<sup>36</sup> within the service provision and claiming system. Disallowances in audits will occur when there is evidence of fraud, waste, or abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this guide are necessary steps to promote compliance.

<sup>35</sup> <https://www.dhcs.ca.gov/Documents/ST RTP-Regulations-version-II.pdf>

<sup>36</sup> Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for “fraud,” “waste,” and “abuse” can also be found in the Medicare Managed Care Manual.

Screening

Assessment

Problem Lists

Care Coordination

Treatment

Care  
Transitions

Discharge

## Care Transitions

Above we discussed the importance of care coordination when multiple providers are serving a person in care. Coordination is also important when a person in care is transitioning from being primarily served in one mental health system (the MHP or the MCP) to being referred for service in the other.

## Transition of Care Tool

DHCS developed and rolled out the transition of care tool in January 2023. The transition of care tool ensures smooth and coordinated transitions when persons in care start receiving additional non-specialty mental health services from MCPs or when they transition their mental health care needs fully from the MHP to the MCP (or vice versa). The transition of care tool provides valuable information about the person in care to healthcare providers to allow for clinically meaningful continuity of care. The transition of care tool is designed to be for all person's in care, adults and youth alike. The decision to add or transition services from the MHP to the MCP must be made by an LPHA<sup>37</sup>. However, once the decision has been made, a non-clinician such as an administrative staff, peer support staff, or other professional who does not meet the definition for clinician may complete the transition of care tool. The transition of care tool can be completed in person, by telephone or by video conference with engagement from the person in care throughout the process.

The transition of care tool includes specific fields to document the following elements:

- Referring plan contact information and care team.
- Demographic and contact information about the person in care.
- The behavioral health diagnosis of the person in care, along with any cultural and linguistic requests made by the person in care.
- The presenting behaviors/symptoms, environment, behavioral health history, medical history, and medications prescribed for the person in care.
- Service requested and receiving plan contact information.

Like the Adult and Youth Screening Tools, the Transition of Care tool must be completed with the specific wording and order of the question prompts as published by DHCS, with translation allowed when necessary. All fields of the transition of care tool must be completed and additional information may not be added to the forms, however, attachments can be included. Providers completing the transition of care tool may provide additional documentation, such as medical history, care plans, and medication lists as attachments to the referral.

Once the Transition of Care Tool has been completed, the person in care must be referred to their MCP or directly to an MCP provider who delivers NSMHS if this direct type of coordination has been established within the MHP. It is the responsibility of the provider to follow up with the person in care to ensure that they have been connected with a provider in the new system, and that the new provider accepts the care of the person in care.

<sup>37</sup> BHIN 22-065 (ca.gov)

Screening

Assessment

Problem Lists

Care Coordination

Treatment

Care  
Transitions

Discharge

## Discharge Planning

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

Discharge planning must include the person in care and their social support as full partners in the planning process and should be done as far in advance as practical. If the person in care is being discharged to a different kind of treatment, including other treatment providers in the process can help pave the way to successful transitions from one care setting to another. Detailed information on discharge planning should be clear, concise, and accurately communicated and documented.

A successful discharge discussion includes a review of how the person can continue to receive any necessary support and how those needs may be addressed post-discharge from the program. Information contained in discharge plans and shared with the person in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the person is expected to receive and by whom, information on crisis supports, and available community services, to name a few. Additionally, providers who work with individuals ages 6 through 20 are required to complete the CANS at discharge as well as a PSC-35 for individuals who are ages 3 through 18<sup>38</sup>.

## Claiming for Services

### Code Sets for Claiming Services

In an earlier section we explored the importance of identifying needs, assessing conditions and/or diagnoses to recommend medically necessary services and initiate care planning and treatment. Here, we will explore the intersection of progress notes with code sets for submitting claims for reimbursement. But first, let us talk about the different code sets and their uses.

- **DSM Diagnosis:** Captures clinical information about the person's behavioral health needs and other conditions (clusters of symptoms) based on the DSM-5. The selection of appropriate treatment interventions is informed by the diagnosis, assessed need and problem list.
- **International Classification of Diseases - Clinical Modification (ICD-10-CM) Codes:** Captures detailed information about the disorder (granular information) and is used in claiming. The ICD is a standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).
- **Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes:** These codes are used to capture uniform information for claiming for medical services and products. Specialty Mental Health Services primarily used HCPCS codes for claiming services prior to July 2023. Following July 2023, as an outcome of the implementation of the CalAIM initiative referred to as "payment reform", SMHS will use a combination of HCPCS codes and CPT codes to bill Medi-Cal. This change will largely impact licensed and licensed-eligible staff, who are able to claim for services using CPT codes. Please see [Appendix VI](#) for a list of commonly used HCPCS/CPT codes by practitioner type.

