



DEPARTMENT OF PUBLIC HEALTH SPECIALTY MENTAL HEALTH SERVICES DOCUMENTATION REQUIREMENTS AT-A-GLANCE

A DESK REFERENCE FOR BASIC STATE DOCUMENTATION REQUIREMENTS



San Francisco Health Network
Community Behavioral Health Services

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List of Medi-Cal Reimbursable Specialty Mental Health Services

Specialty Mental Health Services that may be provided to clients and are reimbursed by Medi-Cal include:

- Rehabilitative Mental Health Services:
 - Mental Health Services
 - Medication Support Services
 - Day Treatment Intensive
 - Day Rehabilitation
 - Crisis Intervention
 - Crisis Stabilization
 - Adult Residential Treatment Services
 - Crisis Residential Treatment Services
 - Psychiatric Health Facility Services
- Psychiatric Inpatient Hospitalization Services
- Targeted Case Management Services
- Psychologist Services
- EPSDT Supplemental Specialty Mental Health Services (including Therapeutic Behavioral Services)
- Psychiatric Nursing Facility Services

Source: CCR, Title 9, Chapter 11

List of Services NOT Medi-Cal Reimbursable

Services that are not reimbursable by Medi-Cal:

- Academic educational services;
- Vocational services that have as a purpose actual work or work training;
- Recreation;
- Socialization, if generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of clients involved;
- Services provided outside a person's scope of practice;
- Services where there is no progress note for the service;
- Services not covered by Short-Doyle Medi-Cal or provided to ineligible populations that are not Medi-Cal eligible (e.g. in Juvenile Justice Center or Jail);
- Services where documentation indicates a different service was provided than the service claimed;
- Travel time where the time to travel from the office to the service location is not documented and no medical necessity is indicated for providing the service at a remote location (e.g. home or residential facility);
- Services already fully reimbursed by other health coverage (e.g. Kaiser);
- Services where the time claimed is greater than the time documented (e.g. time billed is greater than length of service documented in progress note);
- Excessive, medically unnecessary or inappropriate services;
- Representative payee related services;
- Services where there is no signature of the person providing the service;
- Solely transportation services or solely clerical services such as faxing, leaving a message, or filling out applications (e.g. SSI forms);
- Supervision, scheduling appointments, preparing for groups, translation, administrative activities/forms associated with closing a client chart;
- Housing needs (e.g. completing forms for housing);
- Phone contacts among service providers that do not meet medical necessity;
- Grocery store trips that do not include skill training;
- No shows – missed visit/client not at home.

Source: CCR Title 9, Chapter 11, §1840.312/CCR Title 22, Chapter 3, 1458.1(a)(1013)

Lockouts

Lockouts are circumstances when Specialty Mental Health Services cannot be billed to Medi-Cal except under certain conditions as noted below:

- Targeted Case Management Services: when Psychiatric Inpatient Hospital Services (e.g. Zuckerberg San Francisco General Hospital), Psychiatric Health Facility Services (e.g. Langley Porter, McAuley) and Psychiatric Nursing Facility Services (e.g. Skilled Nursing Facility) are reimbursed except on the day of admission (note: Targeted Case Management Services are reimbursable when *solely* for the coordination of placement of a client on discharge from the hospital, psychiatric health facility or psychiatric nursing facility during the 30 calendar days immediately prior to the day of discharge for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility);
- Day Rehabilitation and Day Treatment Intensive: 1) when Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services or Psychiatric Nursing Facility Services are reimbursed except for the day of admission to those services; 2) Mental Health services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive is provided; and 3) two full-day or one full-day and one half-day or two half-day programs may not be provided on the same day;
- Medication Support Services: 1) that exceed 4 hours in a 24-hour period; 2) when Psychiatric Inpatient Hospital Services are reimbursed except on the day of admission; and 3) when Crisis Stabilization services are reimbursed except when a client is in a fee-for-service Hospital Inpatient Unit (primary care or SMHS);
- Crisis Intervention: 1) on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services or Psychiatric Inpatient Hospital Services are reimbursed except for the day of admission to those services; and 2) for Crisis Intervention provided more than 8 hours in a 24-hour period;
- Crisis Stabilization: 1) when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services or Psychiatric Nursing Facility Services are reimbursed except for the day of admission to those services; 2) Crisis Stabilization provided more than 20 hours during a 24-hour period; and 3) Crisis Stabilization is a package program and no other Specialty Mental Health Services may be reimbursed except for Targeted Case Management Services;
- Adult Residential Treatment Services: 1) when Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility or Psychiatric Nursing Facility Services are reimbursed except on the day of admission; and 2) when an organizational provider of both Mental Health Services and Adult Residential Treatment Services allocates the same staff's time under the two cost centers of Mental Health Services and Adult Residential Treatment Services for the same period of time.
- Crisis Residential Treatment Services: on days when the Mental Health Services, Day Treatment Intensive, Day Rehabilitation, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, Adult Residential Treatment, and Crisis Stabilization services are reimbursed except for the day of admission to Crisis Residential Treatment Services.
- Psychiatric Health Facility Services: on days when Adult Residential Treatment Services, Crisis Residential Treatment Services, Crisis Intervention, Day Treatment Intensive, Day Rehabilitation, Psychiatric Inpatient Hospital Services, Medication Support Services, Mental Health Services, Crisis Stabilization, and Psychiatric Nursing Facility Services except for the day of admission to Psychiatric Health Facility Services;
- Psychiatric Inpatient Hospital Services: 1) when Adult Residential Treatment Services, Crisis Residential Treatment Services, Crisis Intervention, Day Treatment Intensive, Day Rehabilitation, Psychiatric Nursing Facility Services (except for circumstances where the client has exercised a bed hold option), Crisis Stabilization, and Psychiatric Health Facility Services; and 2) when Psychiatric Inpatient Hospitalization Services are provided in a Short-Doyle/Medi-Cal hospital, in addition to the non-reimbursable services listed above, psychiatrist services, psychologist services, mental health services and medication support services are included in the per diem rate and not separately reimbursable except for the day of admission.

