CONTRA COSTA HEALTH

CONTRA COSTA BEHAVIORAL HEALTH SERVICES – MENTAL HEALTH PLAN

CLINICAL DOCUMENTATION GUIDE

Revised July 2023

CHAPTER 1: INTRODUCTION

1.1. WHY DO WE HAVE THIS DOCUMENTATION GUIDE?

This Documentation Guide was developed as a resource for providers within the Contra Costa Behavioral Health Services-Mental Health Plan (CCBHS-MHP), which includes County owned and operated programs and programs run by Community Based Organizations (CBOs). It outlines standards and practices required within the Child and Adolescent and Adult and Older Adult systems of care, including Katie A, Forensics, and Transitional Services.

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

All services must be documented using Medi-Cal Specialty Mental Health documentation guidance regardless of the Medi-Cal status of the beneficiary, as CCBHS-MHP submits a claim for each covered service provided by each service provider. Services for beneficiaries with co-occurring mental health and substance use disorders are documented using the rules presented in this Documentation Guide.

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

This Documentation Guide should be considered the CCBHS-MHP standard. The Utilization Review (UR) Unit provides resources as well as trainings, guides, and other helpful documents. The UR Unit welcomes questions and comments at any time. Feel free to email: BHSUtilizationManagementUnit@cchealth.org

This Documentation Guide is posted on the CCBHS-MHP Clinical Documentation web page: cchealth.org/mentalhealth/clinical-documentation/#Documents.

1.2. SOURCES OF INFORMATION

This Documentation Guide includes information from the following sources:

- Code of Federal Regulations (CFR) 45 and 42
- California Code of Regulations (Title 9 and 22)
- California Department of Health Care Services (DHCS) Letters and Information Notices
- American Health Information Management Association (AHIMA)
- Contra Costa County policies and procedures, directives & memos
- Quality Improvement & Utilization Review Department's interpretation and determination of documentation standards.

1.3. FRAUD, WASTE, AND ABUSE

Contra Costa Behavioral Health Services is a County behavioral health organization that provides services to the community and then seeks reimbursement from state and federal funding sources. Failure to comply with any applicable State and Federal policies and procedures when billing the State can have financial, ethical, and legal repercussions, and it can limit the ability of CCBHS-MHP from serving the right people at the right time in the right place.

CCBHS-MHP documentation requirements are detailed in our County Mental Health Plan and are based on guidance and standards established by the US Department of Health and Human Services Office of Inspector General (OIG). The OIG is primarily responsible for investigations of Medicare and Medicaid (Medi-Cal in the state of California) fraud and provides support to the US Attorney's Office for cases that lead to prosecution. The State of California also has a Medicaid/Medicare Fraud Control Unit. Many behavioral health departments in California counties have already been investigated by State and Federal agencies, and in every case either severe compliance plans have been instituted or fraud charges have been filed.

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

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

The role of providers and programs is to:

- Adhere to legal, ethical, code of conduct and best-practice standards for billing and documentation.
- Ensure that all providers participate in proactive training and quality improvement processes.
- Ensure that providers work within their professional scope of practice.
- Have a plan to ensure there is accountability for all CCBHS-MHP program activities and functions. This includes the accuracy and quality of progress note documentation by defined practitioners who will select correct procedure codes and services location to support the documentation of services provided.

1.4. QUALITY

Good-quality documentation is complete, accurate, and consistent. Assessments should be completed in a timely manner and address all seven domains.

Problem lists should include all required elements and be updated regularly. Treatment should address mental health problems and impairments, with special attention given to needs and risk and be informed by the beneficiary's social determinants of health.

Progress notes should be timely and include all required elements. They should depict a narrative that accurately and consistently reflects the beneficiary, interventions, progress, and plans over time and makes sense. Progress notes should reflect efforts in providing continuity of care and addressing co-occurring disorders. Notes also should account for breaks in treatment.

Ultimately, good documentation is meaningful and vital for both providers and beneficiaries.

1.5. UTILIZATION REVIEW

State regulations and CCBHS-MHP policies specify that beneficiary health records must be reviewed by the Utilization Review Unit or designated program clinicians. This process is meant to ensure that the current clinical services are appropriate to address beneficiary behavioral health needs; that documentation aligns with State and Federal regulations as well as CCBHS-MHP policies; and that documentation meets quality standards. The Utilization Review process includes the evaluation and improvement of services through the following practices:

- Utilization Quality Review
- Subcontracted providers or Community Based Organization (CBO) Utilization Review
- Inpatient Utilization Review
- Medication Support Services Utilization Review

Quality reviews cover the following:

- Has the correct level of care been provided, and do the services meet criteria for access to specialty mental health services?
- Do the services benefit the beneficiary by significantly diminishing symptoms and/or impairments, or by preventing significant deterioration in an important area of life functioning?
    - For beneficiaries under 21 years of age, mental health services are not required to be curative or restorative to be able to improve the beneficiary's mental health condition; therefore, services that sustain, improve, or make more tolerable a mental health condition meet medical necessity.
- Have all documents been completed within established CCBHS-MHP standards?

Reviewers use a review tool to provide feedback to providers and the Utilization Review Manager, who is responsible for tracking any findings, following up on quality issues, and providing a plan of corrections.

CHAPTER 2: GENERAL PRINCIPLES OF DOCUMENTATION

2.1. GENERAL PRINCIPLES OF DOCUMENTATION

1. All providers must refer to and adhere to CCBHS-MHP Policy 709-MH, Utilization Management/Utilization Review: Documentation Standards.
2. All CBOs who use an Electronic Health Record (EHR) system must adhere to the UR Signature Certification memo dated June 1, 2016, regarding EHRs and electronic signatures.
3. Contracted providers who use an EHR for documentation must incorporate all required documentation elements identified in Policy 709-MH.
4. Once required clinical documents are entered into the medical record, they become part of a legal document; therefore, the following are not permitted:
    a. Removal of pages from the record.
    b. Erasing or amending notes that have already been entered/filed.
    c. Destroying the content of the medical record.
5. Services may only be entered for billing if there is a corresponding progress note.
6. All services shall be provided by staff acting within their scope of practice. Licensed clinicians must follow specific scope of practice requirements as determined by the applicable license regulations of their governing board.
7. Progress notes should clearly indicate the type of service provided, clinician interventions, and a plan.
8. Staff who provide the service should take care to select the correct procedure code for the service provided that the documentation supports and substantiates this service. This ensures that CCBHS-MHP receives the correct reimbursement for services provided.
9. Some services that are necessary for the wellbeing of the beneficiary are not billable to the State. Nonbillable and nonbillable lockout codes block a service from being billed. Nonbillable services are meant to include a variety of potential services deemed helpful or necessary to the beneficiary but are not reimbursable by the State as a mental health service. These services should be documented by staff working with beneficiaries. Nonbillable services include, but are not limited to:
    a. Transportation of a beneficiary.
        i) **NOTE:** “Travel” is not “Transportation.”
            1) Travel is when a provider travels from their office location to a field location to provide a mental health service.

2) Transportation is when a provider drives a beneficiary/family member to and from a location without provision of a mental health service (such as to or from a doctor's appointment or to pick up a check or medication). If a mental health service is provided while transporting a beneficiary, then the time spent providing the mental health service during transportation may be billed.

b. Sending or receiving a fax.

c. Listening to voicemails.

d. Leaving voicemails.

e. Scheduling appointments.

f. Interpretation/ translation services.

10. "Direct Service Time" billed should be documented on each progress note. It only includes time spent providing services to, on behalf of, the beneficiary. It does not include travel or documentation time.

11. While CPT codes bill in blocks of time, providers should enter their actual direct service time to the minute. Epic/ccLink will convert the documented time to the appropriate block of time on the backend.

12. Each service contact must be documented in a separate progress note, and documentation must be completed in a timely manner. A progress note should be completed for each service provided except for Psychiatric Emergency Services, Crisis Residential Services, and Day Treatment Services.

    a. **Progress Note Timeline**: Progress notes must be completed in a timely manner according to the following guidelines:

        i) Providers should make every effort to complete progress notes on the same day of service.

        ii) Progress notes should be completed within three (3) business days from the date the service was provided. The count begins on the day after the service. For instance, if the encounter occurred on Monday, Thursday would constitute the third and last day to complete a normal (non-crisis) encounter note.

        iii) Crisis intervention notes should be filed within 24 hours of the service.

        iv) If a progress note is not completed within three (3) business days, the clinician must write "late entry" on the progress note.

13. For group notes, staff must detail the purpose of the group and individualize the note for each beneficiary. Documentation must include how the beneficiary benefitted from the group, the beneficiary's participation, and their individual responses to the interventions provided during the group.

14. If a service is concurrently provided by multiple staff, each staff member must complete their own progress note to document their role in the provision of the service and to detail the specific interventions services they provided.
15. Documentation must be legible. Documentation that is not legible is at risk for disallowance.
16. Adult Protective Services or Child Protective Services reports, Incident Reports, Unusual Occurrence Forms, Grievances, Notice of Adverse Benefit Determination, Utilization Review Committee recommendations or forms and audit worksheets shall never be filed in the medical record nor billed. Questions regarding other forms (not already listed) and their inclusion into the medical record should be directed to QI/UR staff.
17. Confidentiality: Do not write another Behavioral Health beneficiary's full name in a beneficiary's medical record. If another Behavioral Health beneficiary must be identified in the record, do not identify them as a Behavioral Health beneficiary unless necessary.
18. Names of family members or support persons should be recorded only when needed to complete intake registration and financial documents; otherwise, refer to the relationship - mother, husband, friend - but do not use names. Providers may use the first name or initials of another person only when needed for clarification.
19. Copy and paste: Do not copy and paste text into a beneficiary's medical record. Content from another document may be inserted as long as it references the original source. Each note needs to be specific to the service provided. Progress notes that appear overly similar might be construed as a duplication of services or containing inaccurate, outdated, or false information; such claims could flag the possibility of fraudulence.

2.2. SIGNATURES

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

If any agency uses an EHR, the electronic signature of the service provider will be accepted and considered valid if the agency has a current and valid "Electronic Signature Certification" form on file with Contra Costa County.

On forms requiring signatures, people in care may either directly sign or give verbal consent. Wet signatures on medication consents for psychotropic medication should be pursued from the beneficiary when they are present at the place of care of the prescribing psychiatrist.

2.2.1. CO-SIGNATURES

Co-signatures for some staff may be required for several reasons:

- DHCS requires that some documents be approved by a licensed clinician.
- County policy requires that some documents be reviewed and co-signed by a supervisor as part of the authorization process.
- Some staff are required to have progress notes co-signed for a period.

Staff should consult with their supervisor for specifics and refer to the most recent CCBHS-MHP Guidelines for Scope of Practice (See Appendix I).

CHAPTER 3. ESTABLISHMENT OF MEDICAL NECESSITY

3.1. THE FLOW OF CLINICAL INFORMATION

As a beneficiary begins services with CCBHS-MHP, there are flows of information to guide staff in providing services to meet a person's mental health needs.

- Clinical assessment organizes and integrates information gathered in various ways, including direct encounters, chart review, and speaking with significant personal and professional people. Mental health symptoms, impairments, and vulnerabilities give way to diagnoses and mental health needs.
- Mental health symptoms, diagnoses, conditions, risk factors, and medical concerns get consolidated into a problem list, which guides treatment.
- Targeted case management care plans, which are formulated into the narrative of progress notes, identify what and how case management services contribute to overall mental health care.
- Interventions documented in the progress note, in turn, reflect elements from the problem list.

3.2. MEDICAL NECESSITY

All Medi-Cal services must be "medically necessary". The definitions of medical necessity are somewhat different based upon the age of the beneficiary. Pursuant to Welfare and Institutions Code section 14184.402(a), 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 set forth in Section 1396d(r)(5) of Title 42. 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, regardless of whether the service is covered under the State Plan. These services need not be curative or restorative, and may be delivered to sustain, support, improve or make more tolerable a mental health condition.

3.3. ACCESS TO SPECIALTY MENTAL HEALTH SERVICES (SMHS)

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 (DHCS Behavioral Health Information Notice No: 21-073). 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. It is important to point out 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.

Criteria for persons aged 21 years of age and older:

- The person has significant impairment in social, occupational, or other important life activities or there is reasonable probability of significant deterioration in important area of life functioning, AND
- The significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5-TR), either diagnosed or suspected.

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
- The person has scored high on the trauma screening tool, placing them at high risk for a mental health disorder (screening tool to be provided in the future by the DHCS), 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, Diagnostic Statistical Manual, Fifth Edition (DSM-5-T.R.), either diagnosed or suspected.

3.4. ASSESSMENT AND OTHER EARLY TREATMENT SERVICES

While the assessment is in process, the beneficiary may also receive clinically appropriate services simultaneous to the assessment services. Appropriate services include prevention, screening, assessment, and treatment services (e.g., therapy, rehabilitation, collateral, case management, medication support) and are covered and reimbursable under Medi-Cal even when:

- Services are provided prior to determination of a diagnosis, during the assessment process, or prior to determination of whether SMHS access criteria are met.
    - 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, a provisional diagnostic impression and corresponding ICD-10 code must be assigned to submit a service claim for reimbursement. There are ICD-10 codes LPHAs may use prior to the determination of a diagnosis – if there is a suspected disorder within the LPHA's scope, "Other Specified" or Unspecified" ICD-10 codes are available. Additionally, the code Z03.89 "Encounter for observation for other suspected diseases and conditions ruled out" may be used.

- As appropriate, LPHAs and non-LPHAs alike may use ICD-10 codes Z55-Z65 “Persons with potential health hazards related to socioeconomic and psychosocial circumstances.

- The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
- Non-specialty mental health services (NSMHS) and specialty mental health services (SMHS) are provided concurrently if those services are coordinated and not duplicative.

3.5. ASSESSMENTS

The goal of an assessment is to understand the person’s needs and circumstances to recommend the best care possible and help the person recover. The assessment must be completed under the guidance of an LPHA. The diagnosis, Mental Status Exam, medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary’s physical and mental health must be completed by a provider, operating in their scope of practice. It may be acceptable in some instances for an MHRS or other qualified staff to offer support to the beneficiary during the assessment process and/or may share information with the treatment team through collaboration. The assessment evaluates the person’s mental health and well-being; it explores the current state of the person’s mental, emotional, and behavioral health and their ability to thrive in their community.

An assessment may require more than one session to complete and/or may require the practitioner to obtain information from other relevant sources, referred to as “collateral information”, such as previous health records or information from the person’s support system to gather a cohesive understanding of the person’s care needs. Services to support the person’s ability to remain safe and healthy in the community are of utmost importance. Therefore, it is important that practitioners ensure that the assessment process begins with risk and safety discussions, then moves on to discuss other matters of urgency to the beneficiary and completes assessment activities by gathering background information that impacts the primary concerns of the beneficiary.

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 MHRS or other qualified staff. Information or results from the tools used should be included as part of the assessment. DHCS requires practitioners to complete an assessment for the determination of behavioral health needs.

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

- Assessments for mental health services for adults aged 21 years and older shall cover all the domains listed in the section below.

- The Child and Adolescent Needs and Strengths (CANS-50) and Pediatric Symptom Checklist (PSC-35) may be used to inform the assessment domain requirements for persons aged 5 through 20 (for CANS) and persons aged 4 through 17 (PSC).
- Assessments for substance use disorders for persons of all ages shall use the American Society of Addiction Medicine (ASAM) criteria when determining level of care.

Central to the completion of a comprehensive assessment is collaboration with the beneficiary. Centering the voice of the beneficiary 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 beneficiary feels seen as a whole person. Assessments must be approached with the knowledge that one's own perspective is full of assumptions, so that staff maintain an open mind and respectful stance towards the beneficiary. Curiosity and reflection indicate humility and a deep desire to truly understand the beneficiary 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 beneficiary, as well as how to best address those needs. The assessment process generates a hypothesis, developed in collaboration with the beneficiary, that helps to organize and clarify service planning.