The above code sets are used throughout healthcare settings and offer standardization and uniformity for data collection, claims processing, and evaluation of disease prevalence and service provision.

<sup>38</sup> BHIN 18-048 (ca.gov)

## Conclusion

We hope that this guide has given you useful tools to implement the service delivery system transformation, documentation redesign and payment reform concepts foundational to CalAIM. Achieving the goals of CalAIM requires transformation across our service delivery system, by all types of practitioners and staff. Through coordination of care and strong engagement with the person in care, clinical staff can streamline documentation and provide higher quality care and further the goals of improving access for all Californians.

# Appendices

## Appendix I: Acronym List

- ACE: Adverse Childhood Experience
- ASAM: American Society of Addiction Medicine
- BHIN: Behavioral Health Information Notice
- BIPOC: Black, Indigenous and People of Color
- CalAIM: California Advancing and Innovating Medi-Cal
- CANS: Child and Adolescent Needs and Strengths
- CMS: Centers for Medicare & Medicaid Services
- CPT: Current Procedural Terminology
- DHCS: Department of Health Care Services
- DMC: Drug Medi-Cal
- DMC-ODS: Drug Medi-Cal Organized Delivery System
- DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
- EPSDT: Early & Periodic Screening, Diagnosis and Treatment
- HCPCS: Healthcare Common Procedure Coding System
- HIPAA: Health Insurance Portability and Accountability Act
- ICD-10: International Classification of Diseases, Tenth Revision
- LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and all sexual and gender minority identities
- LOC: Level of Care
- LPHA: Licensed Practitioner of the Healing Arts
- MAT: Medication for Addiction Treatment
- MCO: Managed Care Organization
- MCP: Managed Care Plan
- MHP: Mental Health Plan
- NSMHS: Non-specialty mental health services
- NTP: Narcotic Treatment Program
- PSC-35: Pediatric Symptom Checklist
- SMHS: Specialty Mental Health Services
- SUD: Substance Use Disorder
- TCM: Targeted Case Management

## Appendix II: Medi-Cal Plans by Type

Medi-Cal Benefits		
System	Services	Service Definition
Mental Health Plan (MHP)	Specialty Mental Health Services (SMHS) – Carved out of overall Medi-Cal benefit within 1915b Waiver <sup>39</sup>	SMHS includes the following <sup>40</sup> : <ul style="list-style-type: none"> <li>• Inpatient psychiatric services</li> <li>• Outpatient services, including intensive and community-based services, such as individual, family and group therapy, collateral, plan development and assessment</li> <li>• Rehabilitative skill building services in individual and/or group settings</li> <li>• Targeted Case Management</li> <li>• Medication Support Services</li> <li>• Day Treatment Intensive or Rehabilitation</li> <li>• Crisis Intervention and Stabilization</li> <li>• Adult and Crisis Residential Treatment</li> <li>• Intensive Care Coordination</li> <li>• Therapeutic Foster Care</li> <li>• Intensive Home-Based Services</li> <li>• Therapeutic Behavioral Services</li> <li>• Peer Support Services</li> <li>• Mobile Crisis Services</li> </ul>
Managed Care Plan (MCP)	Non-Specialty Mental Health Services (NSMHS) and Physical Healthcare	NSMHS include the following: <ul style="list-style-type: none"> <li>• Mental health evaluation and treatment, including individual, group and family psychotherapy</li> <li>• Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition</li> <li>• Outpatient services for purposes of monitoring drug therapy</li> <li>• Psychiatric consultation</li> <li>• Outpatient laboratory, drugs, supplies and supplements</li> </ul>

39 <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

40 [https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate\\_2017-2022\\_MHP\\_Contract-Exhibits\\_A\\_B\\_and\\_E.pdf](https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_and_E.pdf)

