



State of California—Health and Human Services Agency  
Department of Health Care Services



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GOVERNOR

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TO: COUNTY BEHAVIORAL HEALTH DIRECTORS  
COUNTY DRUG & ALCOHOL ADMINISTRATORS  
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA  
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES  
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS  
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.  
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES  
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: CHART DOCUMENTATION REQUIREMENT CLARIFICATIONS

The purpose of this Information Notice (IN) is to provide clarification regarding documentation and related requirements for Medi-Cal Specialty Mental Health Services (SMHS). This IN provides guidance and addresses frequently asked questions regarding chart documentation.

This IN is not exhaustive. It responds to specific questions regarding documentation requirements for the following activities and topics:

- A. Scope of Practice Requirements
- B. Assessment
- C. Client Plan
- D. Provision of Services Prior to a Client Plan Being in Place
- E. Progress Notes
- F. Medication Consents
- G. Location of Services
- H. Family Therapy & Family Counseling
- I. Multiple Provider Signatures on Progress Notes
- J. Case Conferences
- K. Day Treatment
- L. Claiming for SMHS – General
- M. Claiming for Service Functions Based on Minutes of Time

- N. Claiming for Group Therapy
- O. Claiming for Travel Time
- P. Claiming for Chart Review

## **A. SCOPE OF PRACTICE REQUIREMENTS**

The State Plan describes SMHS<sup>1</sup> and specifies the provider types for each service. SMHS must be delivered by mental health professionals working within their scope of practice. (Section 3, Supplement 3 to Attachment 3.1-A, pages 2d, 2m; See also Cal. Code Regs., tit. 9, §1840.314(d)) Please refer to appropriate professional licensing boards for specific information about scope of practice; as well as any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations.

### **1. Who can direct and/or provide SMHS?**

The following mental health professionals may provide and direct others in providing SMHS, within their respective scope of practice<sup>2</sup>:

- (A) Physicians;
- (B) Psychologists;
- (C) Licensed Clinical Social Workers;
- (D) Licensed Professional Clinical Counselors;
- (E) Marriage and Family Therapists;
- (F) Registered Nurses;
- (G) Certified Nurse Specialists; and,
- (H) Nurse Practitioners. (State Plan, Section 3, Supplement 3 to Attachment 3.1-A, pages 2m-2o)

Waivered/registered mental health professionals may only direct services under the supervision of a Licensed Mental Health Professional (LMHP) in accordance with applicable laws and regulations governing the registration or waiver. (Cal. Code Regs., tit. 9 § 1840.314 (e) (1)(F))

Direction may include, but is not limited to being the person directly providing the

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<sup>1</sup> State Plan, Section 3, Supplement 3 to Attachment 3.1-A and Supplement 2 to Attachment 3.1-B Supplement 3 to Attachment 3.1-A addresses SMHS for the categorically needy. Supplement 2 to Attachment 3.1-B addresses SMHS for the medically needy. The provisions in the two documents are the same. To avoid disruptively long citations, references to Supplement 2 to Attachment 3.1-B are omitted from the remainder of this Notice. Psychiatric inpatient hospital services and TCM services are described elsewhere in the State Plan. TCM services are described in Supplement 1 to Attachment 3.1-A, pages 1-4.

<sup>2</sup> The State Plan defines specific minimum provider qualifications for each individual delivering or directing services. State Plan, Section 3, Supplement 3 to Attachment 3.1-A, pages 2m-2p

service, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans. Individuals are not required to be physically present at the service site to execute direction. The licensed professional directing service assumes ultimate responsibility for the SMHS provided. (State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2b; Cal. Code Regs., tit. 9 § 1840.314 (e)(2))

SMHS may be provided by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for SMHS established by Department of Health Care Services (DHCS), to the extent authorized under state law.

The following types of providers must be licensed in accordance with applicable State of California licensure requirements, and, in addition, must work “under the direction of” a licensed professional operating within his or her scope of practice:

- (A) Licensed Vocational Nurses;
- (B) Licensed Psychiatric Technicians;
- (C) Physician Assistants;
- (D) Pharmacists; and,
- (E) Occupational Therapists. (See State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p).

Additional providers who may operate “under the direction of” a LMHP include:

#### Mental Health Rehabilitation Specialists (MHRS)

- A MHRS shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting. A MHRS may provide Mental Health Services (including contributing to Assessment, but excluding Therapy), Targeted Case Management (TCM), Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential, and Crisis Residential Treatment services.

#### Other Qualified Providers

- The State Plan permits the provision of services by “Other Qualified Providers,” defined as, “an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county

mental health department.” Mental Health Services (excluding Therapy), TCM, Day Rehabilitative Services, Day Treatment Intensive Services, Crisis Intervention, Crisis Stabilization, Adult Residential and Crisis Residential Treatment services may be provided by any person determined by the Mental Health Plan (MHP) to be qualified to provide the service, consistent with state law. State law requires these “Other Qualified Providers” to provide services “under the direction of” a LMHP within their respective scope of practice. (State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p; Cal. Code Regs., title 9, section 1840.344, Service Function Staffing Requirements – General)

**2. What is the scope of practice of practicum students and trainees (graduate level students enrolled in an academic program but not yet eligible to be registered or waived) when supervised by a LMHP who co-signs all documentation?**