3.5.1. STANDARDIZED ASSESSMENT REQUIREMENTS

- MHPs shall require providers to use uniform assessment domains as identified below. For persons in care under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool should be used to help inform the assessment domain requirements.
- The initial assessment period for SMHS is 60 days, but circumstances may dictate the need for extension, the length of which is at the discretion of the provider; however, providers shall complete the assessments within a reasonable time and in accordance with generally accepted standards of practice. Subsequent assessments (updates) may be completed as needed but are not required within a set period of time. Level of Care Determination progress notes, however, are required annually starting from the date of the initial assessment. Level of Care Determination notes confirm or deny the ongoing presence of specialty mental health symptoms, subsequent functional impairments or suspicion of impairments, or conditions placing the beneficiary at high risk for a mental health disorder. Assessments and Level of Care Determination notes written by psychiatrists, psychiatric nurse practitioners, and mental health therapists are both valid and satisfy the assessment requirement for both medication and mental health / case management services to be provided over the course of the year. Assessment updates CANS and PSC-35 are additional assessment tools also required; they are required at episode opening and every six months thereafter until termination.
- Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of appropriate level of care are covered and reimbursable, even if the assessment ultimately indicates the person does not meet criteria for SMHS.

- The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.
- The assessment shall include the provider's recommendation for treatment modalities along with determination of appropriate level of care. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.
- 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.
- Other credentialed (Community Support Workers, Designated Mental Health Workers, Mental Health Rehab Specialists, and Peer Support Providers), qualified providers may 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.

3.5.2. ASSESSMENT DOMAIN REQUIREMENTS

The assessment contains universally required domains. Below is information on the standardized domains comprising the assessment for understanding the person's care needs. Include the perspective of the beneficiary and, as apropos, use their quotes within the document. 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. This may include information from additional sources.

DOMAIN 1: PRESENTING PROBLEM/CHIEF COMPLAINT

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 beneficiary. 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.

DOMAIN 2: TRAUMA

Domain 2 involves information on traumatic incidents, the beneficiary's reactions 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

beneficiary — 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.

DOMAIN 3: BEHAVIORAL HEALTH HISTORY

Domain 3 focuses on 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.

DOMAIN 4: MEDICAL HISTORY AND MEDICATIONS

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 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).

DOMAIN 5: PSYCHOSOCIAL FACTORS

Domain 5 supports clinicians in understanding the environment in which the beneficiary 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

DOMAIN 6: STRENGTHS, RISK AND PROTECTIVE FACTORS

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 beneficiary 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.

DOMAIN 7: CLINICAL SUMMARY, TREATMENT RECOMMENDATIONS, LEVEL OF CARE DETERMINATION

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

- Clinical Impression – integrated narrative summary of clinical symptoms consistent with diagnostic impression, related functional impairments, 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 diagnostic uncertainty (rule-outs, provisional, or unspecified), and comorbid diagnoses
- Treatment Recommendations – recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care.

DIAGNOSIS

Information for the determination of a diagnosis is obtained through a clinical assessment and may include a series of structured tools. Information may come directly from the beneficiary as well as 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 American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5-TR).

Diagnoses are determined by a Licensed Practitioner of Healing Arts (LPHA) (including licensed and registered/waivered psychologists, clinical social workers, marriage and family therapists, psychiatrists, nurse practitioners) commensurate with their scope of practice. Diagnoses are used to communicate with other team members the person's mental health symptoms and other conditions as they inform level of distress and impairment. Diagnoses may help practitioners advise the beneficiary about treatment options. Diagnoses should shift in response to changes in clinical presentation. It is a practitioner's responsibility to keep them current.

Specialty Mental Health providers are no longer limited to a list of State-determined "included" diagnoses, but instead by a much broader list of ICD-10 codes recognized by the Center for Medicare and Medicaid Services. Providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established:

- ICD-10 Z codes, primarily 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--and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP 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. LPHA may use any clinically appropriate ICD-10 code. For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.”

As a point of clarification, a mental health disorder diagnosis is not required to receive medically necessary SMHS. However, ICD diagnostic codes are required on claims for DHCS to receive federal financial participation. Z codes meet the federal requirement for claims and do not indicate a diagnosis of a mental health disorder or a substance use disorder (see DHCS Behavioral Health Information Notice [BHIN] 22-013).

Z codes may be used during the assessment phase of a beneficiary's treatment, including before a mental health disorder diagnosis has been established. Z codes may be used after the assessment phase, including after a mental health disorder has been established. Z codes can also be used after the assessment phase even if a mental health disorder diagnosis has not been established, as a mental health disorder diagnosis is not a prerequisite to receive medically necessary SMHS as set forth in W&I Code section 14184.402(f)(1)(A). This is especially relevant for medically necessary SMHS provided to beneficiaries under age 21, for whom access criteria to SMHS includes the ability to receive medically necessary SMHS based on *high risk for a mental health disorder* due to the experience of trauma as specified in BHIN 21-073.

All SMHS must be medically necessary. The assessment or other documentation in the medical record should substantiate the use of a Z code. Please refer to the CMS coding guidelines for additional information about Z codes, including when Z codes may be used as a primary diagnosis.

For additional information about the criteria for beneficiaries to access Specialty Mental Health Services, please refer to BHIN 21-073.

CHAPTER 4: TREATMENT—PROBLEM LISTS AND TREATMENT PLANS

4.1. THE PROBLEM LIST

The use of a Problem List has largely replaced the use of treatment plans, except where federal requirements mandate that 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 beneficiary, 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.

Treatment teams (medical and behavioral health alike) can use the problem list to quickly gain necessary information about beneficiary concerns; how long the issue has been present; the name and credential of the practitioner who recorded the concern; and track the issue over time.

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 DSM diagnosis codes, including Z codes.

4.1.1. PROBLEM LIST REQUIREMENTS

The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary. 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 DSM if applicable).
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the beneficiary 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. 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 should be updated 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 programs.

Sample Problem List

Problem (Provide diagnostic narrative; or list symptoms, conditions, and/or risk factors)	DMS-5 and ICD-10 code (if applicable)	Problem Identified By (Name & Credentials)	Date Problem Identified	Date Problem Resolved / Deleted	Removed by (Name and Credentials)
Problem related to unspecified psychosocial circumstances	Z65.9	[Name], Mental Health Rehabilitation Specialist	7/1/2022	7/19/2022	[Name], LCSW
Unsheltered homelessness	Z59.02	[Name], Substance Use Counselor	7/1/2022	Current	
Food insecurity	Z59.41	[Name], Peer Support Specialist	7/1/2022	Current	
Insufficient social insurance and welfare support	Z59.77	[Name], Peer Support Specialist	7/1/2022	Current	
Major Depressive Disorder recurrent, severe with psychotic features	F33.3	[Name], MD, Psychiatrist	7/19/2022	Current	
Alcohol Use Disorder, unspecified	F10.99	[Name], LCSW	7/19/2022	Current	
Hypertension	I10	[Name], DO, Primary Care Physician	7/25/2022	Current	
Personal history of unspecified abuse in childhood	Z62.819	[Name], LCSW	8/16/2022	Current	

4.2. TREATMENT PLANNING

4.2.1. TARGETED CASE MANAGEMENT (TCM)

TCM 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 beneficiary
- Includes activities such as ensuring the active participation of the beneficiary 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 beneficiary; and
- Includes development of a transition plan when the beneficiary has achieved the goals of the care plan.

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

4.2.2. PEER SUPPORT SERVICES

Peer support services must be based on an approved plan of care. 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.

4.2.3. ADDITIONAL TREATMENT/CARE PLANNING REQUIREMENTS

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

Sample TCM plan note comments (portion of the progress note):

- Goals, treatment, service activities, and assistance.

  > To redress social anxiety, this clinician / program will help beneficiary obtain and maintain individual and group psychotherapies, psychiatric services, primary care, school, parental participation in care, and overall coordination of care.

- Activities such as ensuring the active participation of the beneficiary and working with the person.

  > Clinician co-created this TCM plan with the beneficiary. Beneficiary agrees with the plan.

- Course of action.

  > Refer for group therapy for anxiety; refer for psychiatric consult; coordinate care between therapist and psychiatrist. Brainstorm with schoolteachers different ways the school can respond when the beneficiary is anxious. Teach the beneficiary to communicate with parents around medical concerns. Coordinate with parents to attend IEP meetings and meet with therapist for collaboration.

- Transition plan.

  > Transition beneficiary down from Specialty Mental Health Services (SMHS) to Non-specialty Mental Health Services once the beneficiary no longer meets medical necessity for SMH.

4.2.4. OTHER CARE PLANS

Some programs call for formal treatment plans (such as Partnership Plan for Wellness) required by alternate sources of funding, such as Full-Service Providers receiving Mental Health Services Act funds.

- Intensive Care Coordination: Child and Family Team (CFT) Meeting Action Plan – Client Plan of Care.
- Intensive Home-Based Services: Partnership Plan for Wellness.
- Wraparound Services: Child and Family Wraparound Plan.

- Therapeutic Behavioral Services: TBS Treatment Plan.
- Short-Term Residential Treatment Programs (STRTP): treatment plan.

CHAPTER 5: PROGRESS NOTES

Progress notes have multiple functions. First and foremost, progress notes are used as a basis for planning care and treatment among practitioners and across programs. Progress notes are communication tools; as such, each progress note should be understandable when read independent of other progress notes. This means that documentation should provide an accurate picture of the person's condition, treatment, and response to care at the time of the service.

Secondly, progress notes are considered a legal record describing treatment provided for reimbursement purposes. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment.

Lastly, progress notes are also used to communicate with other care providers. For these reasons, abbreviations should be avoided, unless universally recognized, to facilitate clear and accurate communication across providers and for when notes are used for legal or other reasons. Keep in mind that the beneficiary has legal privilege to their medical record and may review the medical record documentation. They should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

The following list denotes characteristics of a progress note that constitutes quality documentation: clean, consistent, descriptive, reliable, accurate / precise, and timely.

5.1. REQUIREMENTS

Each progress note requires the following information:

- Type of service rendered.
- 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 the service was provided.
- Duration of the service, including travel and documentation time.
- Location of the service.
- A typed or legibly printed name, signature of the service provider, and date of signature.
- Valid ICD-10 code and narrative.
- Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- Next steps, including but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

Group progress notes have two further requirements:

- When a group is facilitated by multiple practitioners, a separate progress note is required for each provider. Each note should include a description of what each provider contributes, including information about the specific involvement and amount of time of involvement of each practitioner in the group activity.
- A list of group participant names shall be maintained but not within any individual medical record.

5.2. PROGRESS NOTE TIMELINESS AND FREQUENCY

Documentation should be completed within three business days of the completion of a service. If a note is submitted outside of the three business days, it is good practice to document that the note is delayed along with a reason. Based on the facility/program type, stricter note completion timelines may be required by state regulation (e.g., STRTPs).

Crisis service notes should be completed within 24 hours.

A note should be written for every service. A daily note is required 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/or abuse within the service provision and claiming system. Disallowance 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 manual promote compliance.

Behavioral health need addressed (problem / need, reason / context for contact, clinical impressions)	• What is the need / problem list you address here? • Why are you providing the service and why now? Are you helping to manage a crisis? Obtain basic goods? Have a routine weekly therapy appointment Give context so the note can stand alone. What is going on that the beneficiary needs your help? • What mental status elements are positively present, including symptoms, impairments, or other problem-related factors.
Focus of Activity (type of service rendered; how the service addressed behavioral health need; how the beneficiary responded—symptoms, condition, diagnosis, and/or risk factors	• What interventions did you use? Did you teach them to catch harmful thought patterns? Prioritize and make sound decisions? How to skillfully set limits with peers? • Document in clinical terms as much as possible in accordance with your scope of practice. • What did the beneficiary do in response to your interventions? Did they calm down? Become visibly unsettled or dissociative? Yawn?

Plan (next steps—action steps by provider or beneficiary, collaboration, updates to the problem list…)	• Have you assigned homework? When do you plan to meet next? Are you making a referral? Do you need to speak with their other providers? Do you need to add a new problem to the problem list? Did it occur to you that another strategy might be good to try next session?

CHAPTER 6: BILLING SERVICE TYPES AND CODES

6.1. BILLING CONSIDERATIONS

Direct Patient Care

- You may only bill for direct patient care.
- Direct patient care includes time spent meeting directly with the patient as well as caregivers, significant support persons, or other support people (including professionals such as teachers).
- Some direct patient care codes involving reviewing the chart may be billable in the absence of patient contact.
- It does not include travel time, administrative activities, chart review, documentation, utilization review, quality assurance activities, or other activities prior to, or after, a patient service is provided.

Travel Time

- Time spent traveling to and from a place where services are rendered during which time no services are provided and the patient is not present.
- Should be documented in billing for tracking purposes only. Travel time does get figured into productivity.

Documentation time

- Time spent documenting services, including writing progress notes, assessments, plans, and other documents.
- Like travel time, documentation time should be documented for tracking purposes and will factor into productivity.

Interactive complexity

- Interference by specific communication factors that complicate the delivery of a mental health service.
- Interactive complexity is identified on the billing form for any service that is complicated by any of the four below:
- The need to manage maladaptive communication (high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
- Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan.

- Evidence or disclosure of a sentinel event and mandated report to third party (abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician and the other qualified health care professional and a patient who has not developed, or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

6.2 SERVICE TYPES/CODES FOR LICENSED, BBS-REGISTERED, WAIVERED, AND UNLICENSED STAFF

Note: Please see the following reference tables for service types and codes for licensed, BBS-Registered, waivered, and unlicensed staff:

- Appendix B: CPT Codes for Clinical and Unlicensed Staff
- Appendix D: Quick-Reference Table for Clinical Staff
- Appendix E: Quick-Reference Table for Unlicensed Staff

6.2.1. ASSESSMENT

- Evaluates the current status of a beneficiary's mental, emotional, or behavioral health. It 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.
    - Diagnosis.
    - Use of testing procedures.

ASSESSMENT CODES FOR LICENSED, BBS-REGISTERED, WAIVERED, AND UNLICENSED STAFF

90791 – Psychiatric Diagnostic Evaluation

- An integrated biopsychosocial assessment, including history, mental status, and recommendations.
- Used for initial assessments, reassessments, briefer assessment updates.
- May include communication with family or other sources (if to help with a clinical formulation) and review and ordering of diagnostic studies.

- In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient (in this case, neither mental status exam may be completed, nor diagnosis rendered other than a Z-code). Completion of an initial assessment, however, still will require completion of a mental status exam.
- May be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such circumstances.
- Lockout codes: psychotherapy: psychotherapy may not be billed on the same day as an assessment.

90885 – Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes

- The provider reviews the medical records of the patient pertaining to psychiatric evaluation to help in establishing the diagnosis and treatment plan.
- Can be used when need to review documents for clinical purposes when beneficiary is not present.
- Used when reading charts in the process of assessing a beneficiary new to a provider, or a current beneficiary's new records, such as inpatient hospital discharge forms.

96110 – Developmental Screening

- Screening the patient for a developmental disorder using a standardized instrument (such as a recognized form) focused on areas such as developmental milestones and age–appropriate maturity of speech and language.

96127 – Brief Emotional/Behavioral Assessment

- Brief emotional and/or behavioral assessment of the patient using a standardized instrument (such as a recognized form).
- Used for tools like CANS, ANSA, PHQ-9, etc.

H0031 – Mental Health Assessment by Non-Physician

- Completed as a non-physician member of a multidisciplinary team .
- May involve gathering psychosocial information including the individual's strengths, weaknesses and needs, family background, social supports, as well as historical mental health and/or physical health information.
- Used to inform initial assessment and/or track ongoing progress in treatment.

H2000 – Comprehensive Multidisciplinary Evaluation

- Evaluation of a beneficiary's progress in treatment by a multidisciplinary team.