Medi-Cal Benefits (cont.)		
System	Services	Service Definition
County Drug Medi-Cal Organized Delivery System (DMC-ODS)	Substance Use Treatment Continuum of Care modeled after ASAM Criteria	<p>Continuum of Care modeled after the American Society of Addiction Medicine (ASAM) criteria<sup>41</sup> including:</p> <ul style="list-style-type: none"> <li>· Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)</li> <li>· Outpatient (ASAM Level 1)</li> <li>· Intensive Outpatient (ASAM Level 2.1)</li> <li>· Partial Hospitalization (ASAM Level 2.5)</li> <li>· Residential Treatment (ASAM Levels 3.1, 3.3, 3.5)</li> <li>· Inpatient (ASAM Levels 3.7 and 4.0) (Medically Monitored or Medically Managed)</li> <li>· Narcotic Treatment Program</li> <li>· Withdrawal Management Services (ASAM Level 1-WM, Level 2-WM, Level 3.2-WM, Level 3.7-WM, Level 4-WM)</li> <li>· Medications for Addiction Treatment</li> <li>· Peer Support Services</li> <li>· Contingency Management</li> <li>· Recovery Services</li> <li>· Care Coordination</li> <li>· Clinician Consultation</li> </ul>
Drug Medi-Cal (DMC)	Substance Use Treatment	<p>Includes the following<sup>42</sup>:</p> <ul style="list-style-type: none"> <li>· Narcotic Treatment Programs</li> <li>· Outpatient drug free treatment, including medication services, treatment planning, crisis intervention, collateral, individual counseling, and group counseling.</li> <li>· Day Habilitative services</li> <li>· Perinatal residential</li> <li>· Naltrexone treatment</li> </ul>

<sup>41</sup> ASAM LOC Criteria

<sup>42</sup> <https://govt.westlaw.com/calregs/Document/I12C91B008DA411E4A0F094BBA3CAFB62?transitionType=Default&contextData=%28sc.Default%29>

Appendix III: Scope of Practice Matrix

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

\*Under the direct supervision of a Behavioral Health Professional

+ Training and certification requirement may apply

++ May require close supervision if issues of danger to self or others are present

+++ Typically limited to post-master's doctorate students

\* While other services may be technically allowable depending on an individual's classification, Certified Peer Specialists mainly utilize the Peer Support Service codes.



## Appendix IV: DHCS Priority SDOH Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.4	Educational maladjustment and discord with teachers and classmates*
Z55.5	Less than a high school diploma*
Z56.0	Unemployment*
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.21	Child in welfare custody*
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z64.0	Problems related to unwanted pregnancy*

Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.4	Victim of crime and terrorism*
Z65.5	Exposure to disaster, war and other hostilities*
Z65.8	Other specified problems related to psychosocial circumstances

\*Indicates CalMHSA recommended SDOH Z-code

## Appendix V: Sample Progress Note Narratives

### Engagement

Peer Support Specialist contacted the client via telephone as an introduction and to support the person in engaging in care. Discussed what to expect during the upcoming session. Answered questions and clarified expectations. Peer Support Specialist shared their role in supporting the person through the process. This staff collaborated with treatment team members and provided pertinent information for upcoming session. Client reported appreciation for the information, including feeling less stressed out about the upcoming session. Client was able to identify the plan for the upcoming session, including the date/time and transportation.

### Developing Recovery Goals

I collaborated with client to review his problem list. I prompted client to share his life goal and brainstormed how it would be incorporated into his problem list. I reviewed the needs and strengths identified during the assessment by the clinician and worked with client to determine how to leverage his strengths to support his areas of need. Client was engaged throughout the session, though he struggled to identify strengths. Client agreed with the problem list developed. This Peer Support Specialist will continue individual therapeutic sessions, with the next session scheduled for later this week.

### Skill Building

In an effort to support wellness skills, I engaged client in an open-ended conversation about her day and how she has been feeling. I praised her for using I statements and ability to reflect on things that went well. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (e.g., reading, listening to music, etc.). I normalized her need to take a break from difficult situations and reminded her to take time outside. Coached client through role play on using healthy ways to let others know that she needs to stay well and healthy. Client was verbal and engaged throughout the session. I will meet with client next week at the community wellness center to support her in the identification of a new class.

### Resource Navigation

This staff provided the following intervention to address the client's inability to manage emotions due to their anxiety: Contacted Group Intervention Center and spoke with intake counselor (Susan) to obtain information about the appropriateness of their Healing Heart Program to meet client's needs. Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Healing Hearts indicated client seemed appropriate for their program group and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend this support group.

### Collaboration with Significant Supports

Client's father and grandmother report that on most days, client closes herself off in her bedroom as soon as she comes home on visits and only leaves her room to meet basic physical needs. These behaviors resulting from client's depression are creating challenges in family relationship, per father. This Peer Support Specialist provided empathic and validating statements, acknowledging caregiver's frustration and concern. Peer Support Specialist provided education on recovery principles and ways to support the client. Peer Support Specialist discussed common challenges amongst families when there are notable differences in the expression of respect between the generations within household. Solicited feedback from caregivers about their understanding of recovery and identified things they can do that may best support the client. Client's caregivers were forthcoming in expressing their challenges to understand how to best support client. They were receptive to information and expressed willingness to try new approaches with client. I will continue to work with client and the client's family in identifying new methods to respond to client's isolative behavior.