The scope of practice depends on the particular program in which the student or trainee is enrolled and the requirements for that particular program, including any scope, supervision, or registration requirements set forth in the Business and Professions Code or associated regulations. In accordance with the Business and Professions Code, the Board of Psychology, and the Board of Behavioral Sciences, non-licensed trainees, interns, and assistants must be under the immediate supervision of a LMHP who shall be responsible for ensuring that the extent, kind, and quality of the services performed are consistent with his or her training and experience and be responsible for his or her compliance with applicable state law. (Business and Professions Code §§2913, 4980.03, 4980.43(b), and 4996.18(d))

An individual participating in a field internship/trainee placement, while enrolled in an accredited and relevant graduate program, working “under the direction” of a licensed, registered, or waived mental health professional and determined to be qualified by the MHP, may conduct the following service activities: comprehensive assessments including mental status exams (MSE) and diagnosis; development of client plans; individual and group therapy; write progress notes; and, claim for any service within the scope of practice of the discipline of his/her graduate program.

If students and trainees do not meet the definition of any of the other defined providers under the State Plan, they may provide some services as Other Qualified Providers under the direction of a LMHP who is authorized to direct services. (See Section 3, Supplement 3 to Attachment 3.1-A; Cal. Code Regs., tit. 9, §1840.314(e))

**3. Who can formulate a diagnosis?**

Formulation of a diagnosis requires a provider, working within his/her scope of practice, to be licensed, waived and/or under the direction of a licensed provider in accordance with California State law. Diagnosis is in the scope of practice for the following provider types:

- (A) Physicians;
- (B) Psychologists;
- (C) Licensed Clinical Social Workers;
- (D) Licensed Professional Clinical Counselors;
- (E) Licensed Marriage and Family Therapists; and,
- (F) Advanced Practice Nurses, in accordance with the Board of Registered Nursing.

**4. Can a non-LMHP complete parts of the assessment? Can a diagnosis made by an LMHP be added to an assessment performed by a non-LMHP with a reference note, “as diagnosed by...”?**

The diagnosis, MSE, 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 his/her scope of practice under California State law, who is licensed, waived, and/or under the direction of a LMHP.

However, the MHP may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary’s mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (Cal. Code Regs., tit.9, § 1840.344; State Plan, Section 3, Supplement 3 to Attachment 3.1-A, pg. 2m-p)

**B. ASSESSMENT**

**1. How is “Assessment” defined?**

Assessment is defined as 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. (Cal. Code Regs., tit, 9 § 1810.204)

**2. What are the required elements of an assessment?**

An assessment must include the following elements:

- a) Presenting Problem - The beneficiary's chief complaint, history of the presenting problem(s), including current relevant family history and current family information;
- b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;
- c) Mental Health History - Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
- d) Medical History - Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
- e) Medications - Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
- f) Substance Exposure/Use - Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications, over-the-counter, and illicit drugs;
- g) Client Strengths - Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- h) Risks - Situations that present a risk to the beneficiary and/or others, including past or current trauma;
- i) Mental Status Exam;
- j) Diagnosis - A complete five-axis diagnosis from the most current Diagnostic and Statistical Manual, or a diagnosis from the most current International Classification of Diseases-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,
- k) Additional clarifying formulation information as needed. (MHP Contract)

**3. Can the diagnosis be documented on a form separate from the assessment? If yes, must the LMHP making the diagnosis sign both forms?**

An MHP may choose to use a separate “Diagnosis Form” if the form is completed and signed off by the LMHP assigning the diagnosis and then linked to the rest of the assessment as an addendum. The diagnosis should be signed off by the person that made the diagnosis instead of being “noted” by another staff person. The LMHP does not have to sign documentation of the rest of the assessment.

**4. Providers are to evaluate the “risks” as part of an assessment. What are examples of “risks” that could be included in an assessment?**

Examples of risks include:

- History of Danger to Self (DTS) or Danger to Others (DTO);
- Previous inpatient hospitalizations for DTS or DTO;
- Prior suicide attempts;
- Lack of family or other support systems;
- Arrest history, if any;
- Probation status;
- History of alcohol/drug abuse;
- History of trauma or victimization;
- History of self-harm behaviors (e.g., cutting);
- History of assaultive behavior;
- Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and,
- Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

**5. Can “By history”, “Rule out”, or “Provisional” diagnoses be used in meeting Medical Necessity?**

“By history”, “Rule Out” and “Provisional” diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a beneficiary may have a “by history”, “rule out”, or “provisional” diagnosis as long as there is also at least one included diagnosis.

For Psychiatric Inpatient Hospital Services, a beneficiary must have one of the included diagnoses listed and meet the other medical necessity criteria in California Code of Regulations, title 9, section 1820.205.

For outpatient SMHS, a beneficiary must have one of the included diagnoses listed and meet the other medical necessity criteria in California Code of Regulations, title 9, sections 1830.205 or 1830.210.

**6. Can a beneficiary's diagnosis determined during a recent inpatient stay be used as the diagnosis for an outpatient assessment?**

The assessment, which includes diagnosis, is designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. The status of the beneficiary's mental, emotional, or behavioral health may change as a beneficiary transitions from inpatient to outpatient services. As such, the MHP and its providers should not rely on an inpatient diagnosis when performing an assessment for outpatient services. However, the outpatient provider should review the inpatient assessment documentation to inform the outpatient assessment and verify that the diagnosis reflects the beneficiary's current mental, emotional, or behavioral health status.