- May be recorded in a progress note and submitted the for claiming in a progress note by only one participant of the meeting. Others participating in the meeting are considered members/attendees and are not billable participants.
- A case conference may be one example.

6.2.2. PLAN DEVELOPMENT

- One or more of the following:
- Development of beneficiary plans.
- Approval of beneficiary plans.
- Monitoring of a beneficiary's progress.

PLAN DEVELOPMENT CODE FOR LICENSED, BBS-REGISTERED, WAIVERED, AND UNLICENSED STAFF

H0032 – Mental Health Service Plan Developed by Non-Physician

- Used by a non-physician to develop a mental health care plan.
- Development of a plan for services such as Intensive Care Coordination, Wraparound, IHBS, Therapeutic Foster Care, Therapeutic Behavioral Services, and Targeted Case Management.
- May be used for consultation and collaboration amongst professional service-providing colleagues that results in some measure of a plan, even if short-term and informal.
- May be used as a collateral service when meeting with caregivers and/or significant support people to develop a plan of care.

6.2.3. PSYCHOTHERAPY

- Focuses primarily on symptom reduction to diminish stress or make it more tolerable and, in turn, diminish functional impairment.
- It may incorporate the principles of development, wellness, adjustment to impairment, resilience, community, and recovery.
- It may support adaptive modifications to feelings, thought, and behavior, especially as they impact relationships, vocation, education, and other areas of functioning.

PSYCHOTHERAPY CODES FOR LICENSED, BBS-REGISTERED, WAIVERED, AND UNLICENSED STAFF

90832, 90834 & 90837 – Individual Psychotherapy

(90832-- Psychotherapy, 37 Minutes or Less with Client)

(90834 – Psychotherapy, 38-52 Minutes with Client)

(90837 -- Psychotherapy, 53 Minutes or More with Client)

- Includes ongoing assessment and adjustment of psychotherapeutic interventions.

- May include involvement of informants in the treatment process.
- Beneficiary must be present for all or a majority of the service.

90839 – Psychotherapy for Crisis

- Urgent, often expedited psychotherapy during an emergency—a time of distress and/or imminent decompensation threatening stability as a functioning community member.
- Full attention to the patient (though caregivers / family may be present) and, therefore, cannot provide services to any other patient during the same time period.
- May be provided more than once by the same provider on the same day, in which case total direct service duration is added together and billed in one encounter, even if the time spent on that date is not continuous.

90847 – Family Psychotherapy (Conjoint Psychotherapy)

Note: For family therapy without the patient present, use code H0032.

- Counseling for the family on the psychological issues affecting the beneficiary and the family.
- Facilitates evaluation of the treatment plan and role of family members in treatment.

90849 – Multi-Family Group Psychotherapy

- Used when the provider performs a psychotherapy session with a group of patients' families.

90853 – Group Psychotherapy

- Provided to a group of people who are not members of the same family and normally not acquainted with each other but are likely to share similar kinds of psychological issues or need the same type of psychological support.

6.2.4. REHABILITATION

- Activities provided to help beneficiaries or their significant support people develop skills.

REHABILITATION CODES FOR LICENSED, BBS-REGISTERED, WAIVERED, AND UNLICENSED STAFF

H2017 – Psychosocial Rehabilitation

Note: This code is used for both individual and group rehabilitation.

- Assistance in improving, maintaining a beneficiary's functional skills, daily living skills, social skills, grooming and personal hygiene skills, meal preparation skills, and support resources and/or medication education.
- Services to support independence and self-advocacy.
- Training in leisure activities needed to achieve whole person recovery and positive outcomes.

- May be used for collateral when meeting with caregiver/significant support person for the purpose of coaching, skill development as a means to support the beneficiary with managing behavioral health needs.
- May be used for IHBS services when meeting with individual/caregiver/significant support person for the purpose of coaching, skill development as a means to support the individual with managing behavioral health needs.

H2021 – Community-Based Wraparound Services

- Community-based wraparound services refers only to coordination of care between providers in the mental health system and providers who are outside the mental health system. It may only be used to show that a delivery-system coordination of care has occurred.
- For other types of coordination of care, other service codes must be used.
- Wraparound services are used to support the strengths and needs of the beneficiary and the family. Providers use a team approach that includes family members, teachers, natural supports, and other service providers involved in the beneficiary's life. This is an intensive level of services that may be provided in the home or in the community.

6.2.5. CASE MANAGEMENT

- Activities provided by a provider to help a beneficiary access needed services.

CASE MANAGEMENT CODE FOR LICENSED, BBS-REGISTERED, WAIVERED, AND UNLICENSED STAFF

T1017 – Targeted Case Management

- Activities provided by a provider to help a beneficiary access needed medical, educational, social, prevocational, vocational, rehabilitative, or other necessary community services.
- Service activities may include communication, consultation, coordination, linkage and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; and monitoring of the beneficiary's progress.
- Intervention may be with family/caregiver, teacher, social worker, probation officer, volunteers (i.e., Big Brother/Sister, and Coaches), or others.
- Can be used for collateral when meeting with caregiver/significant support person for the purpose of connecting them with resources/community support to address the beneficiary’s needs.
- Inclusive of linkage, placement, and case management plan development.
- It is not locked out against residential or inpatient if it is provided 30 days prior to discharge, though services during this period should address placement-related needs.

MISCELLANEOUS CODES FOR LICENSED, BBS-REGISTERED, WAIVERED, AND UNLICENSED STAFF

H2011 – Crisis Intervention Service

- Interventions requiring urgent response to emergencies that threaten further decompensation, distress, and/or loss of stabilization as a functioning community member lasting less than 24 hours, which requires more timely response than a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program.
- Services include assessment, collateral, therapy, record review and referral.
- Maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours.

H2019 – Therapeutic Behavioral Services

- Intensive, individualized, one-to-one behavioral health service available to beneficiaries under age 21 with serious emotional challenges and their families.
- Adjunctive program that supports other services patients,
- Can include functional behavioral analysis, development of a TBS plan, and direct interventions.

H0033 – Oral Medication Administration, Direct Observation

- Used for observation only and does not involve any handling of medications.
- Not locked out against residential services.

90887 – Interpretation or Explanation of Results of Psychiatric or Other Medical Examination and Procedures, or Other Accumulated Data to Family or Other Responsible Persons or Advising them How to Assist Patient

- To explain, educate, and advise families, caregivers, support persons on beneficiary's care and treatment. This can include how to support beneficiaries in their recovery, decreasing symptoms, and increasing strengths.
- Beneficiary's presence is not required.
- This is an adjunctive service that is not used independently,
- Indicate if this service was provided to a primary service code.
- May be used for what was formerly termed collateral services.

6.2.5. SERVICES THAT NO LONGER HAVE DISCRETE SERVICE TYPES

COLLATERAL SERVICES

- A former service code including services provided to caregiver / support people of the beneficiary to provide psychoeducation, explain the treatment plan, provide some skill building, and other collaborative services as needed.

Codes Used to Document Collateral Services

- 90791 – Used when meeting with caregiver/significant support person to gather information to inform an assessment/re-assessment.
- 90887 –Used to explain, educate, and advise families, caregivers, support persons on beneficiary's care and treatment.
    - **NOTE:** Cannot be used with 90791
- H2017 – Used when meeting with caregiver/significant support person for the purpose of coaching, skill development as a means to support the beneficiary with managing behavioral health needs.
- H0032 – Used when meeting with caregiver/significant support person to develop a care plan and/or monitoring of a beneficiary's progress
- T1017 – Used when meeting with caregiver/significant support person for the purpose of connecting them with resources/community supports to address the beneficiary's needs.

PATHWAYS TO WELL-BEING (KATIE A. SERVICES)

- Intensive Home-Based Services and Intensive Care Coordination are no longer documented using a distinct procedure code.
- When documenting these services, providers should select the service code that most closely fits the service provided and the required modifier for these services will be applied in the background.

EXAMPLES OF CODES USED TO DOCUMENT PATHWAYS TO WELLBEING (KATIE A.) SERVICES

- 90791 – Used when meeting with caregiver/significant support person to gather information to inform an assessment/re-assessment.
- H2017 – Used when meeting with caregiver/significant support person for the purpose of coaching, skill development as a means to support the beneficiary with managing behavioral health needs.
- H0032 – Used when meeting with caregiver/significant support person to develop a care plan/beneficiary plan.

6.3. SERVICE TYPES AND CODES FOR MEDICAL STAFF

Note: Please see the following reference tables for service types and codes for medical staff:

- Appendix E: CPT Codes for Medical Staff
- Appendix F: Quick-Reference Table for Medical Staff

6.3.1. ASSESSMENT

- Evaluates the current status of a beneficiary's mental, emotional, or behavioral health. It 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.
- Diagnosis.
- Use of testing procedures.

ASSESSMENT CODES FOR MEDICAL STAFF

90792 – Psychiatric Diagnostic Evaluation with Medical Services

- Integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations.
- May include communication with family or other sources, prescription of medications, and review and ordering of laboratory and other diagnostic studies.
- In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient though this doesn't fully satisfy the requirement to complete a full assessment until it includes a mental status examination and more informed diagnosis.
- May be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such circumstances.
- Code 90792 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient.

90885 – Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes

- Provider reviews the medical records of the patient pertaining to psychiatric evaluation to help in establishing the diagnosis and treatment plan.
- Not for planning or preparation purpose.
- Can be used when need to review documents for clinical purposes when beneficiary is not present.

96127 – Brief Emotional / Behavioral Assessment

- Brief emotional/behavioral assessment of the patient using a standardized instrument (such as a recognized form).
- Used for tools like CANS, ANSA, PHQ-9, etc.
- T1001 – Nursing Assessment/Evaluation
- Nursing staff, including LPT's, evaluate the current status of mental, emotional, or behavioral health of a beneficiary.
- Nursing staff gathers information to contribute to the overall assessment.

H0031 – Mental Health Assessment by Non-Physician

- Completed as a non-physician member of a multidisciplinary team.
- May involve gathering psychosocial information including the individual's strengths, weaknesses and needs, family background, social supports, as well as historical mental health and/or physical health information.
- Used to inform initial assessment and/or track ongoing progress in treatment.

H2000 – Comprehensive Multidisciplinary Evaluation

- Evaluation of a beneficiary's progress in treatment by a multidisciplinary team.
- May be recorded in a progress note and submitted the for claiming in a progress note by only one participant of the meeting. Others participating in the meeting are considered members/attendees and are not billable participants.
- One example is a case conference.

6.3.2. MEDICATION SUPPORT

MEDICATION SUPPORT CODES FOR MEDICAL STAFF

Note: May not be billed with 90792.

- Evaluation and management service
- Differentiated by new patient and established patient
- Includes services such as a follow-up appointment, medication evaluation and/or refill
- Qualified providers usually include physician, nurse practitioner, or clinical nurse specialist
- In contrast with new patients, an established patient has been seen by the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years
- Home visits are provided at the residence.

96372 – Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular

- A therapeutic, prophylactic, or diagnostic substance given via an injection.
- Procedure performed by a physician or by an assistant or nurse under direct supervision of the physician.

H0034 – Medication Training and Support

- Used by a medical staff to train the beneficiary, family, and other personal supports in the appropriate use and understanding of prescribed medication; potential drug interactions; and potential side effects.
- LPT's may use this code when giving injections.

- Used for esketamine observation.

6.3.3. OFFICE OR OTHER OUTPATIENT VISITS

OFFICE OR OTHER OUTPATIENT SERVICES CODES FOR AN ESTABLISHED PATIENT FOR MEDICAL STAFF

99212 – Office or Other Outpatient Visit of an Established Patient, 19 Minutes or Less

- Requires straightforward level medical decision-making and/or the provider spends 19 minutes or less of total time on the encounter on a single date. Medication refill may be billed if the beneficiary is present.

99213 – Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes

- Requires low level of medical decision-making and/or the provider spends 20-29 minutes of total time on the encounter on a single date. Medication refill may be billed if the beneficiary is present.

99214 – Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes

- Requires moderate level of medical decision-making and/or the provider spends 30-39 minutes of total time on the encounter on a single date

99215 – Office or Other Outpatient Visit of an Established Patient, 40 Minutes or More

- Involves high level of medical decision-making and/or the provider spends 40 minutes or more of total time on the encounter on a single date

OFFICE OR OTHER OUTPATIENT VISIT OF A NEW PATIENT FOR MEDICAL STAFF

99202 – Office or Other Outpatient Visit of a New Patient, 29 Minutes or Less

- Straightforward medical decision-making and/or the provider spends 29 minutes or less of total time on the encounter on a single date.

99203 – Office or Other Outpatient Visit of a New Patient, 30-44 Minutes

- Low level of medical decision-making and/or the provider spends 30–44 minutes of total time on the encounter on a single date.

99204 – Office or Other Outpatient Visit of a New Patient, 45-59 Minutes

- Moderate level of medical decision-making and/or the provider spends 45–59 minutes of total time on the encounter on a single date.

99205 – Office or Other Outpatient Visit of a New Patient, 60 Minutes or More

- High level of medical decision-making and/or the provider spends 60 minutes or more of total time on the encounter on a single date.

6.3.4. HOME VISITS

HOME VISIT OF A NEW PATIENT FOR MEDICAL STAFF

99341 – Home Visit of a New Patient, 29 Minutes or Less

- Straightforward medical decision-making and/or the provider spends 29 minutes or less of total time on the encounter on a single date.

99342 – Home Visit of a New Patient, 30-59 Minutes

- Low level of medical decision-making and/or the provider spends 30–59 minutes of total time on the encounter on a single date.

99344 – Home Visit of a New Patient, 60-74 Minutes

- Moderate level of medical decision-making and/or the provider spends 60–74 minutes of total time on the encounter on a single date.

99245 – Home Visit of a New Patient, 75 Minutes or More

- High level of medical decision-making and/or the provider spends 60 minutes or more of total time on the encounter on a single date.

HOME VISIT OF AN ESTABLISHED PATIENT FOR MEDICAL STAFF

99347 – Home Visit of an Established Patient, 29 Minutes or Less

- Straightforward medical decision-making and/or the provider spends 29 minutes or less of total time on the encounter on a single date.

99348 – Home Visit of an Established Patient, 30-39 Minutes

- Low level of medical decision-making and/or the provider spends 30–39 minutes of total time on the encounter on a single date.

99349 – Home Visit of a New Patient, 40-59 Minutes

- Moderate level of medical decision-making and/or the provider spends 40–59 minutes of total time on the encounter on a single date.

99350 – Home Visit of a New Patient, 60 Minutes or More

- High level of medical decision-making and/or the provider spends 60 minutes or more of total time on the encounter on a single date.

6.3.5. PLAN DEVELOPMENT

Plan Development consists of one or more of the following:

- Development of beneficiary plans.
- Approval of beneficiary plans.

PLAN DEVELOPMENT CODE FOR MEDICAL STAFF

H0032 – Mental Health Service Plan Developed by Non-Physician

- Used by a non-physician to develop a mental health care plan

- Includes Intensive Care Coordination (ICC-CFT), Wraparound, IHBS Partnership Plan, Therapeutic Foster Care, Therapeutic Behavioral Services, and Targeted Case Management
- May be used for consultation and collaboration amongst professional service-providing colleagues that results in some measure of a plan, even if short-term and informal
- May be used as a collateral service when meeting with caregivers / significant support people to develop a plan of care
- Used for services pertaining to Clozaril labs.

6.3.6. CASE MANAGEMENT

- Activities provided by a provider to help a beneficiary access needed services.

CASE MANAGEMENT CODE FOR MEDICAL STAFF

T1017 – Targeted Case Management

- Activities provided by a provider to help a beneficiary access needed medical, educational, social, prevocational, vocational, rehabilitative, or other necessary community services.
- Service activities may include communication, consultation, coordination, linkage, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; and monitoring of the beneficiary's progress.
- Intervention may be with family/caregiver, teacher, social worker, probation officer, volunteers (i.e., Big Brother/Sister, and Coaches), or others.
- May be used when a psychiatrist refills medication in the absence of the beneficiary. Can be used for collateral when meeting with caregiver/significant support person for the purpose of connecting them with resources/community support to address the beneficiary's needs.
- Inclusive of linkage, placement, and case management plan development.
- It is not locked out against residential or inpatient if it is provided 30 days prior to discharge, though services during this period should address placement-related needs.