Sources: CCR, Title 9, Chapter 11, §1840.215, §1840.360 §1840.374

Medical Necessity	ICD-10 Qualifying Mental Health Diagnosis Categories
<p>Medical necessity must be documented in the assessment, client plan, progress notes and other chart documentation and must be determined by a person with diagnosis in his or her scope of practice. All three of the following medical necessity criteria must be met to be eligible for reimbursement:</p> <ol style="list-style-type: none"> 1. Diagnostic Criteria A client must be diagnosed with a current ICD 10 mental health diagnosis for non-hospital Specialty Mental Health Services that is related to a client’s behaviors and symptoms. 2. Impairment Criteria As a result of a mental disorder or emotional disturbance, a client must meet at least one of the following criteria: <ol style="list-style-type: none"> a) A significant impairment in an important area of life functioning; or b) A probability of significant deterioration in an important area of life functioning; or c) A probability that the child or youth will not progress developmentally as individually appropriate; or d) For full-scope Medi-Cal clients under age 21, a condition as a result of the mental disorder or emotional disturbance that specialty mental health services can correct or ameliorate (improve). 3. Intervention Criteria The proposed/actual client intervention(s) must address the functional impairment identified as a result of the qualifying mental health diagnosis by meeting each of these criteria: <ol style="list-style-type: none"> a) The focus of the proposed or actual intervention(s) is to address the condition identified under #2 above; b) The expectation that the proposed or actual intervention(s) will do at least one of the following: <ul style="list-style-type: none"> • Significantly diminish the impairment; and/or • Prevent significant deterioration in an important area of life functioning; and/or • Allow a child or youth to progress developmentally as individually appropriate; and/or • For full-scope Medi-Cal clients under age 21, correct or ameliorate the condition. 4. Not Responsive to Physical Health Care Based Treatment The condition would not be responsive to physical health care based treatment (e.g. depression due to hypothyroidism). <p><i>Sources: CCR, Title 9, Chapter 11, § 1830.205, § 1830.210, § 1840.112(b)(1-4), § 1840.314(d); CCR, Title 22, Chapter 3, § 51303(a); Credentialing Bds. For MH Disciplines.</i></p>	<ul style="list-style-type: none"> • Pervasive Developmental Disorders except Autistic Disorder • Disruptive Behavior and Attention Deficit Disorders • Feeding and Eating Disorders • Elimination Disorders • Somatoform Disorders • Adjustment Disorders • Personality Disorders excluding antisocial personality disorders • Dissociative Disorders • Schizophrenia Spectrum and Other Psychotic Disorders* • Mood Disorders* • Anxiety Disorders* • Factitious Disorders • Paraphilias • Gender Identity Disorders • Impulsive Control Disorders not elsewhere classified • Medication-Induced Movement Disorders related to other included diagnoses <p style="text-align: right;"><i>*=except if due to a general medical condition For a crosswalk of outpatient specialty mental health diagnoses, please visit: http://www.dhcs.ca.gov/services/MH/Pages/ICD-10.aspx</i></p>
Mental Health Diagnoses Not Covered	
<ul style="list-style-type: none"> ➤ “Deferred” or “by history” diagnoses (exception: can be used as opening diagnosis) ➤ Stand Alone “Rule Out” (R/O) diagnoses ➤ Provisional Diagnoses (x vs. y) ➤ “V” codes ➤ Intellectual Disability ➤ Learning Disorders ➤ Motor Skills Disorder ➤ Communication Disorders ➤ Delirium ➤ Dementia ➤ Amnesic Disorders ➤ Sleep Disorders ➤ Mental Disorders due to a general medical condition ➤ Autistic Disorder ➤ Tic Disorders ➤ Cognitive Disorders – dementia with depressed mood or delusions ➤ Substance Induced Disorders with psychotic, mood or anxiety disorders ➤ Anti-Social Personality Disorders ➤ Other conditions that may be the focus of clinical attention <p style="text-align: right;"><i>Source: California Department of Health Care Service</i></p>	

Eleven Elements of a Client Assessment

All clients must be initially assessed for their current emotional health status based on Episode Opening date: within 60 calendar days for Outpatient; within 3 full days for Adult Residential treatment; within 1 full day for Crisis Residential; for PPN, as authorized by BHS. Per MHP policy, clients must be reassessed annually by the anniversary date of the client episode opening and/or when a significant change in a client’s condition occurs, whichever occurs sooner. The assessment must document the specific behaviors and symptoms that a client presents to determine whether medical necessity criteria have been met and to inform a client’s treatment plan of care. The client assessment must be completed prior to or on the start date of a client treatment plan of care and must include all of the following 11 elements:

- 1. Presenting Problem:** Client’s chief complaint, history of presenting problems including current level of functioning, relevant family history and current family information.
- 2. Relevant Conditions/Psychosocial Factors:** Factors impacting the client’s physical and mental health, including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma.
- 3. Mental Health History:** Previous treatment including providers, therapeutic modality (e.g. medications, psychosocial treatments) and response, and inpatient admission, as well as information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports.
- 4. Medical History:** Relevant physical conditions reported by the client or a significant support person, and for children and youth, prenatal and perinatal events and relevant/significant developmental history; also include other medical information from medical records and relevant consultations if possible.
- 5. Medications:** Information about medications the client has received or is receiving to treat mental health and medical conditions including the duration of medical treatment and documentation of both the absence or presence of allergies or adverse reactions to medication and an informed consent for medications. Note: Medication consents must be obtained for *each* medication prescribed.
- 6. Substance Exposure/Substance Use:** Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.
- 7. Client Strengths:** The client’s strengths in achieving client plan goals related to the client’s mental health needs and functional impairments as a result of the mental health diagnosis.
- 8. Risks:** Situations that present a risk to the client and/or others including past or current trauma (see *DHCS SMHS Annual Review Protocol*).
- 9. A Mental Status Examination.**
- 10. A Complete Diagnosis:** A *documented* diagnosis from the current ICD-codes consistent with the presenting problems, history, mental status examination and/or other clinical data including any current medical diagnoses.
- 11. Any additional clarifying information.**

All client assessments must include: a) the date of service; b) the signature of the person providing the service (or electronic equivalent); c) the person’s type of professional degree AND licensure OR job title; and d) the date the documentation was entered in the medical record. Sources: CCR, Title 9, Chapter 11, §1810.204, §1840.112(b)(1-4), §1840.314(d)(e); CCR, Title 9, Chapter 4, §851 – Lanterman-Petris Act; MHP contract, Exhibit A, Attachment I

Eleven Elements of Client Plan (Treatment Plan of Care)

The initial client plan time-lines are the same as the initial assessment and based on Episode Opening date (within 60 calendar days for Outpatient; within 3 full days for Adult Residential treatment; within 1 full day for Crisis Residential; for PPN, as authorized by BHS). The client plan must be updated at least annually and/or when there are significant changes in a client's condition whichever occurs sooner. The following eleven elements of a Client Plan must be documented in the client record without exception:

1. **Specific Goals/Objectives:** The client plan must include specific, observable and/or and specific quantifiable goals/treatment objectives related to a client's mental health needs and functional impairments as a result of the client's mental health diagnosis.
2. **Proposed Interventions & Detailed Description:** The client plan must include the type(s) of intervention/modality, including a detailed description of the intervention(s) to be provided (see *DHCS Annual Review Protocol for Specialty Mental Health Services*).
3. **Frequency of Interventions:** The client plan must include the proposed frequency of the intervention(s).
4. **Duration of Interventions:** The client plan must include the proposed duration of the intervention(s).
5. **Focus of Interventions:** The client plan must include interventions that focus and address the identified functional impairments that have resulted from the client's mental disorder or emotional disturbance.
6. **Consistency of Interventions with Objectives:** The client plan interventions must be consistent with the client plan goal(s)/treatment objective(s).
7. **Consistency with Qualifying Diagnoses:** The client plan must be consistent with the qualifying diagnoses.
8. **Staff Signatures (for LPHA) and Co-Signatures (for non-LPHA):** The client plan must be signed by: 1) the person providing the service(s); or 2) a person representing a team or program providing the service(s); or 3) a person representing the Mental Health Plan providing service(s). If the person signing is not a Licensed Practitioner of the Healing Arts (LPHA), then a LPHA must co-sign the Client Plan to establish that services were provided under the direction of an LPHA.
9. **Client Participation & Agreement with Client Plan:** The client's degree of participation and agreement with the Client Plan must be documented in the following three ways: **a)** documentation of a client's degree of participation and agreement with the Client Plan as evidenced by: i) reference to the client's participation in and agreement in the body of the client plan; ii) the client's signature on the Client Plan; or iii) a description of the client's participation and agreement in the medical record (e.g. as in a progress note); **b)** the client's signature or the signature of the client's legal representative when: i) the client is expected to be in "long-term treatment" (defined as 6 months or more for the BHS MHP); and ii) the client plan provides that the client will be receiving more than one type of SMHS; and c) when a client's signature or the signature of the client's legal representative is required on the client plan, and the client refuses or is unavailable for signature, the Client Plan must include a written explanation of the refusal and unavailability of the signature.
10. **Evidence of Offering Copy of Plan to Client:** The medical record must include documentation that the provider offered a copy of the client plan to the client.
11. **Dates & Staff Signature, Degree, and Title/Licensure on Client Plan:** The client plan must include all of the following: a) the date of service; b) signature of the person providing the service (or electronic equivalent), the person's type of professional degree AND licensure OR job title; and c) the date the documentation was entered into the client medical record.

*For clients receiving Therapeutic Behavioral Services (TBS), the client plan must be developed within 30 days of the date of admission (see TBS Documentation Manual for plan elements).

Sources: CCR, Title 9, Chapter 11, §1810.205.2, §1810.254, §1810.440(c)(1)(2), §1840.112(b)(2-5), §1840.314(d(e)); DMH Letter 02-01, Enclosure A; WIC §5751.2, Mental Health Plan Contract, Exhibit A, Attachment I; CCR, Title 16, §1820.5, CA Business and Professional Code, §4999.20.

Progress Notes

Progress notes must be entered in the client record within 24 hours but no later than 5 business days (including those requiring a co-signature) of when a contact is made with the client for mental health services, medication support services, crisis intervention, and targeted case management. Any progress note not entered after 5 business days is considered a LATE ENTRY. Staff must label the progress note entry as "LATE ENTRY" at the beginning of the note (per BHS Policy).

- For crisis residential, crisis stabilization (one per 23-hour period), and day treatment services, progress notes must be entered daily.
- For day treatment intensive, a clinical summary must be completed weekly.
- For day rehabilitation and adult residential, progress notes must be entered weekly.