**7. If the determination about a diagnosis differs between a physician and a non-physician LMHP, which diagnosis should be used for the Assessment?**

The MHP is ultimately responsible for certifying the accuracy, truthfulness, and completeness of the diagnosis and the provision of SMHS. If there is a difference of opinion regarding a beneficiary's diagnosis, the provider should follow the MHP's direction in how to resolve the stated differences. Best practices would indicate that the physician and non-physician providers involved would consult and collaborate to determine the most accurate diagnosis. (Cal. Code Regs., tit. 9 §§ 1820.205 and 1830.205; and State Plan Section 3, Supplement 3 to Attachment 3.1-A, page 1)

**8. If a beneficiary receives services from LMHPs in different programs, can the diagnosis made by an LMHP in one program be used in the other program(s), or must each program independently diagnose the beneficiary?**

The diagnosis of a beneficiary may be used by multiple providers if the diagnosis reflects the current status of the beneficiary's mental, emotional, or behavioral health.

A re-assessment may be required when a client has experienced a significant medical or clinical change, or where a significant amount of time has elapsed since a prior assessment and diagnosis. Determination of whether and when a re-assessment and diagnosis are necessary depends on the MHP's policies and guidelines and on the community standard of care. The interventions applied by each provider must be appropriate to address the beneficiary's included diagnosis and associated functional impairments. Best practices would indicate that a re-assessment should be done on at



least an annual basis or when there is a significant change in the beneficiary's condition.

## **C. CLIENT PLAN**

### **1. Who can develop client plans?**

The MHP determines who can develop client plans. The client plan shall include documentation of the beneficiary's participation in the development of and agreement with the client plan. (MHP Contract; Cal. Code Regs., tit. 9, §1810.440 (c)(1))

### **2. What staff must sign a beneficiary's client plan?**

A client plan must be signed (or electronic equivalent) and dated by either:

- The person providing the services;
- A person representing a team or program providing services; or
- A person representing the MHP providing the services.

In addition to a signature by one of the above, the plan must be co-signed by one of the following providers, if the client plan indicates that some services will be provided by a staff member **under the direction** of one of the categories of staff listed below and/or the person signing the client plan is not one of the categories of staff listed below:

- A physician
- A licensed/waivered psychologist
- A licensed/registered/waivered social worker
- A licensed/registered/waivered marriage & family therapist
- A licensed/registered/waivered professional clinical counselor
- A registered nurse, including but not limited to nurse practitioners and clinical nurse specialists. (MHP Contract Cal. Code Regs., tit. 9. § 1810.440 (c)(1))

### **3. When is a client plan effective?**

A client plan is effective once it has been signed (and co-signed, if required) and dated by the required staff member(s). (MHP Contract; Cal. Code Regs., tit. 9. § 1810.440 (c)(1)).

### **4. When is a beneficiary's signature required on a client plan?**

The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:

- The beneficiary is expected to be in long term treatment as defined by the MHP; **and**,
- The client plan provides that the beneficiary will be receiving more than one SMHS; **or**,
- The MHP documentation standards require it.

If a beneficiary is ***not*** expected to be in “long term treatment” as defined by the MHP ***and*** is only receiving one SMHS; ***and*** the MHP does NOT require a client signature, the beneficiary is not required to sign the client plan. (MHP Contract; Cal. Code Regs., tit. 9, § 1810.440 (c)(2)(A));

**5. If a beneficiary is not required to sign his or her client plan, what specifically must be documented to show that the beneficiary participated in the preparation of and agreed to their client plan?**

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

- Reference in the client plan to the beneficiary’s participation in the development of and agreement with the client plan;
- The beneficiary’s signature on the client plan; or,
- A description in the medical record (e.g., in a progress note) of the beneficiary’s participation in the development of and agreement with the client plan....” (Cal. Code Regs, tit. 9, § 1810.440 (c)(2)); MHP Contract)

The following is an example of a progress note that would meet the requirement in the case where a client signature on the client plan is NOT required:

- *Client participated in treatment planning meetings on (date) and (date). The client participated in developing their treatment plan goals and interventions; in particular, the goals for (state goal or goals that the beneficiary gave specific input for). The client was satisfied with the client plan and stated verbal agreement at the meeting held on (date).*

**6. Is there a minimum age for a minor (under 18 y/o) to independently sign his/her client plan?**

There is no minimum age for a minor to independently sign a client plan, assuming the client plan is not used to obtain the minor’s consent to treatment. The client plan is a collaborative process between the beneficiary and the provider. The beneficiary should understand what they are signing based on their participation in that process.

**7. Does a beneficiary's signature on his or her client plan have to be dated?**

There is currently no requirement that a beneficiary's signature on his or her client plan be dated.