MISCELLANEOUS CODES FOR MEDICAL STAFF

99451 – Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician

- Used by a physician when requested to provide an opinion or treatment recommendation.
- Time may include reviewing beneficiary records, consult via telephone, telehealth, or email, and providing a written report to the requesting health care professional.
- Does not require direct interaction with the beneficiary.

H2011 – Crisis Intervention Service

- Interventions requiring urgent response to emergencies that threaten further decompensation, distress, and/or loss of stabilization as a functioning community member
- Lasting less than 24 hours which requires more timely response than a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program
- Services include assessment, collateral, therapy, record review and referral.
- Maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours

H0033 – Oral Medication Administration, Direct Observation

- Used for observation only and does not involve any handling of medications.
- Not locked out against residential services.

CHAPTER 7: DISCHARGE SUMMARY AND TRANSITION OF CARE TOOL

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

7.1. MINIMUM ELEMENTS FOR DISCHARGE SUMMARY

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

- Discharge Diagnosis (ICD-10 Code with primary DSM-5-TR diagnosis narrative).
- Dates of Treatment.
- Referral Source (Reason for Admission/Presenting Problem).
- Discharge Medication (if applicable).
- Allergies.
- Outcome (Summary of treatment goals/progress made towards goals).
- Post Discharge needs/plans.
- Referrals made.

If a Transition of Care tool has been completed, the Discharge Summary need not cover any of the elements addressed in the Transition of Care Tool.

7.2. TRANSITION OF CARE TOOL

When a patient transitions from one level of care (mental health delivery system) to another, a universal transition care tool must be completed. This most typically would be in the case of a patient stepped down in care, e.g., from a Specialty Mental Health program to Non-Specialty Mental Health network provider or primary case provider. The following comprises the fundamental elements:

- Behavioral health diagnosis
- Supporting clinical documentation
- Cultural and linguistic requests
- Presenting symptoms/behaviors
- Current environmental factors
- Brief behavioral health history
- Brief medical history
- Current medications dosage

CHAPTER 8: NONBILLABLE SERVICES

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

8.1. NON-REIMBURSABLE SERVICES

The following services are not Medi-Cal reimbursable:

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

- Supervision of clinical staff or trainees is not reimbursable because it does not center on beneficiary care (i.e., development of personal insight that may be impacting clinician's work with the beneficiary).
- Utilization management, peer review, or other quality improvement activities.
- Interpretation/Translation; however, an intervention in another language may be claimed.
- Money Management services (i.e., cashing checks, bringing money, buying clothes for the beneficiary).
- Providing transportation ONLY:
    - **NOTE**: "Travel" is not "Transportation."
    - Travel involves the provider going from his/her "home office", to the location where a service will be provided.
    - Transportation involves the provider taking the beneficiary/family from one location to another.
    - If a "behavioral health service" is provided during the time a provider is transporting the beneficiary/family, then the time spent providing the service is not "transportation" and that portion of service time may be claimed.

8.2. EXAMPLES OF NONBILLABLE SERVICES VERSUS BILLABLE SERVICES:

Academic/Educational Situations:

- **Reimbursable:** Sitting with the beneficiary during class and redirecting beneficiary's focus when beneficiary is unable sit still.
- **Not Reimbursable**: Assisting the consumer with his/her homework.
- **Not Reimbursable**: Teaching the beneficiary how to type.

Recreational Situations:

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

Vocational Situations:

- **Reimbursable**: Assisting the beneficiary in learning how to apply for jobs.
- **Not Reimbursable**: Visiting the consumer's job site to teach him/her how to use a cash register.

Travel/Transportation Situations:

- **Reimbursable:** Driving to a beneficiary's home to provide a service – travel time is added to the service time if the beneficiary is there and the service is provided.

- **Reimbursable:** Providing supportive interaction with a beneficiary while accompanying the beneficiary from one place to another in a vehicle. Claimable time is limited to time spent interacting.
- **Not Reimbursable:** Taking a beneficiary to a doctor's appointment and not providing any service other than driving or sitting and waiting with the beneficiary.

Money Management/Budgeting Situations:

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

CHAPTER 9: LOCKOUTS AND LIMITATIONS

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

• Jail • Juvenile Hall (not adjudicated) • Institutes for Mental Disease (IMD) • Mental Health Rehab Center (MHRC)	No service activities are reimbursable if the beneficiary resides in one of these settings (except for the day of admission and discharge).
• Psychiatric Inpatient	No service activities are reimbursable if the beneficiary resides in one of these settings (except for the day of admission and discharge). Exception: Case Management Placement (541) for placement related services provided 30 days prior to discharge.
• Crisis Residential Treatment • Hope House	No service activities are reimbursable if the beneficiary resides in one of these settings (except for the day of admission and discharge). Exception: Medication Support Services (if within scope of practice) and Case Management services are billable.
• Katie A: ICC Services • Hospital • Psychiatric Health Facilities • Psychiatric Nursing Facilities	No service activities are reimbursable if the beneficiary resides in one of these settings. Exception: Can bill for ICC services for placement related services provided 30 days prior to discharge.
• Katie A: IHBS Services • Group Homes / STRTP limitations	IHBS services are not permitted during the same hours of the same day as day treatment, group therapy, TBS, or TCM.
• Limits for Medication Support Services	The maximum amount claimable for Medication Support Services for a beneficiary in a 24-hour period is 4 hours and is based on staff time and is not program specific.
• Limits for Crisis Intervention	The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours and is based on staff time and is not program specific.
• Limits for Day Treatment	Mental Health services are not reimbursable if provided by the same Day Treatment staff during the same time that Day Treatment services are being provided.

CHAPTER 10. SCOPE OF PRACTICE/ COMPETENCE/ WORK

Staff must only provide services that are within their scope of practice and scope of competency.

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

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

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

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

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

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

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

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

10.1.1. CCBHS-MHP PROFESSIONAL CLASSIFICATIONS AND LICENSES

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

AA, Bachelor's, and/or Accrued Experience	
Title	**Definitions/Characteristics**
MHRS (Mental Health Rehabilitation Specialist)	• Possesses a bachelor's degree (BS or BA) in a mental health related field and a minimum of four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. • Or, an associate arts degree and a minimum of six (6) years of experience in a mental health setting. • Or, graduate education may be substituted for the experience on a year-for-year basis. For example, someone with a bachelor's degree, 2 years of graduate school, and 2 years of experience in a mental health setting can qualify to be an MHRS.
Designated Mental Health Worker (DMHW)	Other direct service staff providing beneficiary support services who does not meet any of the other specified licensure or classification definitions or characteristics, i.e., Staff without BA/BS and 4 years' experience, or with an AA & and 6 years' experience.
Certified Peer Support Specialist	A DMHW who: • Is at least 18 years of age with a high school diploma or equivalent degree. • Has successfully completed DHCS-approved curriculum and training requirements for Certified Peer Support Specialists. • Has passed a DHCS-approved certification examination for Certified Peer Support Specialist. • Possesses a NPI number with a valid taxonomy.

Graduate School (pre-master's or pre-doctoral)	
Title	**Definitions/Characteristics**
Psychologist Intern (pre-Doctoral)	• Completed academic courses but have not been awarded their doctoral degree. • Completing one of the final steps of clinical training, which is one year of full-time work in a clinical setting supervised by a licensed psychologist. • Intern status requires a formal agreement between the student's school and the licensed psychologist that is providing supervision.
Psychologist Trainee (pre-Doctoral)	• In the process of completing a qualifying doctoral degree. • Often called "Practicum Students." • Receiving academic credit while acquiring "hands-on" experience in psychology by working within a variety of community agencies, institutions, businesses, and industrial settings. • Supervised by a licensed psychologist.
MSW Trainees	• In the process of completing an accredited Master of Social Work program. • Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. • Completing clinical hours as part of their graduate school internship field placement.
MFT Trainee	• In the process of completing a qualifying doctorate or master's program. • Not officially registered with the CA Board of Behavioral Sciences (BBS); does not have a BBS registration certificate or number. • Completing clinical hours as part of their graduate school trainee practicum course.

Post-Master's, Pre-License (Interns), Post-Doctorate (Waivered)	
Title	**Definitions/Characteristics**
ASW (Associate Social Worker)	• Completed an accredited Master of Social Work (MSW) program. • In the process of obtaining clinical hours towards a LCSW license • Registered with the CA Board of Behavioral Sciences (BBS) as an ASW • Possesses a current BBS registration certificate (which contains a valid BBS registration number)

AMFT (Associate Marriage and Family Therapist)	• Completed a qualifying doctorate or master's degree. • In the process of obtaining clinical hours towards an MFT license • Registered with the CA Board of Behavioral Sciences (BBS) as an IMF (this is the official BBS title, but it is interchangeable with AAMFT) • Possesses a current BBS registration certificate (which contains a valid BBS registration number)
Psychologist (Waivered)	• Issued a waiver by the State of CA Department of Mental Health to practice psychology in CA. Possess valid waiver. • Waiver is limited to 5 years.
APCC (Associate Professional Clinical Counselor)	• Completed a qualifying doctorate or master's degree. • In the process of obtaining clinical hours towards a LPCC license • Registered with the CA Board of Behavioral Sciences (BBS) as an APCC • Possessed a current BBS registration certificate (which contains a valid BBS registration number)

Licensed	
Title	**Definitions/Characteristics**
Psychologist (Licensed)	• Licensed by the CA Board of Psychology • Possesses a current CA Board of Psychology license certificate (which contains a valid license number)
LCSW (Licensed Clinical Social Worker)	• Licensed by the CA Board of Behavioral Sciences (BBS) • Possesses a current BBS license certificate (which contains a valid BBS license number)
LMFT (Licensed Marriage and Family Therapist)	• Licensed by the CA Board of Behavioral Sciences (BBS) • Possesses a current BBS license certificate (which contains a valid BBS license number)
LPCC (Licensed Professional Clinical Counselor)	• Licensed by the CA Board of Behavioral Sciences (BBS) • Possesses a current BBS license certificate (which contains a valid BBS license number)
LPCC with Restricted license	• Licensed by the CA Board of Behavioral Sciences (BBS) • Possesses a current BBS license certificate (which contains a valid BBS license number) • Has not met the required hours to assess and treat couples and families.

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

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

Medical	
Title	**Definitions/Characteristics**
Registered Nurse (RN)	• Registered with the California Board of Registered Nursing (BRN)
Clinical Nurse Specialist (CNS/MSN)	• RN with a master's degree in an area of specialization and certification by BRN.
Psychiatric /Mental Health Nurse	• CNS with a specialization in Psychiatry/Mental Health, certified by BRN.
Nurse Practitioner (NP)	• RN who has completed a Nurse Practitioner program, certified by BRN.
Licensed Psychiatric Technician (LPT)	• Licensed by California Board of Vocational Nursing and Psychiatric Technicians
Physician (MD)	• Licensed by the Medical Board of California

CHAPTER 11. MEDICATION CONSENTS

11.1. MEDICATION CONSENT REQUIREMENTS

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

11.1.3. MEDICATION CONSENT REQUIREMENTS

- Consent must be signed/dated by beneficiary agreeing to each prescribed medication.
- Consent must include the following:
    - Signature (or verbal equivalent) and Licensure/Date of Prescriber.
    - Reason for taking medication.
    - Reasonable for alternative treatments.
    - Type of medication.
    - Range of frequency.
    - Dosage.
    - Method of administration.
    - Duration of taking the medication.
    - Probable side effects.
    - Possible side effects, if taken for longer than three months.
- Consents may be withdrawn at any time.

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

11.2. MEDICATION DOCUMENTATION GUIDELINES

11.2.1. ASSESSMENTS

CCBHS-MHP currently requires an initial assessment within a reasonable assessment period upon episode opening. Assessment updates are required every two years. The completed

assessment of a licensed or license-eligible clinician or Nurse Practitioner with specialty certification in Psychiatry may be substituted for the psychiatric assessment. (Please refer to CCBHS-MHP Policy and Procedure 706-MH and 709-MH)

11.2.2 MEDICATION SUPPORT SERVICES

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

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

TIME CLAIMING LIMITATIONS FOR MEDICATION SUPPORT

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

CHAPTER 12: SPECIAL POPULATIONS

12.1. PATHWAYS TO WELLBEING (FORMERLY KATIE A. SUBCLASS)

As set forth in the Katie A. Settlement Agreement, there are children and youth who need a host of mental health services in their own home, family setting, or the most home-like setting suited to their needs, to facilitate reunification and to facilitate safety, permanence, and well-being.

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

These services are provided to children/youth who:

- Are full scope Medi-Cal (Title 9) eligible.
- Meet Specialty Mental Health Services (SMHS) access criteria as set forth in BHIN 21-073 (which supersedes CCR, title 9, sections 1830.205 and 1830.210).
- One of the two items below:
    - Currently being considered for: Wraparound, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to therapeutic behavioral services or crisis stabilization/intervention (see definitions listed in glossary).
    - Currently in or being considered for STRTP, a psychiatric hospital, or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs.

12.1.2. INTENSIVE CARE COORDINATION (ICC)

Intensive Care Coordination (ICC) is similar to activities routinely provided in Case Management. ICC, however, must be delivered using a Child/Youth/Child and Family Team (CFT) to develop and guide the planning and service delivery process. ICC typically requires more frequent and active participation by the ICC Coordinator to ensure that the needs of the child/youth are being met.

12.1.3. INTENSIVE HOME-BASED SERVICES (IHBS)

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

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

12.1.4. RESTRICTIONS FOR ICC & IHBS SERVICES

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

12.2. THERAPEUTIC BEHAVIORAL SERVICES (TBS) CLASS

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

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

12.2.1. TBS SERVICES

Therapeutic behavioral services (TBS) are an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health service. TBS is an intensive one-to-one, short-term outpatient treatment intervention.