Progress notes must document all of the following:

1. Timely documentation of relevant aspects of client care including documentation of medical necessity;
2. Documentation of client encounters including relevant clinical decisions, when decisions are made, and alternative approaches for future interventions;
3. Interventions applied, the client's response to interventions, and the local of the interventions;
4. Date of service;
5. Documentation of referrals to community resources and other agencies, when appropriate;
6. Documentation of follow-up care or as appropriate a discharge summary;
7. Amount of time taken to provide services;
8. Documentation of linking a client to culture-specific and/or linguistic services where language assistance is identified in assessment; and
9. Signature of the person providing the service (or electronic equivalent), the person's type of professional degree, AND licensure OR job title and the date the documentation was entered in the medical record.

For progress notes where services are being provided to, or on behalf of, a client by two or more persons at one point of time, all of the following must be documented:

1. Date of service;
2. Documentation of each person's involvement in the context of the mental health needs of the client;
3. Exact number of minutes used by persons providing the services; and
4. Signatures of the persons providing the service (or electronic equivalent), their type of professional degree, AND licensure OR job title and the date the documentation was entered in the medical record.

Sources: CCR, Title 9, Chapter 11, §1810.254, §1810.440(c), §1840.112(b)(2-6), §1840.314, §1840.316-1840.322; CCR, Title 22, Chapter 3, §51458.1, §51470;

Mental Health Plan Contract, Exhibit A, Attachment I

More on Progress Notes	
Services	Reimbursable <u>Only</u> When the Following Conditions Are Met...
Multiple Staff 2 or more persons providing services to one or more clients	<ol style="list-style-type: none"> Staff must be intervening simultaneously. A legitimate reason for multiple staff must be documented. Each person's involvement must be documented in the context of the mental health needs of the client (e.g. nature, scope and duration of interventions). While best practice is to have each provider write his/her own progress note, if one note, then signature of each provider is required on the progress note. Time claimed for each provider must be documented separately by separate claims or same claim with the time separately indicated.
Group Therapy	<ol style="list-style-type: none"> The total number of clients present must be documented in Avatar; Staff must document each person's contribution. "Group Therapy" is a service code/service intervention, but THERAPY is the CCR Title 9 service modality.
Collateral	<ol style="list-style-type: none"> Service is provided to the client's significant support person for the purpose of meeting the needs of the client in achieving the goals of their client plan. Service includes, but is not limited to: a) consultation and training to the significant support person to assist in utilization of services by the client and/or to assist the person in better understanding the client's mental illness; and b) family counseling with the significant support person. Client may or may not be present for the service. "Family Therapy" is a service code/service intervention, but THERAPY is the CCR Title 9 service modality.
Case Conference	<ol style="list-style-type: none"> Case conference notes must meet medical necessity. All staff submitting claims must be a provider to the client. All staff must document their contribution to the meeting. All staff must document the amount of time they participated. All staff claiming time must sign the progress note.
Targeted Case Management	Service must assist client in accessing services including communication, coordination, and referral; monitoring service delivery to ensure access; monitoring client's progress; placement services; and plan development.
Medication Support Services	<ol style="list-style-type: none"> Progress notes should include: (a) an evaluation of client's signs/symptoms; (b) response to medication; (c) drug interactions; (d) adverse drug effects; and (e) change in dosage, when applicable. Progress notes for medication administration must include: (a) medication, dosage, frequency and route; (b) date and time of administration; (c) site/location of any injection; (d) the lot and/or vial number if medication is dispensed from a multi-dose container; and (e) any unusual or adverse response to the medication.

Sources: CA Department of Health Care Services, Non-Hospital NSMH Documentation Training, August 2015; SD/MC Provider Certification Protocol, Category 7, Criteria 4, June 2014; BHS Policy 3.01-4, 5/17/2

Specialty Mental Health Services Non-Compliance At-A-Glance

Each year, the California Department of Health Care Services (DHCS) and the San Francisco Department of Public Health monitor the top reasons for non-compliance findings. In FY 2015-16, the top reasons for non-compliance included:

- Documentation in the client record does not establish the client has a qualifying mental health diagnosis.
- Documentation in the client record does not establish that as a result of a mental health disorder, the client has at least one of the required impairments (e.g. a probability of significant deterioration in an important area of life functioning).
- Documentation in client record does not establish that the focus of the proposed intervention is to address the condition identified (e.g. a significant impairment is an important area of life functioning).
- Documentation in the client record does not establish the expectation that the proposed intervention will significantly diminish the impairment, prevent further significant deterioration in an important area of life functioning, allow a child/youth to progress developmentally as individually appropriate, or for full-scope Medi-Cal clients under age 21 years, correct or ameliorate the condition.
- For outpatient mental health services, the initial Client Plan was not completed within 60 calendar days of intake.
- The Client Plan was not completed at least on an annual basis.
- No documentation of client or legal guardian participation in the plan or written explanation of client's refusal or unavailability to sign the plan.
- An incorrect service code was selected for the service provided.
- The services provided were outside the person's scope of practice.
- Time claimed was greater than time documented (amount of time billed was greater than the duration of service documented in the progress note).
- The progress note indicated the service was provided while the client was in a setting where the client was ineligible to be served (e.g. Jail).
- The progress note indicated that the service provided was solely for one of the following: academic vocational services; vocational services that has work or work training as its actual purpose; or recreation or socialization that consisted of generalized group activities not providing systemic, individualized feedback to the specific targeted behaviors.
- The progress note indicated that the service provided was solely transportation, solely clerical, or solely representative payee related.
- The claim for group activity was not properly apportioned to all clients present.
- The documentation was not legible (e.g. signatures on treatment plans).
- For beneficiaries receiving Therapeutic Behavioral Services (TBS), there was no documentation of a plan for TBS.
- For TBS clients, the service was solely provided for the convenience of the family, caregivers, physician or teacher; to provide supervision or to ensure compliance with the terms and conditions of probation; to ensure a client's physical safety or the safety of others (e.g. suicide watch); or to address conditions that are not part of a client's mental health condition.
- For TBS clients, the progress note clearly indicates that TBS was provided to a client in a hospital mental health unit, psychiatric facility, nursing facility or crisis residential facility.