**8. What if a beneficiary refuses to sign their client plan?**

Each time a beneficiary's signature or the signature of the beneficiary's legal representative is required on a client plan or an updated client plan "and the beneficiary refuses or is unavailable for signature, the client plan [or updated plan] shall include a written explanation of the refusal or unavailability." The written explanation may be on the plan itself or in a progress note. Although not required, it is best practice to make additional attempts to obtain the beneficiary's signature and document the attempts in the client record. (MHP Contract; Cal. Code Regs., tit. 9. § 1810.440 (c)(2)(B))

**9. What is the maximum time period allowed for a provider to complete a beneficiary's client plan? How often must client plans be updated?**

A client plan must be completed prior to service delivery for all planned services. The State Plan requires services to be provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to the State of California requirements. (State Plan, Section 3, Supp. 3 to Att. 3.1-A, page 2c)

The client plan must be updated at least annually or when there are significant changes in the beneficiary's condition. MHPs may require more frequent updates. (MHP Contract)

**10. What is considered a "significant change" in a beneficiary's condition that would require a provider to prepare an updated client plan?**

There is no specific language in regulation or in the MHP contract defining a "significant change" in a beneficiary's condition. Examples may include a beneficiary who has never been suicidal makes a suicide attempt; or, a beneficiary who regularly participates in client plan services suddenly stops coming to appointments. Major life events that might lead to a change in the beneficiary's condition include, but are not limited to: job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), change in residence/living situation.

**11. If a provider treats a beneficiary with only one service modality, is the provider required to prepare a client plan for the beneficiary?**

A client plan is required whether a beneficiary receives only one service modality or multiple service modalities. SMHS are to be provided, “based on medical necessity criteria, in accordance with an individualized Client Plan...” (State Plan, Section 3, Supp. 3 to Att. 3.1-A, page 2c; MHP Contract)

**12. What is the difference between a “proposed intervention” on a client plan and an “actual intervention”?**

Proposed interventions are the services a provider anticipates delivering to a beneficiary when preparing the beneficiary’s client plan. MHPs are required to ensure that client plans “identify the proposed type(s) of intervention/modality...to be provided” to the beneficiary. The actual interventions are those that are actually delivered to a beneficiary. The actual interventions are documented in progress notes.

**13. Can the frequency for delivery of an intervention in a client plan be specified as “PRN,” “as needed,” “ad hoc,” or as a frequency range (i.e., from 1-4 x’s per month)?**

Use of terms such as “as needed” and “ad hoc” do not meet the requirement that a client plan contain a proposed frequency for interventions. The proposed frequency for delivery of an intervention must be stated specifically (e.g., daily, weekly, etc.), or as a frequency range (e.g., 1-4 x’s monthly). Duration must also be documented in the client plan and refers to the total expected timespan of the service (e.g., the beneficiary will be provided with two individual therapy sessions per week for 6 months. (MHP Contract)

**D. PROVISION OF SERVICES PRIOR TO A CLIENT PLAN BEING IN PLACE**

**1. What SMHS can be provided to a beneficiary before his or her client plan is approved?**

Prior to the client plan being approved, the following SMHS and service activities are reimbursable:

- a. Assessment
- b. Plan Development
- c. Crisis Intervention
- d. Crisis Stabilization
- e. Medication Support Services (for assessment, evaluation, or plan development; or *if there is an urgent need, which must be documented*)
- f. Targeted Case Management and Intensive Care Coordination (ICC) (for assessment plan development, and referral/linkage to help a beneficiary obtain

needed services including medical, alcohol and drug treatment, social, and educational services)

**2. What services will be disallowed if, at the time the services were provided, the beneficiary being treated did not have an approved client plan?**

The State Plan requires SMHS to be provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to State of California requirements. An approved client plan must be in place prior to service delivery for the following SMHS:

- a. Mental health services (except assessment, client plan development)
- b. Intensive Home Based Services (IHBS)
- c. Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs
- d. Therapeutic Behavioral Services (TBS)
- e. Day treatment intensive
- f. Day rehabilitation
- g. Adult residential treatment services
- h. Crisis residential treatment services
- i. Medication Support (non-emergency)
- j. Psychiatric Health Facility Services (Cal. Code Regs., tit. 22, § 77073.)
- k. Psychiatric Inpatient Services (Code Fed. Regs., tit. 42, § 456.180(a); Cal. Code Regs tit. 9 §§ 1820.230 (b), 1820.220 (l)(i))

**3. What services are reimbursable during the time that there is a “gap” between client plans?**

A “gap” between client plans results when a client plan has expired and there is an amount of time that passes before the updated client plan is in effect. When there is a gap between client plans those services that can be provided prior to a client plan being approved can be provided and are reimbursable. However, services provided in the “gap” that are services that cannot be provided prior to a client plan being in effect are not reimbursable and will be disallowed.

For TCM, ICC, and Medication Support Services provided prior to a client plan being in place, the progress notes must clearly reflect that the service activity provided was a component of a service that is reimbursable prior to an approved client plan being in place, and not a component of a service that cannot be provided prior to an approved client plan being in place.

**4. Can a provider (or MHP) prepare an initial client plan for a beneficiary in order to begin providing services to that beneficiary prior to completion of a comprehensive client plan?**

Yes, the provider (or MHP) may prepare a client plan within a short period of time of the beneficiary coming into the system or program in order to quickly begin providing services that cannot be provided without a client plan. However, all client plan requirements must be met. The client plan is a dynamic and living document and services can be added over time based on the individual beneficiary's needs.

At a minimum the client plan, even if for just one service, must include:

- a) Specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- b) Proposed type(s) of intervention/modality;
- c) Detailed description of the intervention to be provided;
- d) Proposed frequency and duration of intervention(s);
- e) Interventions that focus and address the identified functional impairments as a result of the mental disorder and are consistent with the client plan goal; and must be
- f) Consistent with the qualifying diagnoses;
- g) Be signed (or electronic equivalent) by the required staff.