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

TBS INTERVENTION

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

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

TBS COLLATERAL

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

TBS ASSESSMENT

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

TBS PLANS

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

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

CHAPTER 13: WORDING SAMPLES

13.1. SAMPLE STRENGTHS

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

Motivated to change	Has a support system –friends, family, etc.
Employed/does volunteer work	Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
Intelligent, artistic, musical, good at sports	Acknowledges mental health diagnosis or symptoms
Sees value in taking medications	Assess reasons for symptoms of anxiety
Explore triggers/situations	Refer for medication evaluation to address
Discuss benefits of taking medication	Encourage reading on subject of anxiety
Discuss how medication is helping	Has a spiritual program/connected to church
Good physical health	Adaptive coping skills
Capable of independent living	Interested in restoring relationships

13.2. SAMPLE INTERVENTION WORDS

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

13.3. SAMPLE INTERVENTION PHRASES FOR SPECIFIC PSYCHIATRIC SYMPTOMS AND CONDITIONS

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

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

SUBSTANCE USE/ABUSE (impulsivity, poor judgment, mood disorder)	
Explore how mental health symptoms lead to drugs/alcohol	Refer for physical exam to primary care physician

Encourage follow up with physician	Support and encourage evaluation for psychotropic medication
Discuss benefits/effectiveness of medication	Encourage participation in appointments with psychiatrist
List/identify negative consequences of substance use/abuse and establish replacement behavior	Educate on consequences of substance use on mental health
Encourage to remain open to discussion around denial/acceptance	Refer to inpatient/outpatient program
Facilitate/explore understanding of risk factors	List positive aspects of using adaptive replacement behavior (to maintain sobriety)
Reinforce development of substance free relationships	Review effects of negative peer influences
Encourage exercise and social activities that do not include substances	Encourage positive change in living situation
Identify positive aspects of sobriety on family unit/social support system	Explore effects of self-talk
Reframe negative self-talk	Assess stress management skills
Teach stress management skills	Reinforce use of stress management skills
Explore effective after-Beneficiary Plan	

TRAUMA	
Work together on building trust	Explore issues around trust
Teach/explore trust in others	Research family dynamics and how they play out
Explore effects of childhood experiences	Encourage healthy expression of feelings
Encourage use of journaling	Encourage outside reading on trauma
Explore how trauma impacts parenting patterns	Educate on dissociation as a coping response
Explore history of dissociative experiences	Support confronting of perpetrator

Utilize empty-chair exercise to work through trauma	Explore/identify benefits of forgiveness
Explore roles of victim and survivor and how they are playing out	

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

DEPRESSION	
Assess history of depressed mood	Identify symptoms of depression
Identify what behaviors associated with depression	Explore/assess level of risk
Assess/monitor suicide potential and risk	Teach and identify coping skills to decrease suicide risks
Identify patterns of depression	Encourage journaling feelings as coping skill
Identify support system	Develop WRAP plan
Encourage use of WRAP plan	Encourage/reinforce positive self-talk

Explore issues of unresolved grief/loss	Teach/identify coping skills to manage interpersonal problems
Reinforce/recommend physical activity	Monitor and encourage self-care (hygiene/grooming)
Normalize feelings of sadness and responses	Explore potential reasons for sadness/pain
Connect anger/guilt with depression	

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

BIPOLAR DISORDER	
Explore symptoms concerning bipolar disorder	Educate on mania and depression
Use reflection to identify mania/depression behaviors	Educate on risky behaviors associated with mania
Explore behaviors associated with mania	Identify coping skills
Identify early warning signs and energy levels	Explore grandiosity
Encourage/discuss effectiveness of medication	Encourage participation in appointments with psychiatrist

Identify effects of stress on psychiatric symptoms	Identify/discuss issues of impulsivity
Discuss consequences of impulsivity	Model/reinforce effective communication
Utilize cognitive reframe	Encourage education on bipolar disorder

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

APPENDICES

APPENDIX A: TITLE 9 SERVICE DEFINITIONS

TITLE 9.

CALIFORNIA CODE OF REGULATIONS

Chapter 11.

Medi-Cal Specialty Mental Health Services

Assessment (§1810.204)

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

Plan Development (§1810.232)

"Plan Development" means a service activity which consists of development of beneficiary plans, approval of beneficiary plans, and/or monitoring of a beneficiary's progress.

Mental Health Services (§1810.227)

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

Therapy (1810.250)

"Therapy" means a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

Rehabilitation (§1810.243)

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

Collateral (§1810.206)

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

Medication Support Services (§1810.225)

"Medication Support Services" means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent,

medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Crisis Intervention (§1810.209)

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

Case Management (§1810.249)

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

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

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

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

APPENDIX B: CPT CODES FOR CLINICAL AND UNLICENSED STAFF

These CPT codes may be used by licensed/registered/waivered (CPT codes and HCPCS codes) and non-registered (HCPCS codes only) staff.

Code	Code Description	Psychologist/ Waivered Psychologist	LMFT & LPCC (Licensed & Registered)	LCSW (Licensed & Registered)	Mental Health Rehab Specialist (& Trainees)	Certified Peer Support Specialist	Other Qualified Provider	Type of Service
90791	Psychiatric Diagnostic Evaluation	X	X	X				Assessment Codes
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes	X	X	X				Assessment Codes
96110	Developmental Screening	X	X	X				Assessment Codes
96127	Brief Emotional/Behavioral Assessment	X	X	X				Assessment Codes
90832	Psychotherapy, 30 Minutes or Less with Patient	X	X	X				Therapy Codes
90834	Psychotherapy, 45 Minutes with Patient	X	X	X				Therapy Codes
90837	Psychotherapy, 60 Minutes or More with Patient	X	X	X				Therapy Codes
90839	Psychotherapy for Crisis	X	X	X				Therapy Codes
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present)	X	X	X				Therapy Codes
90849	Multiple-Family Group Psychotherapy	X	X	X				Therapy Codes

90853	Group Psychotherapy (Other Than of a Multiple-Family Group)	X	X	X				Therapy Codes
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons	X	X	X				Supplemental Services Codes
H2000	Comprehensive Multidisciplinary Evaluation	X	X	X	X	X	X	Assessment Codes
H2017	Psychosocial Rehabilitation	X	X	X	X	X	X	Rehabilitation Codes
H2021	Community-Based Wrap-Around Services	X	X	X	X	X	X	Rehabilitation Codes
T1017	Targeted Case Management	X	X	X	X	X	X	Case Management
H2011	Crisis Intervention Service	X	X	X	X	X	X	Crisis Intervention Codes
H2019	Therapeutic Behavioral Services	X	X	X	X	X	X	Therapeutic Behavioral Codes
H0031	Mental Health Assessment by Non-Physician	X	X	X	X	X	X	Assessment Codes
H0032	Mental Health Service Plan Developed by Non-Physician	X	X	X	X	X	X	Plan Development Codes
H0033	Oral Medication Administration, Direct Observation	X	X	X	X	X	X	Medication Support Codes
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)					X		Certified Peer Support Services Codes
H0038	Self-help/peer services					X		Certified Peer Support Services Codes

APPENDIX C: QUICK-REFERENCE TABLE FOR CLINICAL STAFF

New CPT/ HCPCS Code	New Code Label	Description (e.g., types of service)	Old Code
ASSESSMENT			
90791	Psychiatric Diagnostic Evaluation	• Initial Assessment and Reassessments • Briefer assessment activities not documented on the assessment form. • Includes mental status, diagnosis, and recommendations, among others.	331 - Assessment
90885	Psychiatric Evaluation of Hospital Record or Reports	• Review of medical records for diagnostic purposes.	331 - Assessment
96127	Brief Emotional/Behavioral Assessment	• Assessment using standardized instrument, e.g., CANS and PHQ-9.	313 - Evaluation or 331 - Assessment
H0031	Mental Health Assessment by Non-Physician	• As part of a multidisciplinary team: • Monitoring & review of progress • Gathering psychosocial, historical, and medical info to be used in assessments by a qualified provider	313 - Evaluation
H2000	Comprehensive Multidisciplinary Evaluation	• Multidisciplinary group meeting to evaluate patient. • Only one member of the group meeting may bill.	None
PLAN DEVELOPMENT			
H0032	Mental Health Service Plan Development by Non-Physician	• Development of care plan • Includes IHBS, ICC-CFT Action Plan, Wrap-Around Plan, TBS, and TCM plan note	315 - Plan Development 571 - Case management-plan development
CASE MANAGEMENT			

New CPT/ HCPCS Code	New Code Label	Description (e.g., types of service)	Old Code
T1017	Targeted Case Management	• Help access needed services.	561 - Linkage 541 - Placement 571 - Plan Development
THERAPY			
90832 90834 90837	Psychotherapy	• Individual therapy • Focus is on symptom reduction	341 - Individual Therapy
90839	Psychotherapy for Crisis	• Psychotherapy when patient is in crisis	371 - Crisis
96127	Family Psychotherapy [Conjoint Psychotherapy] (with patient present)	• Psychotherapy for family with patient to address family psychological issues which are affecting progress in treatment.	320 - Family Therapy-Client Present
H0032	Family Psychotherapy (with patient not present) (Mental Health Service Plan Developed by Non-Physician)	• Psychotherapy for family without patient to address family issues that are impacting patient progress in treatment. • Interventions limited in accord with scope of practice.	319 - Family Therapy-Client not Present
90849	Multi-family Group Psychotherapy	• Psychotherapy for more than one family at a time.	351 - Group Therapy
90853	Group Psychotherapy	• Psychotherapy for a group of people not normally acquainted with each other but might be sharing similar kinds of psychological issues. • Patients are not members of the same family.	351 - Group Therapy
REHABILITATION			
H2017	Psychosocial Rehabilitation	• Assistance developing, maintaining, or improving skills such as: daily living, social, grooming and hygiene, meal preparation, medication education • Supporting independence and self-advocacy • Training leisure activities for whole person recovery	317 - Rehabilitation

New CPT/ HCPCS Code	New Code Label	Description (e.g., types of service)	Old Code
H2017	Psychosocial Rehabilitation (group)	• Group which provides psychosocial rehabilitation	355 - Group Rehabilitation
H2021	Community-Based Wrap-Around Services	• Wraparound Services • Delivery System Coordination of Care • Coordination of care between providers inside the Mental Health System with providers outside Mental Health	571 - Case Management-plan development
MISCELLANEOUS			
H2011	Crisis Intervention	• Provision of urgent service to stabilize an immediate crisis.	371 - Crisis
H0033	Oral Medication, Administration, Direct Observation	• Observing patient self-administer medication.	None
(add on)	Interpretation or Explanation of Results...	• Explanation of results of psychiatric exams or procedures to caregivers to advise them on caring for the patient.	311 - Collateral
(Collateral) 90791 H2017 H0032 T1017	Psychiatric Diagnostic Evaluation Psychosocial Rehabilitation Plan Dev by non-Physician Targeted Case Management	• (See respective code definitions above)	311 - Collateral
(Pathways to Well Being / Katie A. Services) 90791 H2017 H0032	Psychiatric Diagnostic Evaluation Psychosocial Rehabilitation Plan Dev by Non-physician	• (See respective code definitions above)	358 - IHBS 564 - ICC 565 - ICC-CFT

APPENDIX D: CPT CODES FOR UNLICENSED STAFF

New CPT/ HCPCS Code	New Code Label	**Description (e.g., types of service)**	Old Code
ASSESSMENT			
H0031	Mental Health Assessment by Non-Physician	• As part of a multidisciplinary team: • Monitoring & review of progress • Gathering psychosocial, historical, and medical info to be used in assessments by a qualified provider	
H2000	Comprehensive Multidisciplinary Evaluation	• Multidisciplinary group meeting to evaluate patient functioning. • Only one member of the group meeting may bill.	
PLAN DEVELOPMENT			
H0032	Mental Health Service Plan Development by Non-Physician	• Development of care plan • In addition to patient, may include professional or personal supports • Includes IHBS, ICC-CFT Action Plan, Wrap-Around Plan, TBS, and TCM plan note	315 - Plan Development 571 - Case management-plan development
REHABILITATION			
H2017	Psychosocial Rehabilitation	• Assistance developing, maintaining, or improving skills such as: daily living, social, grooming and hygiene, meal preparation, medication education • Supporting independence and self-advocacy • Training leisure activities for whole person recovery	317 - Rehabilitation
H2017	Psychosocial Rehabilitation (group)	• Group which provides psychosocial rehabilitation	355 - Group Rehabilitation

H2021	Community-Based Wrap-Around Services	• Wraparound Services • Delivery System Coordination of Care • Coordination of care between providers inside the Mental Health System with providers outside Mental Health	571 - Case Management-plan development
CASE MANAGEMENT			
T1017	Targeted Case Management	• Help access needed services. • Some include mental or medical health, school, justice, transportation, housing, and more. • Services include communication, consultation, linkage, referral, monitoring service delivery, and more.	561 - Linkage 541 - Placement 571 - CM Plan Dev
MISCELLANEOUS			
H2011	Crisis Intervention	• Provision of urgent service to stabilize an immediate crisis.	371 - Crisis
H2019	Therapeutic Behavioral Services	• Adjunct service (not a stand-alone) service • 1:1 intensive behavior modification • Prevents placement in high level of care such as STRTP	(TBS codes)
H0033	Oral Medication, Administration, Direct Observation	• Observing patient self-administer medication.	None
H0025 Peer Support	Behavioral Health Prevention Education Service	• Groups: • Help beneficiaries / families cope and learn problem-solving. • Promote skill-building in areas such as socializing, recovery, self-sufficiency, etc.	None (peer support only)
H0038 Peer Support	Self-help/peer services	• Provide self-help education. • Link to tools and resources • Support in identifying goals. • Dispel myths and provide encouragement	None (peer support only)

Pathways to Well Being / Katie A. Services H2017 H0032	Psychosocial rehabilitation Plan Development by non-physician	• (See respective codes defined above)	358 - IHBS 564 - ICC 565 - ICC-CFT

APPENDIX E: CPT CODES FOR MEDICAL STAFF

Code	Code Description	Psychiatrist/ Contracted Psychiatrist	Nurse Practitioner	Registered Nurse	Licensed Psychiatric Technician	Type of Service
96372	Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular. Do not use this code to indicate administration of vaccines/toxoids or intradermal cancer immunotherapy injection.	X	X	X		Medication Support Codes
99202	Office or Other Outpatient Visit of New Patient, 29 Minutes or Less	X	X			Medication Support Codes
99203	Office or Other Outpatient Visit of a New patient, 30-44 Minutes	X	X			Medication Support Codes
99204	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	X	X			Medication Support Codes
99205	Office or Other Outpatient Visit of a New Patient, 60 Minutes or More	X	X			Medication Support Codes
99212	Office or Other Outpatient Visit of an Established Patient, 19 Minutes or Less	X	X			Medication Support Codes
99213	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	X	X			Medication Support Codes
99214	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	X	X			Medication Support Codes
99215	Office or Other Outpatient Visit of an Established Patient, 40 Minutes or More	X	X			Medication Support Codes
99341	Home Visit of a New Patient, 25 Minutes or Less	X	X			Medication Support Codes

99342	Home Visit of a New Patient, 26-35 Minutes	X	X			Medication Support Codes
99344	Home Visit of a New Patient, 51-65 Minutes	X	X			Medication Support Codes
99345	Home Visit of a New Patient, 66 Minutes or More	X	X			Medication Support Codes
99347	Home Visit of an Established Patient, 20 Minutes or Less	X	X			Medication Support Codes
99348	Home Visit of an Established Patient, 21-35 Minutes	X	X			Medication Support Codes
99349	Home Visit of an Established Patient, 36-50 Minutes	X	X			Medication Support Codes
99350	Home Visit of an Established Patient, 51 Minutes or More	X	X			Medication Support Codes
H0033	Oral Medication Administration, Direct Observation	X	X	X	X	Medication Support Codes
H0034	Medication Training and Support	X	X	X	X	Medication Support Codes

APPENDIX F: QUICK-REFERENCE TABLE FOR MEDICAL STAFF

New Code	New Code Label	Description (e.g., types of service)	Old Code	Available in ccLink to:
ASSESSMENT				
90792	Psychiatric Diagnostic Evaluation With Medical Service	• Integrated psychiatric initial assessment or reassessment • Not limited to full assessments	361 - Evaluation/Rx	MD,NP
90885	Psychiatric Evaluation of Hospital Record or Reports	• Review of medical records for diagnostic purposes.	361 - Evaluation/Rx	MD,NP
96127	Brief Emotional/Behavioral Assessment	• Assessment using standardized instrument, e.g., CANS and PHQ-9.	361 - Evaluation/Rx	MD,NP,RN
T1001	Nursing Assessment/Evaluation	• Nursing/LPT collection of information about patient's mental health to be support •	361 - Evaluation/Rx	NP,RN,LPT
H0031	Mental Health Assessment by Non-Physician	• As part of a multidisciplinary team: • Monitoring & review of progress • Gathering psychosocial, historical, and medical info to be used in assessments by a qualified provider	313 - Evaluation	NP,RN,LPT
H2000	Comprehensive Multidisciplinary Evaluation	• Multidisciplinary group meeting to evaluate patient. • Only one member of the group meeting may bill.	None	MD,NP,RN,LPT
MEDICATION SUPPORT				
99202-99205	Office or Other Outpatient Services (New Patient: received no care from this group practice for at least 3 years)	• Outpatient visit involving evaluation and management. • Prescribing, administering, and dispensing medication, lab work, vitals • Observation for effectiveness, side effects, and adherence to treatment • Obtaining informed consent for medications	361 - Evaluation/Rx	MD,NP