Sources: CA Department of Health Care Services Reasons for Recoupment for FY 2015-2016, Non-Hospital Services & DPH Office of Compliance and Privacy Affairs

Medication Support Services

Medication support services include prescribing, administering, dispensing, and monitoring psychiatric medications or biologicals that are necessary to alleviate mental illness symptoms. These services may include evaluation of the clinical effects of medication, medication regimen adjustment, obtaining informed consent for medication prescribed, medication education, medication plan development, medication administration or dispensing, medication related consultation with providers, phone calls to client and significant support person(s) about medication, and phone calls to pharmacies and transmitting medication orders. Medication support services may be provided anywhere in the community by the following staff within their scope of practice:

- | | | |
|---|--|--|
| <input type="checkbox"/> Licensed Physician | <input type="checkbox"/> Certified Nurse Specialist | <input type="checkbox"/> Licensed Pharmacist |
| <input type="checkbox"/> Certified Nurse Practitioner | <input type="checkbox"/> Licensed Vocational Nurse | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Licensed Psychiatric Technician | |

Source: CCR, Title 9, Chapter 11, §1810.225

Evaluation and Management Services: Client Face-to-Face Medication Management Services

Evaluation and Management (E/M) service billing codes are used by medical doctors and nurse practitioners to bill for medication management services when they are evaluating a client face-to-face to inform progress toward a client’s treatment plan of care goals. In general, the more complex a client visit, the higher the level that can be billed within the appropriate category. To bill E/M services, services provided must meet the definition of the E/M billing level (e.g. EEML2), be documented in the client record, and reflect the services provided. **No more than one E/M service code may be billed per day unless progress notes include a reason tied to medical necessity and a code modifier is used.** For initial psychiatric assessments, prescribers should use Billing Code 90792, and then for re- assessment, using either Billing Code 90792 or the appropriate E/M code.

Note that for initial client assessments and client re-assessments, all 11 elements of the assessment must be completed.

There are three key components and five types of service that must be considered when selecting the appropriate E/M billing level. The three key components are: 1) history; 2) examination; and 3) medical decision making. The four types of exam or history are: 1) problem-focused; 2) expanded problem-focused; 3) detailed; and 4) comprehensive. The chart below shows requirements that must be met for each of the five levels of E/M services across the three key components along with “Typical Face-to-Face Time” with clients. Additionally, the “Typical Face-to-Face Time” with clients is listed for each service type.

Note: Two of three components (history, exam, medical decision making) must be met to use an E/M code.

Key Components When Selecting Appropriate E/M Billing Levels For Existing Clients

EEML 1 to 5 Codes	History	Exam	Medical Decision Making	Typical Face-to-Face Time
EEML1	Not required	Not required	Not required	5
EEML2	Problem-focused	Problem-focused	Straight Forward	10
EEML3	Expanded problem-focused	Expanded problem-focused	Low	15
EEML4	Detailed	Detailed	Moderate	25
EEML5	Comprehensive	Comprehensive	High	40

Component #1: Client History

To determine which of the five types of service to select under each of the three key components of a client history, refer to the table below.

Note: To qualify for a given type of service, all items indicated in a row must be met.

E/M Code	Type	Chief Complaint	History of Present Illness (HPI)	Review of Systems (ROS)	Past Medical, Family and/or Social History
EEML2	Problem-focused	Required	Brief HPI 1 to 3 elements	N/A	N/A
EEML3	Expanded problem- focused	Required	Brief HPI 1 to 3 elements	1 pertinent problem	N/A
EEML4	Detailed	Required	Extended HPI 4+ elements	Extended ROS 2 to 9 elements	1 Problem Pertinent
EEML5	Comprehensive	Required	Extended HPI 4+ elements	Complete ROS 10+ elements	Complete PMFSH at least 2 elements

Component #2: Client Examination

To choose the type of examination, perform and document the required number of examination elements in the table below.

Problem-Focused EEML2	Expanded EEML3	Detailed EEML4	Comprehensive EEML5
1 to 5 elements	At least 6 elements	At least 9 elements	All elements from constitutional & psychiatric sections, plus at least 1 from musculoskeletal

System/Body/Area	Examination Elements
Constitutional	<ul style="list-style-type: none"> 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight General appearance
Musculoskeletal	<ul style="list-style-type: none"> Muscle strength and tone
Psychiatric	<ul style="list-style-type: none"> Speech Thought process Associations Abnormal/psychotic thoughts Judgment and insight Orientation Recent and remote memory Attention and concentration Language Fund of knowledge Mood and affect

Component #3: Criteria for Each Type of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option by considering the following criteria:

1) the number of possible diagnoses and/or the number of management options that must be considered; 2) the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and 3) the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Note: In choosing the type of medical decision making, at least two of three criteria must be met for the type of decision making.