For example, if a beneficiary is initially assessed to need day rehabilitation services, the MHP or provider could prepare a client plan that includes day rehabilitation services only, as long as the other client plan requirements are met. As the assessment continues and a comprehensive assessment of the beneficiary is completed, other services would be added to the client plan based on medical necessity and individual client needs.

## **E. PROGRESS NOTES**

### **1. What are the contract documentation requirements for progress notes?**

Documentation requirements for progress notes include the following:

The Contractor shall ensure that progress notes describe how services provided reduced the impairment(s), restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:

- a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
- b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- c) Interventions applied, beneficiary's response to the interventions, and the location of the interventions;
- d) The date the services were provided;
- e) Documentation of referrals to community resources and other agencies, when appropriate;
- f) Documentation of follow-up care, or as appropriate, a discharge summary; and
- g) The amount of time taken to provide services; and
- h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.

**2. What components of medical necessity need to be established and documented in every progress note for each outpatient service?**

Components of medical necessity that must be documented in the progress note include the specific intervention that was provided, how the intervention provided reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the client plan, and the beneficiary's response to the intervention.

While not all components of medical necessity must be documented in a progress note, the progress notes must clearly link the intervention to the identified functional impairment(s), which are as a result of the beneficiary's identified mental health diagnosis.

The interventions should be described in such a way that a reviewer reading the note would be able to determine whether the interventions were clinically appropriate to the impairments and whether there was a reasonable likelihood that the interventions would reduce those impairments, restore functioning, prevent deterioration, or allow developmental progress as appropriate.

**3. Is the use of check boxes acceptable in progress notes and other documentation?**

If allowed by the MHP, the use of check boxes for routine information can be captured by using check boxes; however, use of check boxes would not be adequate or descriptive enough to capture specific individualized information regarding how the intervention reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of

life functioning outlined in the client plan, and the beneficiary's response to the intervention.

- An example of how a check box might be used in a progress note would be to specifically indicate whether services were provided in the beneficiary's preferred language.
- An example of how a check box might be used on the client plan is to indicate that a copy of the client plan was offered to the beneficiary.

**4. How should the use of techniques such as motivational interviewing, unconditional positive regard, empathetic listening, etc., be documented to ensure medical necessity and progress note requirements are met?**

Progress notes documenting the use of evidence-based practices such as motivational interviewing, and techniques such as unconditional positive regard, and empathetic listening should describe how the technique used during the intervention assisted to reduce impairment, restore functioning, allow developmental progress as appropriate, or prevent significant deterioration in an important area of life functioning outlined in the client plan, and the beneficiary's response to the intervention.

**F. MEDICATION CONSENTS**

**1. What are the Medication Consent requirements?**

The MHP shall require providers to obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication. The documentation shall include, but not be limited to: the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and, that the consent, once given, may be withdrawn at any time by the beneficiary. (MHP Contract)

These requirements apply to all beneficiaries. For specific consent requirements applicable to foster children, see Question 5 below. For specific consent requirements applicable to minors generally, see Question 6 below.

Additional requirements for informed consent for antipsychotic medications include:

“A voluntary patient shall be treated with antipsychotic medications only after such person has been informed of his or her right to accept or refuse such medications and has consented to the administration of such medications. In order to make an



informed decision, the patient must be provided with sufficient information by the physician prescribing such medications (in the patient's native language, if possible) which shall include the following:

- (a) The nature of the patient's mental condition;
- (b) The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;
- (c) The reasonable alternative treatments available, if any;
- (d) The type, range of frequency, and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications;
- (e) The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient;
- (f) The possible additional side effects which may occur to patients taking such medications beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued." (MHP Contract)

**2. Can there be more than one medication listed on one form?**

There may be more than one medication listed on a consent form as long as all the required elements are present for each of the medications.

**3. Does a change in dosage require a new consent?**

Yes, a change in dosage would require the beneficiary to sign a new consent form. MHPs may consider using a "dosage range" on the consent form to reduce the frequency with which medication consent forms would need to be changed. (MHP Contract)

**4. Is it acceptable for the medication consent to include an attestation by the physician that the required consent components were discussed with the beneficiary?**

Yes, it is acceptable for the medication consent to include attestations, signed by the provider and the beneficiary, that the provider discussed each of the required components of the medication consent with the beneficiary. For example, a physician may indicate that he or she discussed the type, range of frequency, amount, method (i.e., oral or injection), and duration of the medication(s), rather than specifying, "Prozac, for depression, 10-20mg, p.o BID for 6 months." The provider and beneficiary must sign and acknowledge the statement of attestation.

**5. Does the use of check boxes on the medication consent form indicating that the provider discussed the need for the medication and potential side effects with the beneficiary suffice without listing the specific reasons and side effects?**

The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the beneficiary. The reasons a provider prescribed a medication for a beneficiary must be documented in the beneficiary's medical record, but is not required specifically on the medication consent form.

**6. Do the Court Forms authorizing the administration of psychotropic medication to a foster child (Forms JV-217 through JV-224) suffice to meet the MHP Contract requirement for documenting informed consent to medication?**

The court forms do not currently include all of the required components for informed consent to medication(s); specifically, the court forms do not include information on the method of administration (oral or injection) or additional side effects if the child were to take the medication for more than three months. The method of administration for each medication must be documented in the medical record. The side effects (if the child were to take the medication for more than three months) may be documented in the beneficiary's medical record or may be included in written information about the medication which is provided to the beneficiary or the beneficiary's legal representative. In addition, the beneficiary's and/or the beneficiary's legal representative's signature is required to be on the medication consent form.