New Code	New Code Label	Description (e.g., types of service)	Old Code	Available in ccLink to:
99212-99215	Office or Other Outpatient Services (Established Patient)	• Outpatient visit involving evaluation and management. • Prescribing, administering, and dispensing medication, lab work, vitals • Observation for effectiveness, side effects, and adherence to treatment • Obtaining informed consent for medications	361 - Evaluation/Rx	MD,NP
99341 - 99345	Home Visit (New Patient)	• Same as 99202-99205	361 - Evaluation/Rx	MD,NP
99347 - 99350	Home Visit (Established Patient)	• Same as 99212-99215	361 - Evaluation/Rx	MD,NP
H0034	Medication Training and Support	• Education of support figures regarding medication, drug interactions, and potential side effects	363 - Education	MD,NP,RN,LPT
H0034	Medication Training and Support	• Use for medication injections (LPTs only)	362-RN Injection	LPT
96372	Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular	• Drug injected via intramuscular or subcutaneous route in the patient's body • Performed by physician or assistant/nurse under prescriber supervision	362-RN Injection	MD,NP,RN
T1001	Nursing Assessment/Evaluation	• Nursing/LPT collection of information about patient's mental health • Information gathered for an assessment by provider licensed to complete a full assessment, including diagnosing	361 - Evaluation/Rx	NP,RN,LPT
PLAN DEVELOPMENT				
H0032 (Non-prescribers)	Mental Health Service Plan Development by Non-Physician	• Development of care plan • Conferencing with MD/NP • Developing care plan with patient support person	364 - Plan Dev	NP,RN,LPT
REHABILITATION				

New Code	New Code Label	Description (e.g., types of service)	Old Code	Available in ccLink to:
H2017	Psychosocial Rehabilitation	• Assistance developing, maintaining, or improving skills such as: daily living, social, grooming and hygiene, meal preparation, medication education • Supporting independence and self-advocacy • Training leisure activities for whole person recovery	317 - Rehabilitation	MD,NP,RN,LPT
H2017	Psychosocial Rehab (group)	• Group which provides psychosocial rehabilitation	355 - Group Rehab	MD,NP,RN,LPT
CASE MANAGEMENT				
T1017	Targeted Case Management	• Help accessing needed services.	541 - Placement 561 - Linkage 571 - CM-Plan Dev	MD,NP,RN,LPT
MISCELLANEOUS				
H2011	Crisis Intervention	• Provision of urgent service to stabilize an immediate crisis.	371 - Crisis	MD,NP,RN,LPT
H0033	Oral Medication, Administration, Direct Observation	• Observing patient self-administer medication.	None	MD,NP,RN,LPT
99451	Inter-Professional Telephone/Internet/Electronic Health Record Assessment by a Consultative Physician	• Consultant uses for consultation with another physician.	None	MD

APPENDIX G: ABBREVIATIONS

Numbers	
1:1	One to one
1º	Primary
2º	Due to; Secondary to
24/7	24 hours a day, 7 days a week
5150	WIC 72-hour hold for mental health evaluation
5250	WIC 14-day hold
A	
Ā	Before
@	At
A/H	Auditory Hallucinations
A/O	Alert & Oriented
AA	Alcoholics Anonymous
ACBH	Antioch Children's Behavioral Health
ADD	Attention Deficit Disorder
ADHD	Attention Hyperactive Disorder
ADL	Activities of Daily Living
ADOL	Adolescent
AFS	Alternative Family Services
AM	Morning
AMA	Against Medical Advice
AOD	Alcohol and Other Drugs
AOT	Assisted Outpatient Treatment
APPT	Appointment
APPROX	Approximately
APS	Adult Protective Services
ASAP	As soon as possible
ASSMT	Assessment
ASW	Associate of Social Work
ATOD	Alcohol, Tobacco, and other drugs

ATTN	Attention
AVG	Average
AWOL	Absence Without Leave
B	
BA	Bachelor of Arts
BACR	Bay Area Community Resource
BARM	Bay Area Rescue Mission
B&C	Board & Care
BDI	Beck Depression Inventory
BF	Boyfriend
BIB	Brought in by
Bid	Twice a day
Bio	Biological
BPD	Borderline Personality Disorder
Bro	Brother
b/t	Between
Bx	Behavior
C	
C	With
C/O	Complains of
CALOCUS	Child and Adolescent Level of Care Utilization System
CANS	Children and Adolescent Needs and Strengths Assessment
CBO	Community Based Organization
CBT	Cognitive Behavioral Therapy
CCAMH	Central County Adult Mental Health
CCBHS	Contra Costa Behavioral Health Services
CCBHS-MHP	Contra Costa Mental Health Plan
CCC	Contra Costa County
CCCMH	Central County Children’s Mental Health
CCRMC	Contra Costa Regional Medical Center
CD	Chemical Dependency
CFS	Child and Family Services
CFT	Child and Family Team

CHAA	Community Health for Asian Americans
CLT	Client
CM	Case Management
COFY	Community Options for Family and Youth
COLL	Collateral
CON REP	Conditional Release Program
cont.	Continuously
CPS	Child Protective Services
Crisis Res.	Crisis Residential
CSW	Community Support Worker
CTI	Child Therapy Institute
CWAT	County Wide Assessment Team
D	
D	Divorced
DAU	Daughter
Day Tx	Day Treatment
DBT	Dialectical Behavior Treatment
D/C	Discharge
DC	Discontinue
DHCS	California Department of Health Care Services
DD	Developmentally Disabled
DMH	Department of Mental Health
DMV	Department of Motor Vehicles
DOB	Date of Birth
DOS	Date of Service
Dr	Doctor
DSM	Diagnostic & Statistical Manual
DTN	Detention
DTO	Danger to Others
DTS	Danger to Self
DUI	Driving Under the Influence
DV	Domestic Violence
DVR	Diablo Valley Ranch

Dx	Diagnosis
Dz	Disease
E	
EBP	Evidence-Based Practice
ECAMH	East County Adult Mental Health
EFC	Emergency Foster Care
EMDR	Eye Movement Desensitization Reintegration
EPSDT	Early & Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ERMHS	Educationally Related Mental Health Service
EtOH	Alcohol
EVAL	Evaluation
F	
F/U	Follow Up
Fa	Father
FAS	Fetal Alcohol Syndrome
FOI	Flight of Ideas
FFT	Functional Family Therapy
FSP	Full-Service Partnership
G	
GAD	General Anxiety Disorder
GAF	Global Assessment of Functioning
GD	Gravely Disabled
Gfa	Grandfather
G/F	Girlfriend
GLBTQQ	Gay, Lesbian, Bisexual, Transgendered, Queer, Questioning
GM	Grandmother
Group Tx	Group Therapy
H	
H	Heroin
H&P	History and Physical
H&R	Hospital and Residential
Hal	Hallucinations

H/I	Homicidal Ideation
HIPAA	Health Insurance Portability & Accountability Act
Hosp	Hospitalized
HS	High School
HUD	Housing and Urban Development
HUSB	Husband
HV	Home Visit
Hx	History
I	
ICC	Intensive Care Coordination
ICCco	Intensive Care Coordinator
ICU	Intensive Care Unit
IEP	Individual Education Plan
IHBS	Intensive Home-Based Service
IMD	Institute of Mental Disease
IN-PT	Inpatient
IHSS	In Home Support Services
J	
JACS	Juvenile Assessment and Consultation Services (Juvenile Hall)
JMBH	John Muir Behavioral Health
JUV	Juvenile
K	
KTA	Katie A.
L	
LCSW	Licensed Clinical Social Worker
LD	Learning Disability
LOCUS	Level of Care Utilization System
LMFT	Licensed Marriage and Family Therapist
LPT	Licensed Psychiatric Technician
LPS	Lanterman-Petris-Short
LVN	Licensed Vocational Nurse
M	
M	Male

Ma	Married
MD	Medical Doctor/Physician
MDD	Major Depressive Disorder
Med Hx	Medical History
Meds	Medications
MFT	Marriage & Family Therapist
AMFT	Marriage & Family Therapist Intern
MH	Mental Health
MHCS	Mental Health Clinical Specialist
MHP	Mental Health Plan
MHRC	Mental Health Rehabilitation Center
MHRS	Mental Health Rehab Specialist
MHSA	Mental Health Services Act or Prop 63
MHTC	Mental Health Treatment Center
MHW	Mental Health Worker
MI	Motivational Interviewing
MJ	Marijuana
MMPI	Minnesota Multiphasic Personality Inventory
Mo	Mother
MRN	Medical Record Number
MRT	Mobile Response Team
MSE	Mental Status Exam
MSG	Message
MST	Multisystemic Therapy
MSW	Masters of Social Worker (not registered with the board)
Mt. D	Mount Diablo Unified School District
MTG	Meeting
MWC	Miller Wellness Center
N	
N/A	Not Applicable
NA	Narcotics Anonymous
NAMI	National Alliance for the Mentally Ill
NARC	Narcotic

N/C	No Complaints
NEG	Negative
NKA	No Known Allergies
NKDA	No Known Drug Allergies
NOA	Notice of Action
NOC	Night
NOS	Not Otherwise Specified
NPI	National Provider Identifier
NS	No Show
O	
OCC	Occasionally
OCD	Obsessive Compulsive Disorder
OCE	Office of Consumer Empowerment
Od	Overdose
OD	Officer of the Day
OFF	Oppositional Defiant Disorder
OT	Occupational Therapy
Outpt	Outpatient
P	
p.c.	After meals
Prn	As needed
P/C	Phone Call
PCP	Primary Care Physician
PD	Plan Development
PDD	Pervasive Developmental Disorder
PDR	Physician’s Desk Reference
PEI	Prevention and Early Intervention
PES	Psychiatric Emergency Services
PhD	Doctor of Philosophy
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHN	Public Health Nurse
PHQ	Patient Health Questionnaire

Pm	Afternoon
PN	Psychiatric Nurse
PO	Probation Officer
Po	By mouth
PREG	Pregnant
PROB	Problem
PROG	Progress
PST	Problem Solving Therapy
PsyD	Doctor of Psychology
Pt	Patient
P/T	Part Time
PTSD	Post-Traumatic Stress Disorder
P/U	Pick Up
Q	
Q	Every
q2h	Every 2 hours
QA	Quality Assurance
Qam	Every morning
Qh	Every hour
Qhs	At night
Qid	Four times a day
R	
R/O	Rule Out
R&B	Room and Board
REC'D	Received
Re	Regarding
REC	Recommend
REG	Regular
REHAB	Rehabilitation
REL	Relationship
ROI	Release of Information
REV	Review
RI	Recovery Innovations

RN	Registered Nurse
Rx	Prescription
Rxn	Reaction
S	
S	Single
SA	Substance Abuse
s/b	Should be
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIZ	Schizophrenia
SED	Severely Emotionally Disturbed
S/S	Signs and Symptoms
S/A	Suicide Attempt
S/I	Suicide Ideation
SIB	Self-Injurious Behavior
Sib	Sibling
Sis	Sister
SOC	System of Care
S/O	Significant Other
SPIRIT	Service Provider Individualized Recovery Intensive Training
SSRI	Selective Serotonin Reuptake Inhibitor
START	Short Term Assessment of Resources and Treatment
SW	Social Worker
Sx	Symptoms
T	
TAY	Transitional Age Youth
T/C	Telephone Call
TV	Television
TBI	Traumatic Brain Injury
TBS	Therapeutic Behavioral Service
TCM	Targeted Case Management
Tid	Three times a day
TAR	Treatment Authorization Request
TRO	Temporary Restraining Order

Tox	Toxicology
TT	Transition Team
Tx	Treatment
U	
UNK	Unknown
UON	Unusual Occurrence Notice
UR	Utilization Review
V	
VA	Veteran's Administration
V/H	Visual Hallucinations
VM	Voicemail
W	
W	Widowed
W&I	California Welfare and Institutions Code
w/o	Without
w/	With
WCAMH	West County Adult Mental Health
WCCMH	West County Children's Mental Health
WCCUSD	West Contra Costa County Unified School District
W/D	Withdrawal
WNL	Within Normal Limits
WRAP	Wellness Recovery Action Plan
Wt.	Weight
X	
X	Multiplied by/times
Y	
Y/O	Years Old
YSB	Youth Service Bureau
YR	Year
Symbols	
Ψ	Psychiatric/ Psychiatrist/Psychology
≤	Less Than or Equal To
≥	Greater Than or Equal To

↑	Increase
↓	Decrease
♀	Female
♂	Male
#	Number
%	Percent
+	Plus, positive, yes
-	Minus, negative, no
”	Inches
‘	Feet
?	Unknown
&	And
@	At
=	Equal

APPENDIX H: LOCATION OF CLINICAL FORMS

PDF copies of CCBHS-MHP clinical forms are available here:
http://cchealth.org/mentalhealth/clinical-documentation/

APPENDIX I: SCOPE OF PRACTICE DOCUMENTATION

The following documents are attached following this page.

- Scope of Practice Definitions
- Guidelines for Scope of Practice for Clinical Staff
- Guidelines for Scope of Practice for Medical Staff
- Guidelines for Scope of Practice for Unlicensed Staff

These documents are also available at **https://cchealth.org/mentalhealth/provider/**.

The establishment of provider selection criteria is a required activity of County MHPs.[1] MHPs are authorized to establish additional requirements "as part of a credentialing or other evaluation process."[2] This document specifies the required credentials, supervision, and approved activities for Psychiatrists, Nurse Practitioners, Registered Nurses, Psychiatric Technicians, Psychologists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Psychologist Interns, Associate Social Workers, Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Psychology Trainees, Social Work Trainees, Marriage and Family Therapist Trainees, Professional Clinical Counselor Trainees, Mental Health Rehabilitation Specialists (MHRSs), Designated Mental Health Workers (DMHWs), Therapeutic Foster Care (TFC) Parents, and Certified Peer Support Specialists.

MEDICAL

PSYCHIATRIST (MD, DO)

A Psychiatrist shall have a license to practice as a physician and surgeon granted by the California Medical Board or by the Board of Osteopathic Medical Board of California,[3] and be board-eligible or board-certified in psychiatry.

Psychiatrists must possess a valid, unrestricted DEA registration and a NPI number with a valid taxonomy.

Supervision Requirements: Ongoing supervision conducted by the Medical Director or designee is required. Individual clinical supervision *may* be required by the Medical Director or Lead Psychiatrist. Psychiatrists may request individual clinical supervision from the Medical Director or Lead Psychiatrist.

[1] CCR, Title 9, §1810.435
[2] CCR, Title 9, §1810.435(b)(6)
[3] Title 9, §782.39

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

An FNP/PMHNP is a registered nurse who possesses additional preparation and skill in physical diagnosis, psycho-social assessment, and management of episodic and chronic mental illness. FNP/PMHNPs are certified by the State of California, Board of Registered Nursing to practice under standardized procedure[4] and to furnish drugs and devices.[5]

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

Family Nurse Practitioners and Psychiatric Mental Health Nurse Practitioners must possess a valid, unrestricted DEA registration and a NPI number with a valid taxonomy.

Supervision Requirements: Ongoing supervision conducted by an assigned Psychiatrist is required. Individual clinical supervision *may* be required by the Medical Director or Lead Psychiatrist. FNPs and PMHNPs may request individual clinical supervision from the Medical Director or Lead Psychiatrist.

REGISTERED NURSE (RN)

A registered nurse shall have a license as a registered nurse by the State of California, Board of Registered Nursing.[6]

Registered Nurses must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Supervision Requirements: Monthly group clinical supervision by the Nursing Program Manager is required. Individual clinical supervision *may* be required by the Nursing Program Manager. RNs may request individual clinical supervision.