E/M Code	Type of Decision Making	Criterion #1: Number of Diagnoses/Management Options	Criterion #2: Amount and/or Complexity of Data to be Reviewed	Criterion #3: Risk of Significant Complications, Morbidity, and/or Mortality
EEML2	Straightforward	Minimal	Minimal/none	Minimal
EEML3	Low Complexity	Limited	Limited	Low
EEML4	Moderate Complexity	Multiple	Moderate	Moderate
EEML5	High Complexity	Extensive	Extensive	High

Client Medication Consents

Providers must obtain and retain a current written medication consent form signed by the client or parent/caregiver agreeing to the treatment of each prescribed medication. A new consent form must be completed and signed for each new medication prescribed. Even if no new medications are prescribed, medication consents for minors must be updated annually. **Compliant psychiatric medication consent forms must contain the following elements, all of which must be discussed with the client:** 1) reasons for taking the medications; 2) reasonable alternative treatment available, if any; 3) medication type; 4) range of frequency of administration; 5) dosage; 6) administration method (oral/injection); 7) duration of taking the medication; 8) probable side effects; 9) possible side effects if taken longer than 3 months or long-term; and 10) consent, once given, may be withdrawn at any time. All client medication consent forms must include: a) date of service; b) signature of person providing the service (or electronic equivalent); c) person’s type of professional degree AND licensure OR job title; and d) the date the documentation was entered into the medical record.

Sources: CCR, Title 9, Chapter 11, §1810.204, §1840.112(b)(1-4), §1840.314(d)(e); CCR, Title 9, Chapter 4, §851, Lanterman-Petris Act; MHP Contract, Exhibit A, Attachment I

Psychotherapy Add-on Codes

When a beneficiary receives an Evaluation and Management Service (E&M) service with a psychotherapeutic service on the same day, by the same provider, both services are payable if they are significant and separately identifiable and billed using the correct codes. New add-on codes (in the bulleted list below) designate psychotherapeutic services performed with E&M codes. An add-on code (often designated with a "+" in codebooks) describes a service performed with another primary service. An add-on code is eligible for payment only if reported with an appropriate primary service performed on the same date of service. Time spent for the E&M service is separate from the time spent provided psychotherapy and time spent providing psychotherapy cannot be used to meet criteria for the E&M service. **Because time is indicated in the code descriptor for the psychotherapy CPT codes, it is important for providers to clearly document in the patient's medical record the time spent providing the psychotherapy service rather than entering one time period including the E&M service.**

For Psychotherapy Services Provided WITH an E&M Service

Code	Service	Notes
Code + 90833	Psychotherapy- 30 mins	Psychotherapy, 30 minutes with patient and/or family member when performed with an E&M service*
Code + 90836	Psychotherapy- 45 mins	Psychotherapy, 45 minutes with patient and/or family member when performed with an E&M service*
Code + 90838	Psychotherapy- 60 mins	Psychotherapy, 60 minutes with patient and/or family member when performed with an E&M service*

*List separately in addition to the code for primary procedure

DPH Office of Compliance & Privacy Affairs * Frequently Used Mental Health Billing Codes			
AVATAR CODES	SERVICES	STAFF ELIGIBLE TO BILL (within their scope of practice)	NOTES
ASMT1	Psychiatric Diagnostic Evaluation*	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician - cannot establish client diagnosis (LPHA must co-sign) MHRS - cannot establish client diagnosis (LPHA must co-sign) Graduate Students (LPHA must co-sign) 	Evaluation/analysis of a client's historic and current mental, emotional, and/or behavioral disorders. Review of any relevant family, cultural, medical, substance abuse, legal or other complication factors. Establishes diagnosis and may include the use of testing. TBS Assessment is the Initial Assessment of a child or youth referred for TBS services.
90792	Psychiatric Diagnostic Evaluation with Medical Services*	<ul style="list-style-type: none"> LPHA: MD, NP only 	Evaluation/analysis of a client's historic and current mental, emotional, and/or behavioral disorders. Review of any relevant family, cultural, medical, substance abuse, legal or other complication factors. Establishes diagnosis and may include the use of testing. TBS Assessment is the Initial Assessment of a child or youth referred for TBS services.
H0032	Plan Development	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician (LPHA must co-sign) MHRS (LPHA must co-sign) 	Development and approval of client plan and monitoring of client progress toward goal attainment, evaluating if the plan needs modification, consultation/collaboration with mental health staff/other professionals involved in a client's treatment plan to assist, develop, and modify plan.
H0034	Medication Support Services	<ul style="list-style-type: none"> LPHA: MD, NP only Non-LPHA Nurse, Psychiatric Technician, Pharmacist 	Medication support services include prescribing, administering, dispensing, and monitoring psychiatric medications or biologicals that are necessary to alleviate the mental illness symptoms.
INDTPY	Individual Psychotherapy	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Graduate Students (LPHA must co-sign) 	Used by licensed, waived staff and graduate students (with LPHA co-signature) only.
IREHAB	Rehabilitation & Psychosocial Service to Individual Client	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician MHRS MHW (LPHA/MHRS must co-sign) Graduate Students (LPHA must co-sign) 	Services to assist, improve, maintain, restore a client's functional skills, daily living skills, social or leisure skills, and grooming and personal hygiene skills.
GRPTPY	Group Psychotherapy (other than Multi-Family Group)	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Graduate Students (LPHA must co-sign) 	Used by licensed, waived staff and graduate students (with LPHA co-signature) only.
GREHAB	Group Rehabilitation	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician MHRS MHW (LPHA/MHRS must co-sign) Graduate Students (LPHA must co-sign) 	Group sessions to assist, improve, maintain, restore a client's functional skills, daily living skills, social or leisure skills, and grooming and personal hygiene skills such as healthy living or stress management groups.
90849	Multi-Family Group Psychotherapy	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered 	Used by licensed, waived staff and graduate students (with LPHA co-signature) only.
90847	Family Therapy	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Graduate Students (LPHA must co-sign) 	Family Therapy with the Client Present
ICOLL	Collateral	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician, Pharmacist MHRS MHW (LPHA/MHRS must co-sign) Graduate Students (LPHA must co-sign) 	Consultation and training of the significant support person(s) such as a family member or roommate to assist in better utilization of services and in understanding the client's serious mental health issues. Significant support persons exclude other specialty mental health service professionals.
CRISIS	Crisis Intervention	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician, Pharmacist MHRS MHW (LPHA/MHRS must co-sign) Graduate Students (LPHA must co-sign) 	Crisis includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic intervention to minimize the potential for psychological trauma to address typically life threatening or complex and requires immediate attention to a client in high distress. Used to report the first 30-74 minutes of Psychotherapy for Crisis on a given date and additional block(s) of time, up to 30 minutes each beyond the first 74 minutes.
T1017	Targeted Case Management, Brokerage, Wellness Check	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician, Pharmacist MHRS MHW (LPHA/MHRS must co-sign) Graduate Students (LPHA must co-sign) 	Activities provided to assist a client in being able to access medical, educational, social, prevocational, rehabilitative, or other community services and treatment. Can include interagency or intra-agency communication, coordination, and monitoring regarding appointments and forms, as well as linkages to housing, transportation and finance services.
NM	Medi-Cal Non-Billable	<ul style="list-style-type: none"> LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician (LPHA must co-sign) Pharmacist MHRS and MHW (MHRS/LPHA must co-sign for MHW) 	Used for any services provided by a clinical provider when the client is in a "service lock-out" situation such as an inpatient hospital setting; these services may not duplicate services provided by the lock-out facility and are not billable to Medi-Cal. This service code time is reflected in worker productivity.
ADM99	Admin Code, Not Billable	<ul style="list-style-type: none"> All LPHA & LPHA-Registered/Waivered Non-LPHA Nurse, Psychiatric Technician (LPHA must co-sign) Pharmacist MHRS and MHW (MHRS/LPHA must co-sign for MHW) Graduate Students (LPHA must co-sign) 	Used when a clinical provider is providing services that cannot be billed to either Medi-Cal and/or Medicare such as a phone call to schedule an appointment or completing SSI forms. This service code time is reflected in worker productivity.
ADM00	No Show	<ul style="list-style-type: none"> All staff 	Used for client no shows. This service code time is not billable and is not