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

Under Family Code section 6924 and Health and Safety Code section 124260, children 12 years of age or older may provide legal consent to mental health treatment or counseling on an outpatient basis without the consent of their parent or legal guardian. However, this authority to consent to treatment does not extend to psychotropic medication. Family Code section 6924(f) and Health and Safety Code section 124260(e) clarify that, ***a parent or guardian's consent is needed for a child to receive psychotropic medication.*** In the case of foster children, a court will determine who is authorized to consent to psychotropic medication on the child's behalf. (Welfare and Institutions Code sections 369.5(a) and 739.5(a)). If the medication is not a psychotropic medication and all statutory requirements are met, a child 12 years of age or older may be the sole signatory of a medication consent form.

## **G. LOCATION OF SERVICES**

Rehabilitative Mental Health Services are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency. Mental Health Services, Crisis Intervention, TCM and Medication Support may be provided face-to-face, by telephone, or by telemedicine with the beneficiary or significant support person and may be provided anywhere in the community. (State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c)

### **1. Must there be a reason related to medical necessity documented in progress notes in order to provide services in a location other than a clinic setting?**

It is not necessary to document the reason for providing services in a location other than a clinic setting, e.g., at a beneficiary's home, in a park setting, in a vehicle. Services should be provided in the least restrictive setting.

### **2. Can a provider claim Medi-Cal reimbursement for services provided in a vehicle or while the provider is driving if the intervention is therapeutic, included in the client plan, benefits the client, and documentation meets progress note requirements?**

These services may be claimed as long as the medical necessity criteria are met for the provision of SMHS, the intervention is on the client plan when a client plan is required, and all progress note requirements are met.

## **H. FAMILY THERAPY AND FAMILY COUNSELING**

### **1. How is family therapy defined?**

“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.” (Cal. Code Regs., tit. 9 § 1810.250)

Family therapy is not specifically defined services under Medi-Cal; however, these services may be provided, when medically necessary, and claimed as Therapy. Each beneficiary for which a family therapy claim will be submitted must be present at the therapy session. Progress notes for each therapy session must clearly document how the session focused primarily on reducing each beneficiary's symptoms as a means to improve his or her functional impairments or to prevent deterioration and to assist the beneficiary in meeting the goals of their client plan.

## **2. How is family counseling defined?**

Family counseling is not a specifically defined service under Medi-Cal. However, family counseling may be provided, when medically necessary, and claimed as Collateral, and the beneficiary or beneficiaries may or may not be present at the family counseling session. Progress notes for family counseling sessions must clearly document how the purpose of the session was to meet “the needs of the beneficiary in terms of achieving the goals of the beneficiary’s client plan.” (Cal. Code Regs., tit. 9, § 1810.206)

Collateral is defined as, “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.” (Cal. Code Regs., tit. 9 § 1810.206)

“Significant Support Person” is defined as “persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary’s spouse, and relatives of the beneficiary.” (Cal. Code Regs., tit. 9 § 1810.246.1)

## **3. What is the difference between family therapy and family counseling?**

Family therapy (individual or group) should be claimed under Mental Health Services as “Therapy” not as “Collateral” and the beneficiary must be present. On the other hand, family counseling should be claimed under Mental Health Services as “Collateral” and the beneficiary may or may not be present.

### **I. MULTIPLE PROVIDER SIGNATURES ON PROGRESS NOTES**

#### **1. If multiple staff claims for a group session, does each clinician have to co-sign each client progress note?**

If one progress note is done for a group session it may be signed by one provider. In addition, while one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note must clearly document the specific involvement and the specific amount of time of involvement of each provider

of the group activity, including documentation time. All other progress note requirements must also be met.

Furthermore, when services are being provided “by two or more persons at one point in time, each person’s involvement shall be documented in the context of the mental health needs of the beneficiary.” (Cal. Code Regs., tit. 9 § 1840.314(c))

## **J. CASE CONFERENCES**

### **1. What is the definition of “case conference”? Can a provider bill Medi-Cal for time in a case conference?**

Although the term “case conference” is not specifically defined in the State Plan, MHP contract, or applicable regulations, it may refer to a discussion between direct service providers and other significant support persons or entities involved in the care of the beneficiary. It may be similar or comparable to a multi-disciplinary team meeting. If the case conference concerns the development of a treatment plan for a beneficiary, the conference could be claimed as Plan Development. Similarly, if the term refers to a discussion between multiple providers concerning the assessment of a beneficiary, the conference could be claimed as Assessment. If the discussion between multiple providers concerns coordination of services and linkage or referrals, etc., the conference could be claimed as TCM.

Individual participants claiming for their participation in these types of services (e.g., plan development, assessment, or TCM) must describe their role and involvement in the service. Any participation time claimed, which may include active listening time, must be supported by documentation showing what information was shared and how it can/will be used in planning for client care or services to the client (i.e., how the information discussed will impact the client plan).

## **K. DAY TREATMENT**

### **1. What must be included in the Program Description for a Day Treatment Program?**

Each provider is required to develop and maintain a written detailed program description for both Day Treatment Intensive and Day Rehabilitation programs that must describe the specific activities of the service and reflect each of the required components of the program.