[4] CCR, Title 16, §1474
[5] BPC Section 4076
[6] Title 9, §782.44

LICENSED PSYCHIATRIC TECHNICIAN (LPT)

A Licensed Psychiatric Technician shall have a license as a psychiatric technician by the State of California, Board of Vocational Nurses and Psychiatric Technician Examiners.[7]

Licensed Psychiatric Technicians must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Supervision Requirements: Monthly group clinical supervision by the Nursing Program Manager is required. Individual clinical supervision *may* be required by the Nursing Program Manager. LPTs may request individual clinical supervision.

[7] Title 9 §782.28

LICENSED MENTAL HEALTH PROFESSIONALS (LMHP)

LICENSED PSYCHOLOGIST (PhD, PsyD)

A Licensed Psychologist shall have obtained a license to practice as a psychologist granted by the State of California Board of Psychology.[8]

LICENSED CLINICAL SOCIAL WORKER (LCSW)

A Licensed Clinical Social Worker is licensed as a clinical social worker by the State of California, Board of Behavioral Sciences.[9]

LICENSED MARRIAGE & FAMILY THERAPIST (LMFT)

A Licensed Marriage & Family Therapist shall have obtained a license to practice as a marriage, family and child therapist by the State of California, Board of Behavioral Sciences.[10]

LICENSED PROFESSIONAL CLINICAL COUNSELOR (LPCC)

A Licensed Professional Clinical Counselor shall have obtained a license to practice as a professional clinical counselor by the State of California Board of Behavioral Sciences.[11]

Psychologists, LCSWs, LMFTs, and LPCCs must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Supervision Requirements: Weekly individual or group clinical supervision by the Program Manager/Supervisor is recommended. Individual clinical supervision *may* be required by the Program Manager/Supervisor. Staff in this category may request individual clinical supervision.

[8] Title 9, §782.42
[9] Title 9, §782.48
[10] Title 9, §782.32
[11] CA Bus & Prof Code §4999.20 and CCR, Title 16 §1820.5

PSYCHOLOGIST INTERNS and TRAINEES

PSYCHOLOGIST INTERNS

Post-Doctoral Interns: A Post-Doctoral intern must possess an earned doctorate degree in psychology, in education psychology, or in education with the field of specialization in counseling psychology or educational psychology in order to obtain supervised post-doctoral hours towards licensure as a psychologist.[12] The Post-Doctoral intern can be registered with the State of California, Board of Psychology as a Registered Psychologist/Registered Psychological Assistant or sign an official Supervision Agreement in a formal internship placement or as an employee of an exempt setting. Post-doctoral Interns must earn a minimum of 1500 supervised hours of experience within 30 consecutive months.[13]

Pre-Doctoral Interns: A Pre-Doctoral Intern is one who is in the process of earning a doctoral degree with a formal internship. A Pre-Doctoral Intern is not required to be registered with the State of California, Board of Psychology if working in a governmental agency. Pre-doctoral Interns may earn a maximum of 1500 supervised hours of experience within 30 consecutive months.[14]

Post-Doctoral and Pre-Doctoral Interns must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

(See next page for waiver requirements)

[12] CA Bus & Prof Code § 2914 (2016)
[13] CCR, Title 16, §1367(a)(1)(A)-(D)
[14] CCR, Title 16, §1387)(a)(1)(A)-(E)

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

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

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

Qualifications and Responsibilities of a Primary Supervisor:

- All primary supervisors shall be Licensed Psychologists while the psychologist candidate is accruing *Supervised Professional Experience* hours toward licensure. Primary supervisors must possess and maintain a valid, active license free of any formal disciplinary action. Primary supervisors who are licensed by the board shall complete a minimum of six (6) hours of supervision coursework every two years.[16]
- Primary supervisors are responsible for ensuring compliance and monitoring the welfare of the Intern's clients, as well as for monitoring the performance and professional development of the interns.[17]
- The primary supervisor must be employed in the same work setting at least half the time as the Intern and be available to the Intern 100% of the time they are accruing supervised professional experience.[18] Primary supervisors shall ensure that each client or patient is informed prior to the rendering of services by the Intern (1) that the Intern is unlicensed and is functioning under the direction and supervision of the supervisor; (2) that the primary supervisor shall have full access to the treatment records in order to perform supervision responsibilities and (3) that any fees paid for the services of the Intern must be paid directly to the primary supervisor or employer.[19]

[15] CCR, Title 16, §1387(b)(4)-(5)
[16] CCR, Title 16, §1387.1(b)
[17] CCR, Title 16, §1387.1
[18] CCR, Title 16, §1387(b)(6)
[19] CCR, Title 16, §1387.1(g) and 1392.6(b)

Qualifications and Responsibilities of a Delegated Supervisor:

- Primary supervisors may delegate supervision to other qualified psychologists or to other qualified mental health professionals including Licensed Marriage and Family Therapists, Licensed Educational Psychologists, Licensed Clinical Social Workers and board certified Psychiatrists.[20] However, the primary supervisor remains responsible for the minimum one hour per week of direct, individual face-to-face supervision.[21] Once the collection of Supervised Professional Experience hours has been completed, supervision by a licensed mental health professional is required until the psychologist candidate obtains a license to practice.
- Delegated supervisors are responsible for monitoring the welfare of the intern's clients while under their delegated supervision and abide by all provisions of the California Code of Regulations §1387.2.

PSYCHOLOGIST TRAINEES

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

In order to gain experience as a Psychologist Trainee, the student must have a field placement agreement with their graduate school. There must be an individual contract signed by the student, individual supervisor and/or training coordinator and school field placement liaison that specifies the duration of the contract. There is no minimum experience level required and the hours worked cannot be counted toward licensure.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Psychologist Trainees must possess a NPI number with a valid taxonomy.

Supervision Requirements: Students are provided with a minimum of one hour of individual supervision by a Licensed Psychologist and weekly group supervision.[22]

[20] CCR, Title 16, §1387(c)(1)
[21] CCR, Title 16, §1387(c)(2)
[22] Refer to Wright Institute and California School of Professional Psychology Office of Professional Training description of clinical practice.

MASTER'S LEVEL INTERNS

- **ASSOCIATE MARRIAGE and FAMILY THERAPIST (AMFT)**

  An Associate Marriage and Family Therapist (AMFT) must possess a master's degree in Marriage and Family Therapy from an accredited graduate school program that prepares the student for licensure as a marriage and family therapist.

- **ASSOCIATE CLINICAL SOCIAL WORKER (ASW)**

  An Associate Clinical Social Worker (ASW) must possess a master's degree in Social Work from an accredited graduate school program that prepares the student for licensure as a social worker.

- **ASSOCIATE PROFESSIONAL CLINICAL COUNSELOR (APCC)**

  An Associate Professional Clinical Counselor (APCC) must possess a master's degree in Clinical Counseling or Psychotherapy from an accredited graduate school program that prepares the student for licensure as a professional clinical counselor.

AMFTs, ASWs, and APCCs must be registered with the State of California, Board of Behavioral Sciences and must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Supervision Requirements for AMFTs, ASWs, and APCC Interns:

The State of California, Board of Behavioral Sciences requires 3000 hours of supervised professional experience and 104 weeks of supervision to qualify for licensure as LMFT, LCSW, or LPCC.[23] For the purposes of Contra Costa County MHP, the supervision requirements for AMFTs, ASWs, and APCCs Interns are as follows:

- A minimum of one (1) unit of supervision[24] during any week in which experience is gained in each work setting.[25]
- If an Intern provides more than 10 hours of direct clinical counseling during a single week in a work setting, the Intern must receive a total of two (2) units of supervision in that same week in that setting.[26]
- Of the 104 weeks of supervision required for licensure, 52 must be weeks in which the AMFT, ASW, or APPC received at least one (1) hour of individual or triadic[27] supervision.
- Group supervision sessions shall include no more than eight (8) persons receiving supervision, even if there are two or more supervisors present. Group supervision can be broken into one-hour sessions as long as both increments (two full hours) are provided in the same week as the experience being claimed.[28]
- Interns may obtain supervision via live two-way videoconferencing; supervision may not be provided by telephone.[29]

(See next page for AMFT, ASW, and APCC supervisor requirements)

[23] For more detailed information about supervision and licensure requirements for AMFTs, ASWs, and APCCs, visit the Board of Behavioral Sciences website at www.bbs.ca.gov and select "Applicants."
[24] A "unit" of supervision is equivalent to one (1) hour of individual or triadic supervision OR two (2) hours of group supervision.
[25] Source: Board of Behavioral Sciences: *Important Answers to Frequently Asked Question for Associate Marriage and Family Therapists and MFT Trainees*, *Important Answers to Frequently Asked Questions for Associate Clinical Social Workers*, and *Important Answers to Frequently Asked Questions for Associate Professional Clinical Counselors*
[26] Ibid.
[27] Triadic supervision is defined as face-to-face supervision consisting of one supervisor and two supervisees; it is equivalent to individual supervision.
[28] Ibid.
[29] Ibid.

Supervisor Qualifications for AMFT, ASW, and APCC Interns:[30]

All supervisors of AMFTs, ASWs, and APCC Interns are required to:

- Possess a current and active California license that is not under suspension or probation as one of the following:

  Licensed Marriage and Family Therapist (LMFT)
  Licensed Clinical Social Worker (LCSW)
  Licensed Professional Clinical Counselor (LPCC)
  Licensed Clinical Psychologist *licensed through the Board of Psychology*
  Licensed Physician and Surgeon *certified in Psychiatry by the Board of Psychiatry and Neurology*

- have been licensed in California or any other state for at least two (2) years out of the last five (5) years prior to the commencement of supervision; and
- have practiced psychotherapy during at least two (2) out of the last five (5) years prior to the commencement of supervision **OR** provided direct supervision to trainees or interns who perform psychotherapy during at least two (2) out of the last five (5) years prior to the commencement of supervision; and
- sign and comply with required supervision-related forms; and
- have submitted the one-time *Supervisor Self-Assessment Report* form to the Board of Behavioral Sciences (NOTE: Licensees serving as a supervisor for the FIRST TIME on or after January 1, 2022, must submit the form within 60 days of commencing supervision for the first time; licensees who served as a supervisor PRIOR TO January 1, 2022, must submit the form by January 1, 2023).[31]

Supervisor Training Requirements for LMFTs, LCSWs, and LPCCs:

- LMFTs, LCSWs, and LPCCs who served as a supervisor PRIOR TO January 1, 2022 must have completed a 6-hour supervision training within the two-year period immediately preceding the commencement of supervising; six hours of continuing professional development in supervision is required for all supervisors each renewal period cycle thereafter.
- LMFTs, LCSWs, and LPCCs who commence supervision for the FIRST TIME on or after January 1, 2022 must complete a minimum of 15 hours of supervision training within 60 days of commencement of supervision. Six hours of continuing professional development in supervision is required for all supervisors each renewal period cycle thereafter.
- Licensed Clinical Psychologists and Psychiatrists are exempt from these requirements.

[30] Source: MFT TRAINEE & ASSOCIATE MARRIAGE AND FAMILY THERAPIST SUPERVISOR INFORMATION & QUALIFICATIONS; ASSOCIATE CLINICAL SOCIAL WORKER SUPERVISOR INFORMATION & QUALIFICATIONS; ASSOCIATE PROFESSIONAL CLINICAL COUNSELOR SUPERVISOR INFORMATION & QUALIFICATIONS
[31] Source: Supervisor Self-Assessment Report (ca.gov)

MASTER'S LEVEL TRAINEES

MARRIAGE and FAMILY THERAPIST TRAINEE (MFT)

A Marriage and Family Therapist (MFT) Trainee is a pre-masters practicum student participating in a field placement while enrolled in an accredited masters level counseling program that prepares the student for licensure as a Marriage and Family Therapist.

There is no minimum experience required, nor is BBS registration required.

MFT Trainee Educational Requirements:

To begin gaining fieldwork experience, the MFT Trainee is required to:

- be enrolled in a practicum course;[32] and
- have completed a minimum of 12 semester or 18 quarter units of coursework in a qualifying MFT degree program; and
- the organization providing fieldwork experience must have an agreement with the school; and
- there must be a placement agreement or contract signed by the student, individual supervisor and/or training coordinator, and school field placement liaison that specifies the duration of the contract.

Marriage and Family Therapist Trainees must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

[32] The only condition under which a MFT Trainee may provide counseling services while *not* enrolled in a practicum course is if the period of time is less than 90 calendar days AND the 90-day or shorter period is immediately preceded by enrollment in a practicum course and immediately followed by enrollment in a practicum course or completion of the degree program

CLINICAL SOCIAL WORKER TRAINEE

A Clinical Social Worker Trainee is a pre-master's student participating in a field placement while enrolled in an accredited master's level counseling program that prepares the student for licensure as a Clinical Social Worker.[33]

Clinical Social Worker Trainee Educational Requirements:
The fieldwork requirements for Clinical Social Worker trainees are as follows:

- the community organization providing fieldwork experience must have an agreement with the school; and
- there must be a placement agreement or contract signed by the student, individual supervisor and/or training coordinator, and school field placement liaison that specifies the duration of the contract.

PROFESSIONAL CLINICAL COUNSELOR TRAINEE

A Professional Clinical Counselor Trainee is a pre-master's student participating in a field placement while enrolled in an accredited master's level professional counseling program that prepares the student for licensure as a Professional Clinical Counselor.[34]

Professional Clinical Counselor Trainee Educational Requirements:
The fieldwork requirements for Clinical Social Worker trainees are as follows:

- the community organization providing fieldwork experience must have an agreement with the school; and
- there must be a placement agreement or contract signed by the student, individual supervisor and/or training coordinator, and school field placement liaison that specifies the duration of the contract.

Clinical Social Worker and Professional Clinical Counselor Trainees must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

[33] Accredited master's level social work programs prepare the student for licensure; however, unlike MFTs, hours of experience earned pre-degree do not accrue toward licensure as a LCSW.
[34] Accredited master's level Professional Clinical Counseling programs prepare the student for licensure; however, hours of experience earned pre-degree do not accrue toward licensure as a LPCC.

Supervision Requirements for Marriage and Family Therapist, Clinical Social Worker, and Professional Clinical Counselor Trainees:

Trainees must be under the immediate supervision of a Licensed Mental Health Professional (LMHP) who shall be responsible for ensuring that the extent, kind, and quality of services performed are consistent with the student's training and experience, and be responsible for the student's compliance with applicable state law.[35] The State of California, Board of Behavioral Sciences requires 3000 hours of supervised professional experience and 104 weeks of supervision to qualify for licensure.[36] General supervision requirements for Marriage and Family Therapist (MFT), Clinical Social Worker, and Professional Clinical Counselor Trainees are outlined below:

- A minimum of one (1) unit of supervision[37] during any week in which experience is gained in each work setting.[38]
- One unit of supervision is required for *every* five hours of direct clinical counseling provided in a single week in each setting.
- Supervision may be individual, triadic,[39] or group.
- Group supervision sessions shall include no more than eight (8) persons receiving supervision, even if there are two or more supervisors present. Group supervision can be broken into one-hour sessions as long as both increments (two full hours) are provided in the same week as the experience being claimed.[40]
- Trainees may obtain supervision via live two-way videoconferencing; supervision may not be provided by telephone.[41]

(See next page for Trainee supervisor requirements)

[35] Department of Health Care Services, MHDUDS Information Notice 17-040, August 24, 2017
[36] The Board of Behavioral Sciences mandates licensing and supervision requirements for LCSWs, LMFT, LPCCs, as well as ASWs, AMFTs, and APCCs; however, hours of professional experience earned by pre-degree master's students enrolled in accredited Social Work or Professional Clinical Counseling programs do not accrue toward licensure, nor are supervision requirements specified by the Board. Generally, hours of experience and supervision requirements for pre-master's students are school-specific. It should be noted that Clinical Social Work and Professional Clinical Counseling master's degree programs provide students with educational field opportunities to demonstrate core competencies which include but are not necessarily limited to clinical work.
[37] A "unit" of supervision is equivalent to one (1) hour of individual or triadic supervision OR two (2) hours of group supervision.
[38] Source: Board of Behavioral Sciences *Important Answers to Frequently Asked Questions for Associate Marriage & Family Therapists and MFT Trainees*
[39] Triadic supervision is defined as face-to-face supervision consisting of one supervisor and two supervisees; it is equivalent to individual supervision.
[40] Source: Board of Behavioral Sciences *Important Answers to Frequently Asked Questions for Associate Marriage & Family Therapists and MFT Trainees*
[41] Ibid.