## Appendix VI: Commonly Used Service Codes

The table below identifies commonly used service codes and the disciplines allowed to bill each code. This list of codes is not comprehensive. Every county's implementation of service codes in their electronic health record (EHR) is different. For example, some EHRs use the code description set by the Centers for Medicare and Medicaid Services (CMS), whereas others use simplified code descriptions. For additional information on service codes, please refer to the CalMHSA CPT for Direct Service Providers LMS Training here. While services other than those identified as Peer Support Services may be technically allowable depending on an individual's classification, Certified Peer Specialists mainly utilize the Peer Support Service codes.

Assessment		
Code	CMS Code Description	Allowable Discipline
H0031	Mental Health Assessment by Non-Physician, 15 Minutes	Pharmacist, PhD/PsyD (licensed or waived), LCSW (licensed, registered or waived), MFT (licensed, registered or waived), PCC (licensed or registered), Psychiatric Technician, PA, NP or CNS (certified), RN, LVN, MHRS, Occupational Therapist, Other Qualified Practitioner, Peer
Crisis Intervention		
Code	CMS Code Description	Allowable Discipline
H2011	Crisis Intervention Service, per 15 Minutes	All Disciplines
Community-Based Mobile Crisis Intervention Services		
Code	CMS Code Description	Allowable Discipline
H2011	Mobile Crisis	N/A
Peer Support Services		
Code	CMS Code Description	Allowable Discipline
H0038	Self-help/peer services per 15 minutes	Peer
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	Peer
Rehabilitation		
Code	CMS Code Description	Allowable Discipline
H2017	Psychosocial Rehabilitation, per 15 Minutes	All Disciplines
H2021	Community- Based Wrap-Around Services, per 15 minutes	All Disciplines
Therapeutic Behavioral Services		
Code	CMS Code Description	Allowable Discipline
H2019	Therapeutic Behavioral Services, per 15 Minutes	All disciplines
Referral		
Code	CMS Code Description	Allowable Discipline
T1017	Targeted Case Management, Each 15 Minutes	All disciplines

## Appendix VII: Documentation Guide Change Log

Section	Change Description	Revision Date
Introduction to this guide	Edits to grammar and clarified language	7/1/2023
Health Care Systems	Edits to grammar and clarified language	7/1/2023
Medi-Cal Programs	Edits to grammar, clarified and updated language specific to DMC, DMC-ODS, and MCPs	7/1/2023
Access to the SMHS System	Edits to grammar and clarified language	7/1/2023
Screening	Added information and updated language specific to Standardized Screening Tools and Screening Tool Administration	7/1/2023
Assessment	Clarified guidance about applying additional assessment tools and added link to CMS ICD-10 list.	7/1/2023
Problem List	Clarified guidance about use of ICD-10 codes, added information about SNOMED codes in problem lists; Clarified information about Treatment Plan Requirements and updated Example of a Problem List	7/1/2023
Treatment	Removed information about Stages of Change and Motivational Interviewing, added general information about the function of treatment in behavioral health; Updated definitions of ICC, collateral, and Peer Support Services; Added definitions for IHBS, TBS, TFC, Community-Based Mobile Crisis Services; Added language about co-occurring treatment and information about No Wrong Door; Clarified language around audit disallowances; Added footnote 27, 28, and 30; clarified language about the need to separate travel and documentation time from total service time	7/1/2023
Care Transitions	Updated Care Transition paragraph for clarity; added information about Transition of Care Tool	7/1/2023
Discharge	Edits for clarity within Discharge Planning paragraphs; Clarified age ranges for CANS and PSC-35	7/1/2023
Claiming for Services.....	Added information related to Payment Reform	7/1/2023
Appendices	Updated Appendix I, II, III, IV, V, and added VI	7/1/2023
Assessment	Clarified language around co-occurring treatment and services during assessment; Clarified age ranges for CANS and PSC-35	6/23/2022
Problem List	Updated Example Problem List header titles and provider types	6/23/2022
Care Coordination	Added information on federal care coordination requirements	6/23/2022
Treatment	Clarified language around audit disallowances	6/23/2022
Appendices	Updated Appendix I and III; removed former Appendix III: Sample Progress Note Treatment Plan Template	6/23/2022
Multiple	Updated use of person-centered language; fixed typos / formatting issues	6/23/2022

Any questions & comments related to this guide can be submitted to:

[calaim@calmhsa.org](mailto:calaim@calmhsa.org)