In addition, both Day Treatment Intensive and Day Rehabilitation programs are required to have an established protocol for responding to clients experiencing a mental health

crisis. In most cases, the crisis protocol is included in the Program Description, but it may also be a separate document. The crisis protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other SMHS necessary to address the client's urgent or emergency psychiatric condition (crisis services).

**2. What are the required service components of a Day Treatment Intensive or Day Rehabilitation Program and how often must they occur?**

Day Treatment Intensive/Day Rehabilitation programs must include, at a minimum, the following service components:

- Therapeutic Milieu
  - Community Meetings
  - Process Groups
  - Skill-building Groups
  - Adjunctive Therapies

In addition, Day Treatment Intensive must include psychotherapy (which may be individual or group therapy), an established mental health crisis protocol, and written weekly schedules. Day Rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

In terms of program frequency requirements, community meetings must be conducted at least once per day, and, in the Day Treatment Intensive setting, must include a provider whose scope of practice includes psychotherapy. There are no explicit frequency requirements for other service components of the therapeutic milieu.

**3. What are the requirements related to a Written Weekly Schedule for Day Treatment Intensive/Day Rehabilitation?**

A written weekly schedule is required for both Day Treatment Intensive and Day Rehabilitation Programs and must include all required service components, as well as document when and where all service components of the program will be provided. The schedule must include the program staff delivering each component of the program, including their qualifications and scope of responsibilities. The weekly detailed schedule must be available to beneficiaries and as appropriate to their families, caregivers or significant support persons.

**4. What are the attendance expectations for a beneficiary in a Day Treatment Program?**

The beneficiary is expected to be present for ALL scheduled hours of operation for each day. In addition, a Day Treatment Program consists of the following:

- Half day: Minimum of 3 program hours
- Full day: More than 4 program hours

**5. Can breaks and meal times be counted towards the total required hours of operation?**

No, breaks, including meals, cannot be counted towards the total hours of the daily program.

**6. How is beneficiary attendance in Day Treatment Intensive programs to be documented?**

Providers must document the actual number of hours and minutes a beneficiary attends a Day Treatment Intensive program each day (e.g., 3 hours and 58 minutes).

**7. What can be claimed when a beneficiary attends the program on a given day but must arrive late or leave early due to an “unavoidable absence?”**

Entire full or half days of day treatment/rehabilitation services may be claimed *only if* the beneficiary was present for at least 50% of the program time on a given day and there is a documented reason for an “unavoidable absence” which clearly explains why the beneficiary could not be present for the full program.

Examples include:

- Family emergency,
- Beneficiary became ill,
- Court appearance,
- Appointment that cannot be rescheduled (note needs to explain why an appointment cannot be rescheduled),
- Family event (e.g., funeral, wedding),
- Transportation issues.

In cases where absences are frequent, it is the responsibility of the MHP to ensure that the provider re-evaluates the beneficiary’s need for the day rehabilitation or day treatment intensive program and takes appropriate action.

**8. What are the chart documentation requirements for Day Treatment and Day Rehabilitation?**

The documentation of both Day Treatment Intensive and Day Rehabilitation services shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, date of signature and the total number of minutes/hours the beneficiary actually attended the program.

In addition, Day Treatment Intensive documentation requirements include the following:

- Daily progress note.
- Weekly clinical summary that must be reviewed and signed by an MD, RN, or licensed/waivered/registered psychologist, clinical SW, LPCC or MFT who is either staff to the day treatment intensive program or the person directing the services.
- Monthly – One documented contact with family, caregiver, or significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. Adults may decline this service component. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

Day Rehabilitation documentation requirements include the following:

- Weekly progress note.
- Monthly – One documented contact with family, caregiver, or significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. Adults may decline this service component. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

## **L. CLAIMING FOR SMHS - GENERAL**

### **1. Who can claim Medi-Cal reimbursement for providing SMHS?**

Individuals, groups, and/or organizational providers who have been screened and enrolled (pursuant to 42 C.F.R. §438.214 and 438.602) with the MHP to provide SMHS



may claim for Medi-Cal reimbursement if they are operating within their scope of practice and, if required, under the direction of a licensed mental health professional in accordance with the State Plan. (State Plan, Section 3, Supplement 3 to Attachment 3.1-A; Cal. Code Regs., tit. 9, §§ 1840.314 and 1840.344)

**2. Are claims for services provided to a beneficiary with a substance use disorder reimbursable?**

If there is a co-occurring substance use disorder, interventions are claimable as long as the primary focus of the interventions is to address the functional impairment(s) that is a result of the included mental health diagnosis. The treatment of a beneficiary who has the requisite medical necessity for SMHS is reimbursable through Medi-Cal regardless of the co-occurrence of a substance use disorder. (Cal. Code Regs., tit. 9 §§1820.205(a) (1)(H) and 1830.205)

**3. Can assessment including diagnostic services be claimed when an assessment is in process or when the assessment results in a non-included diagnosis?**

Assessment activities including diagnostic services, are reimbursable by a provider acting within his or her scope of practice when an assessment is in process or when the assessment results in a non-included diagnosis.

**M. CLAIMING FOR SERVICE FUNCTIONS BASED ON MINUTES OF TIME**

**1. Which services are billed based on minutes of time? What requirements apply to claims for those services?**

For the following services, the billing unit is the time of the person delivering the service in minutes of time:

- (1) Mental Health Services
- (2) Medication Support Services
- (3) Crisis Intervention
- (4) Targeted Case Management
- (5) Therapeutic Behavioral Services (TBS)
- (6) Intensive Care Coordination (ICC)
- (7) Intensive Home Based Services (IHBS)

The following requirements apply for claiming of services based on minutes of time:

- (1) The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time

be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.