Supervisor Qualifications for Marriage and Family Therapist, Social Work, and Professional Clinical Counselor Trainees:[42]

All supervisors of Marriage and Family Therapist, Social Work, and Professional Clinical Counselor Trainees are required to:

- possess a current and active California license that is not under suspension or probation as one of the following:

  Licensed Marriage and Family Therapist (LMFT)
  Licensed Clinical Social Worker (LCSW)
  Licensed Professional Clinical Counselor (LPCC)
  Licensed Clinical Psychologist *licensed through the Board of Psychology*
  Licensed Physician and Surgeon *certified in Psychiatry by the Board of Psychiatry and Neurology*

- have been licensed in California or any other state for at least two (2) years out of the last five (5) years prior to the commencement of supervision; and
- have practiced psychotherapy during at least two (2) out of the last five (5) years prior to the commencement of supervision **OR** provided direct supervision to trainees or interns who perform psychotherapy during at least two (2) out of the last five (5) years prior to the commencement of supervision; and
- sign and comply with required supervision-related forms; and
- have submitted the one-time *Supervisor Self-Assessment Report* form to the Board of Behavioral Sciences (NOTE: Licensees serving as a supervisor for the FIRST TIME on or after January 1, 2022, must submit form within 60 days of commencing supervision for the first time; licensees who served as a supervisor PRIOR TO January 1, 2022, must submit form by January 1, 2023).[43]

Supervisor Training Requirements for LMFTs, LCSWs, and LPCCs

- LMFTs, LCSWs, and LPCCs who served as a supervisor PRIOR TO January 1, 2022 must have completed a 6-hour supervision training within the two-year period immediately preceding the commencement of supervising; six hours of continuing professional development in supervision is required for all supervisors each renewal period cycle thereafter.
- LMFTs, LCSWs, and LPCCs who commence supervision for the FIRST TIME on or after January 1, 2022 must complete a minimum of 15 hours of supervision training within 60 days of commencement of supervision. Six hours of continuing professional development in supervision is required for all supervisors each renewal period cycle thereafter.
- Licensed Clinical Psychologists and Psychiatrists are exempt from these requirements.

[42] Source: MFT TRAINEE & ASSOCIATE MARRIAGE AND FAMILY THERAPIST SUPERVISOR INFORMATION & QUALIFICATIONS; ASSOCIATE CLINICAL SOCIAL WORKER SUPERVISOR INFORMATION & QUALIFICATIONS; ASSOCIATE PROFESSIONAL CLINICAL COUNSELOR SUPERVISOR INFORMATION & QUALIFICATIONS

[43] Source: Supervisor Self-Assessment Report (ca.gov)

UNLICENSED WORKERS

MENTAL HEALTH REHABILIATION SPECIALIST (MHRS)

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

- An associate degree in the field of psychology or closely related field and six (6) years of experience in a mental health setting as a specialist.[44] Two years of the experience must have been accrued after obtaining the associate degree. Two years of post-associate arts clinical experience requires a sequence where first, an associate degree is obtained and second, clinical experience is obtained.[45]
- A baccalaureate degree in the field of psychology or closely related field and four (4) years of experience in a mental health setting as a specialist.[46]
- A master's degree in the field of psychology or closely related field and two years of experience[47] in a mental health setting as a specialist.[48]

Mental Health Rehabilitation Specialists must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Required Supervision: MHRSs must receive ongoing oversight through a minimum of 1 hour of weekly individual or group supervision. The supervisor must be a Licensed Mental Health Professional who is in good standing in accordance with their licensing board.

[44] "Specialist" is defined as a role primarily working with/providing services to clients
[45] CCR, Title 9, §630
[46] "Specialist" is defined as a role primarily working with/providing services to clients
[47] "Experience" is defined as verifiable experience, either paid/unpaid, full-time or full-time equivalence, including practicum experiences gained in professional training program.
[48] "Specialist" is defined as a role primarily working with/providing services to clients

DESIGNATED MENTAL HEALTH WORKER (DMHW)

Designated Mental Health Worker (DMHW) is staff that does not meet the MHRS educational and experience requirements. The MHP has the prerogative and program flexibility to integrate and define other staff that can provide direct or supportive specialty mental health services as determined by the Mental Health Director. DMHWs must meet the following requirements:

- Be at least 18 years of age; and
- Possess a high school diploma or equivalent degree.

Designated Mental Health Workers must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Required Supervision: DMHWs must receive ongoing oversight through a minimum of 1 hour of weekly individual or group supervision. The supervisor must be a Licensed Mental Health Professional who is in good standing in accordance with their licensing board.

THERAPEUTIC FOSTER CARE (TFC) PARENT

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

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

Therapeutic Foster Care Parents must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Required Supervision: TFC parents must receive ongoing oversight through a minimum of 1 hour of weekly face-to-face supervision in the TFC parent's home. The supervisor must be a Licensed Mental Health Professional who is in good standing in accordance with their licensing board.

CERTIFIED PEER SUPPORT SPECIALIST

A Certified Peer Support Specialist is an individual who meets all of the following requirements:

- Must be at least 18 years of age with a high school diploma or equivalent degree; and
- Must have successfully completed DHCS-approved curriculum and training requirements for a Certified Peer Support Specialist; and
- Must pass a DHCS-approved certification examination for Certified Peer Support Specialist.

Certified Peer Support Specialists must possess a NPI number with a valid taxonomy.

Scope of Practice: Refer to the Guidelines for Scope of Practice for your discipline.

Required Supervision: A Certified Peer Support Specialist must receive ongoing oversight through a minimum of one (1) hour of weekly individual or group supervision provided by a qualified Peer Support Specialist Supervisor under the direction of a Licensed Mental Health Professional (LMHP) who is in good standing in accordance with their licensing board. [49]

See next page for Certified Peer Support Specialist supervisor

[49] DHCS, MHSUDS Information Notice 22-026

Peer Support Specialist Supervisor Qualifications and Training Requirements

Peer Support Specialist Supervisors must meet *at least* one of the below qualifications:[50]

- Have a Medi-Cal Peer Support Specialist Certification Program certification; have two years of experience working in the behavioral health system; and have completed a DHCS-approved peer support supervisory training curriculum; OR
- Be a non-peer behavioral health professional who has worked in the behavioral health system for a minimum of two years, and has completed a DHCS-approved peer support supervisory training; OR
- Have a high school diploma or GED, four years of behavioral health direct service experience that may include peer support services; and have completed an approved peer support supervisory training curriculum.

[50] DHCS, MHSUDS Information Notice 21-041

CONTRA COSTA HEALTH

CONTRA COSTA MENTAL HEALTH PLAN
GUIDELINES FOR SROPE OF PRACTICE FOR CLINICAL STAFF

Code	Code Description	Psychologist (Licensed & Waivered)	LMFT & LPCC (Licensed & Registered)	LCSW (Licensed & Registered)
Assessment				
90791	Psychiatric Diagnostic Evaluation	X	X	X
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes	X	X	X
96110	Developmental Screening	X	X	X
96127	Brief Emotional/Behavioral Assessment	X	X	X
H0031	Mental Health Assessment by Non- Physician	X	X	X
H2000	Comprehensive Multidisciplinary Evaluation	X	X	X
Plan Development				
H0032	Mental Health Service Plan Developed by Non-Physician	X	X	X
Therapy				
90832	Psychotherapy, 30 Minutes or Less with Patient	X	X	X
90834	Psychotherapy, 45 Minutes with Patient	X	X	X
90837	Psychotherapy, 60 Minutes or More with Patient	X	X	X
90839	Psychotherapy for Crisis	X	X	X
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present)	X	X	X
90849	Multiple-Family Group Psychotherapy	X	X	X
90853	Group Psychotherapy (Other Than of a Multiple-Family Group)	X	X	X
Rehabilitation				
H2017	Psychosocial Rehabilitation	X	X	X
H2021	Community-Based Wrap-Around Services	X	X	X
Case Management				
T1017	Targeted Case Management	X	X	X
Crisis Intervention				
H2011	Crisis Intervention Service	X	X	X
Therapeutic Behavioral Services				
H2019	Therapeutic Behavioral Services	X	X	X
Medication Support				
H0033	Oral Medication Administration, Direct Observation	X	X	X
Collateral				
90791	Psychiatric Diagnostic Evaluation	X	X	X
H2017	Psychosocial Rehabilitation	X	X	X
H0032	Mental Health Service Plan Developed by Non-Physician	X	X	X
T1017	Targeted Case Management	X	X	X
Pathways to Well-Being (Katie A Services)				
90791	Psychiatric Diagnostic Evaluation	X	X	X
H2017	Psychosocial Rehabilitation	X	X	X
H0032	Mental Health Service Plan Developed by Non-Physician	X	X	X

CONTRA COSTA MENTAL HEALTH PLAN
GUIDELINES FOR SCOPE OF PRACTICE FOR MEDICAL STAFF

Code	Code Description	Psychiatrist	Nurse Practitioner	Registered Nurse	Licensed Psychiatric Technician
Medication Support					
96372	Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular. Do not use this code to indicate administration of vaccines/toxoids or intradermal cancer immunotherapy injection.	X	X	X	No Privilege
H0033	Oral Medication Administration, Direct Observation	X	X	X	X
H0034	Medication Training and Support	X	X	X	X
Office or Other Outpatient Visit of NEW Patient					
99202	Office or Other Outpatient Visit of New Patient, 29 Minutes or Less	X	X	No Privilege	No Privilege
99203	Office or Other Outpatient Visit of a New Patient, 30- 44 Minutes	X	X	No Privilege	No Privilege
99204	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	X	X	No Privilege	No Privilege
99205	Office or Other Outpatient Visit of a New Patient, 60 Minutes or More	X	X	No Privilege	No Privilege
Office or Other Outpatient Visit of an ESTABLISHED Patient					
99212	Office or Other Outpatient Visit of an Established Patient, 19 Minutes or Less	X	X	No Privilege	No Privilege
99213	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	X	X	No Privilege	No Privilege
99214	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	X	X	No Privilege	No Privilege
99215	Office or Other Outpatient Visit of an Established Patient, 40 Minutes or More	X	X	No Privilege	No Privilege
Home Visit of a NEW Patient					
99341	Home Visit of a New Patient, 29 Minutes or Less	X	X	No Privilege	No Privilege
99342	Home Visit of a New Patient, 30-59 Minutes	X	X	No Privilege	No Privilege
99344	Home Visit of a New Patient, 60-74 Minutes	X	X	No Privilege	No Privilege
99345	Home Visit of a New Patient, 75 Minutes or More	X	X	No Privilege	No Privilege
Home Visit of an ESTABLISHED Patient					
99347	Home Visit of an Established Patient, 29 Minutes or Less	X	X	No Privilege	No Privilege
99348	Home Visit of an Established Patient, 30-39 Minutes	X	X	No Privilege	No Privilege
99349	Home Visit of an Established Patient, 40-59 Minutes	X	X	No Privilege	No Privilege
99350	Home Visit of an Established Patient, 60 Minutes or More	X	X	No Privilege	No Privilege
Assessment					
90792	Psychiatric Diagnostic Evaluation with Medical Services	X	X	No Privilege	No Privilege
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes	X	X	No Privilege	No Privilege
96127	Brief Emotional/Behavioral Assessment	X	X	X	No Privilege
H0031	Mental Health Assessment by Non- Physician		X	X	X
H2000	Comprehensive Multidisciplinary Evaluation	X	X	X	X
T1001	Nursing Assessment/Evaluation	No Privilege	X	X	X
Plan Development					
H0032	Mental Health Service Plan Developed by Non-Physician	No Privilege	X	X	X
Crisis Intervention					
H2011	Crisis Intervention Service	X	X	X	X
Case Management					
T1017	Targeted Case Management	X	X	X	X
Consultation					
99451	Interprofessional Telephone/Internet/Electronic Health Record Consultations	X	No Privilege	No Privilege	No Privilege
Rehabilitation					
H2017	Psychosocial Rehabilitation	X	X	X	X
H2021	Community-Based Wrap-Around Services	X	X	X	X
Collateral					
H2017	Psychosocial Rehabilitation	X	X	X	X
H0032	Mental Health Service Plan Developed by Non-Physician	No Privilege	X	X	X
T1017	Targeted Case Management	X	X	X	X

CONTRA COSTA HEALTH

CONTRA COSTA MENTAL HEALTH PLAN
GUIDELINES FOR SCOPE OF PRACTICE FOR UNLICENSED STAFF

Code	Code Description	TRAINEES (Graduate Student) Students in educational Mental Health programs granting an MSW, MA, MS, or PhD/PsyD degree. May have existing: AA,AS, BA, BS, MA, MS	**MENTAL HEALTH REHABILITATION SPECIALIST (MHRS) (Degree + MH experience): (1) AA, AS + 6yr (2) BA, BS + 4yr (3) MA, MS, PHD, PSYD + 2yr but not waivered or registered with the Board.	DESIGNATED MENTAL HEALTH WORKER (DMHW) Minimum Requirements: Must be at least 18 years of age with a high school diploma or GED	THERAPEUTIC FOSTER CARE (TFC) PARENT Minimum Requirements: Must be at least 21 years of age with a high school diploma or GED; must be an approved resource parent; and must complete 40 hours of initial TFC parent training and 24 hours of annual/ongoing training	CERTIFIED PEER SUPPORT SPECIALIST Minimum Requirements: Must be at least 18 years of age with a high school diploma or GED; must have successfully completed DHCS-approved curriculum and training requirements for a Certified Peer Support Specialist; must pass a DHCS-approved certification examination for Certified Peer Support Specialist
Assessment						
H0031	Mental Health Assessment by Non- Physician	X	X	X	X	X
H2000	Comprehensive Multidisciplinary Evaluation	X	X	X	X	X
Plan Development						
H0032	Mental Health Service Plan Developed by Non-Physician	X	X	X	X	X
Rehabilitation						
H2017	Psychosocial Rehabilitation	X	X	X	X	X
H2021	Community-Based Wrap-Around Services	X	X	X	X	X
Case Management						
T1017	Targeted Case Management	X	X	X	X	X
Crisis Intervention						
H2011	Crisis Intervention Service	X	X	X	X	X
Therapeutic Behavioral Services						
H2019	Therapeutic Behavioral Services	X	X	X	X	X
Certfied Peer Support Services						
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	No Privilege	No Privilege	No Privilege	No Privilege	X
H0038	Self-help/peer services	No Privilege	No Privilege	No Privilege	No Privilege	X
Medication Support						
H0033	Oral Medication Administration, Direct Observation	X	X	X	X	X
Collateral Services						
H2017	Psychosocial Rehabilitation	X	X	X	X	X
H0032	Mental Health Service Plan Developed by Non-Physician	X	X	X	X	X
T1017	Targeted Case Management	X	X	X	X	X
Pathways to Well-Being (Katie A Services)						
H2017	Psychosocial Rehabilitation	X	X	X	X	X
H0032	Mental Health Service Plan Developed by Non-Physician	X	X	X	X	X

NOTE: The following credentialing classifications require a co-signature from a Licensed Mental Health Professional (LMHP): Trainee, Designated Mental Health Worker (DMHW), Therapeutic Foster Care (TFC) Parent, and Certified Peer Support Specialist. LMHPs are Licensed Psychologists, Licensed Clinical Social Workers, Licensed Marriage & Family Therapists, and Licensed Professional Clinical Counselors.

****Co-signature has been waived for Mental Health Rehabilitation Specialist (MHRS). Programs will be responsible to maintain appropriate level of supervision for each credentialing category.**