LPHA: Licensed Practitioner of the Healing Arts which includes: Medical Doctor (MD), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC), Licensed PhD, and Licensed PsyD.

LPHA-Registered/Waivered: Associate Clinical Social Worker (ASW); Marriage and Family Therapist Intern (MFTi); Professional Clinical Counselor Intern (PCCI); Waivered PhD, and Waivered PsyD.

Non-LPHA Nurses, Psychiatric Technicians, and Pharmacists: Registered Nurse (RN - BA/AA), Licensed Vocational Nurse (LVN), Psychiatric Technician, and Pharmacist.

MRHS & MHWs: Mental Health Rehabilitation Specialist (MHRS) and Mental Health Worker (MHW)

Graduate Students: Unlicensed graduate student enrolled in school: Masters of Social Work, Master of Arts in Counseling, and Doctoral Psychology.

"LPHA must co-sign": Refers to the LPHA signature on the Client Assessment and Treatment Plan of Care, not a Progress Note that documents an assessment or plan development service.

Name of Service	Licensed Practitioner of the Healing Arts (LPHA)								LPHA-Registered/Waivered					Non-LPHA Nurses, Psychiatric Technicians & Pharmacist				Mental Health Rehab Specialist (MHRS)	Mental Health Worker (MHW) and Peer Specialist	Graduate Students (Enrolled in School; Unlicensed)		
	MD	NP	CNS	LCSW	LMFT	LPCC	Licensed PhD	Licensed PsyD	ASW	MFTI	PCCI	Waivered PhD	Waivered PsyD	RN (BS or AA)	LVN	Psych Tech	Pharmacist			MSW Student	MA Counseling	Doctoral Psychology
Assessment	90792 Psychiatric Diagnostic w/Medical Service	90792 Psychiatric Diagnostic w/Medical Service	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	ASMT1	No Priv. <i>(see Exception in Notes field below)</i>	No Priv. <i>(see Exception in Notes field below)</i>	No Priv. <i>(see Exception in Notes field below)</i>	No Priv.	ASMT1 (Cannot establish Diagnosis; LPHA must co-sign)	No Priv.	ASMT1 (LPHA must co-sign)		
Plan Development	H0034/H2010	H0034/H2010	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	H0032	No Priv. <i>(see Exception in Notes field below)</i>	No Priv. <i>(see Exception in Notes field below)</i>	No Priv. <i>(see Exception in Notes field below)</i>	No Priv.	H0032 (LPHA must co-sign)	No Priv.	H0032 (LPHA must co-sign)		
Individual Psychotherapy	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	INDTPY	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	INDTPY (LPHA must co-sign)		
Group Psycho-therapy	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	GRPTPY	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	GRPTPY (LPHA must co-sign)		
Individual Rehabilitation	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	IREHAB	No Priv.	IREHAB (LPHA or MHRS must co-sign)	IREHAB (LPHA or MHRS must co-sign)	IREHAB (LPHA must co-sign)		
Group Rehabilitation	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	GREHAB	No Priv.	GREHAB (LPHA or MHRS must co-sign)	GREHAB (LPHA or MHRS must co-sign)	GREHAB (LPHA must co-sign)		
Collateral	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL	ICOLL (LPHA or MHRS must co-sign)	ICOLL (LPHA or MHRS must co-sign)	ICOLL (LPHA must co-sign)		
Targeted Case Management	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017	T1017 (LPHA or MHRS must co-sign)	T1017 (LPHA or MHRS must co-sign)	T1017 (LPHA must co-sign)		
Crisis Intervention	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS	CRISIS (LPHA or MHRS must co-sign)	CRISIS (LPHA or MHRS must co-sign)	CRISIS (LPHA must co-sign)		
TBS Assessment; TBS Plan Development	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A	H2019A (LPHA must co-sign)	H2019A (LPHA must co-sign)	H2019A (LPHA must co-sign)	No Priv.	H2019A (LPHA must co-sign)	No Priv.	H2019A (LPHA must co-sign)		
TBS Direct Service	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	H2019	No Priv.	H2019	No Priv.	H2019 (LPHA must co-sign)		
TBS Collateral	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	H2019C	No Priv.	H2019C	No Priv.	H2019C (LPHA must co-sign)		
Medication Support	E/M Code or H0034, as appropriate	E/M Code or H0034, as appropriate	H0034	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	H0034	H0034	H0034	H0034	No Priv.	No Priv.	No Priv.	
Group Meds	GMEDS	GMEDS	GMEDS	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	No Priv.	GMEDS	GMEDS	GMEDS	GMEDS	No Priv.	No Priv.	No Priv.	

Notes: (1) No Priv. = staff member has no privileges to provide the service; (2) Exception for RN/LVN/PsychTech = if a staff member also meet MHRS criteria, then the staff may deliver assessment and plan development using same MHRS restrictions; (3) this version of the document (07/01/2017-v2Peer) introduced new information (added "Peer Specialist" and corrected "90792 Psychiatric Diagnostic"); (4) Staff Contact: SFDPH Compliance and Privacy Affairs Unit (415-255-3914)

Services	Specialty Mental Health Service Definitions from CCR Title 9, Division 1, Chapter 11
Assessment	§1810.204. Assessment: "Assessment" means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
Plan Development	§1810.232. Plan Development: "Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
Therapy	§1810.250. Therapy: "Therapy" means a service activity that 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: "Rehabilitation" means a service activity which includes, but is not limited to 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: "Collateral" means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.
Crisis Intervention	§1810.209. Crisis Intervention: "Crisis Intervention" means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.
Medication Support Services	§1810.225. Medication Support Services. "Medication Support Services" means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.
Targeted Case Management	§1810.249. Targeted Case Management. "Targeted Case Management" 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.
Therapeutic Behavioral Services	<p>Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Title 9, California Code of Regulations (CCR), Section 1810.215 states, "EPSDT supplemental specialty mental health services" means those services defined in Title 22, [CCR] Section 51184, that are "provided to correct or ameliorate the diagnoses listed in Section 1830.205, and that are not otherwise covered by this chapter."</p> <p>TBS is an intensive, individualized, one-to-one behavioral mental health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service. TBS is available for children/youth who are being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children/youth and their parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child' and family's needs.</p>

Helpful Federal, State and Local Documentation Resources


<p>Centers for Medicare & Medicaid Services The Centers for Medicare and Medicaid Services website offers information on federal requirements and regulations for both Medicare and Medicaid (Medi-Cal in California). The website is updated periodically with bulletins and special publications on topics of interest such as Evaluation & Management Services.</p>	<p>www.cms.gov</p>
<p>California Department of Health Care Services (DHCS) The DHCS website provides information on State requirements and regulations for Medi-Cal and Medicare. In addition to web pages listed below, the DHCS website has a search function for links to topics such as the Mental Health Plan Boilerplate Contract for counties or the Medi-Cal Billing Manual.</p>	<p>www.dhcs.ca.gov</p>
<p>DHCS Main Medi-Cal Web Page</p>	<p>www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx</p>
<p>DHCS Providers & Partners Web Page</p>	<p>www.dhcs.ca.gov/provgovpart/Pages/default.aspx</p>
<p>DHCS Medi-Cal Bulletins & Manuals Web Page</p>	<p>http://files.medi-cal.ca.gov/pubsdoco/Bulletins_menu.asp http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp</p>
<p>DHCS Forms, Laws & Regulations Web Page</p>	<p>www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx</p>
<p>DHCS Bulletins, Information Notices and Letters</p>	<p>www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx</p>
<p>San Francisco Department of Public Health The Department of Public Health website includes helpful resources for providers including current BHS policies and procedures, Avatar user support, and outpatient mental health services billing codes.</p>	<p>www.sfdph.org</p>
<p>BHS Policies and Procedures</p>	<p>https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSmnuPolyProc.asp</p>
<p>BHS Documentation Manual</p>	<p>https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/default.asp</p>
<p>Avatar User Support</p>	<p>https://www.sfdph.org/dph/comupg/oservices/mentalHlth/BHIS/avatarUserDocs.asp</p>
<p>BHS Outpatient Mental Health Billing Codes</p>	<p>https://www.sfdph.org/dph/comupg/oservices/mentalHlth/BHIS/avatarUserDocs.asp</p>
<p>BHS Outpatient MH Service Code Definitions</p>	<p>https://www.sfdph.org/dph/comupg/oservices/mentalHlth/BHIS/avatarUserDocs.asp</p>

For more information regarding mental health documentation policies and regulations, please contact:

Behavioral Health Services Compliance Office
Phone: 415-255-3443

For more information regarding mental health documentation requirements, please contact:

Joseph A. Turner, PhD, Clinical Documentation Specialist
Clinical Documentation Improvement Program (CDIP)
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 The Desk Reference was developed as a quick reference for State documentation requirements and non-compliance findings; it is not intended to be a “how to guide” for documentation. This is the purpose of the DPH Specialty Mental Health Services Documentation Manual.