(2) When a person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

(3) The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity. (Cal. Code Regs., tit. 9 §1840.316)

For example:

- 1) An Licensed Clinical Social Worker (LCSW) provides individual therapy (mental health services) in the Medi-Cal office to a beneficiary for 45 minutes. She spends 12 minutes following the therapy session documenting the interventions provided in a progress note that demonstrates that the interventions address the beneficiary's diagnosis, impairments, and client goals as indicated in the client plan. This documentation time is reimbursable as mental health services. The total time for this service would be 57 minutes (45 for the individual therapy plus 12 minutes for the related documentation).
- 2) An LCSW drives 23 minutes from the MHP clinic or a contract provider site to a beneficiary's home to provide individual therapy (mental health services) for 48 minutes to a beneficiary. Following the intervention, the clinician drives 24 minutes back to the clinic and spends 13 minutes documenting the intervention provided in a progress note in the beneficiary's client record. The travel and documentation time are reimbursable as they are directly linked to providing the mental health service. (i.e.: 48-minute session, plus 47 minutes of travel time, plus 13 minutes of documentation time for a total of 108 minutes).
- 3) A clinician or other staff member drives 15 minutes from their primary office to a beneficiary's school to provide 50 minutes of collateral services (mental health services) to a parent and teacher. Following the intervention, the Marriage and Family Therapist Intern (MFTI) travels 30 minutes to their next community based client. At the end of the day, the MFTI spends 16 minutes documenting the collateral intervention to the client's significant support persons (collateral resources). The travel time to the school (15 minutes), the 50-minute session

and the 16-minute documentation time can be claimed as a collateral service to the first beneficiary for a total of 81 minutes. The 30-minute travel time to the next community-based client would be included in the claim for the service provided to the next beneficiary, including travel time back to the office and documentation time.

- 2. Should the amount of time a provider claims for performing an assessment of a beneficiary be estimated? For example, if a provider conducts a face-to-face assessment of a beneficiary, but does not prepare the written assessment until a later day, should the provider estimate the time it would take to write the assessment and include it in the time claimed for the face-to-face assessment?**

Providers should not estimate the amount of time they spend assessing a beneficiary. Time performing an assessment can either be claimed piece by piece or the time can be totaled and submitted as one claim (e.g., separate claims can be submitted for conducting the face-to-face assessment; for reviewing the beneficiary's records to obtain history, and for writing up the assessment; or, a single claim can be submitted detailing all of these activities).

## **N. CLAIMING FOR GROUP THERAPY**

### **1. How should providers bill for Group Therapy sessions?**

When services are being provided by two or more persons at one point in time, the number of staff group facilitators and the unique involvement of each shall be documented in the context of the mental health needs of the beneficiary. The progress note should include the total number of group participants (Medi-Cal and non-Medi-Cal participants) *and clearly indicate length of group session with documentation time included (or documentation time clearly recorded separately)*. In addition, when multiple providers render a covered service to more than one participant, the total number of minutes of the session must be distributed among the group participants (regardless of payer source), and prorated among the providers at the group session." (Cal. Code Regs., tit. 9 § 1840.314(c); Medi-Cal Billing Manual Chapter 7, section 7.5.5)

The example below demonstrates the approach to use to determine the number of minutes each provider may claim for each Medi-Cal beneficiary participating in the group session.

#### **EXAMPLE 1:**

Set of Facts:

1. Group: 100 minutes
2. Providers: 2
3. Participants: 10
4. Provider 1: renders 100 minutes of a covered service
5. Provider 2: renders 60 minutes of a covered service

Method:

Divide each provider's minutes providing a covered service by the number of group participants.

- Provider 1:  $100/10=10$
- Provider 2:  $60/10=6$

Provider 1 would bill 10 minutes per Medi-Cal beneficiary and provider 2 would bill 6 minutes per Medi-Cal beneficiary.

**EXAMPLE 2: In this example one provider does the progress notes on all 10 beneficiaries documenting the specific involvement of each of the 2 providers as well as the specific service time of each provider and their documentation time**

Set of Facts:

1. Group Session: 100 minutes
2. Providers: 2
3. Participants: 10
4. Provider 1 renders 100 minutes of a covered service
5. Provider 2 renders 60 minutes of a covered service
6. Documentation Time: Provider 1 spends 80 minutes to complete all ten (10) progress note for both providers on all beneficiaries

Method:

- Provider 1: 100 minutes of service time + 80 minutes of documentation time = 180 minutes divided by 10 beneficiaries = 18 minutes
- Provider 2: 60 minutes of service time divided by 10 beneficiaries = 6 minutes

Provider 1 would bill 18 minutes per beneficiary and provider 2 would bill 6 minutes per beneficiary

**EXAMPLE 3: In this example each provider does separate progress notes on all 10 beneficiaries documenting their specific involvement and the amount of service and documentation time**

Set of Facts:

1. Group Session: 100 minutes
2. Providers: 2
3. Participants: 10
4. Provider 1 renders 100 minutes of a covered service
5. Provider 2 renders 60 minutes of a covered service
6. Documentation Time: Provider 1 spends 80 minutes to complete progress notes on all ten (10) beneficiaries and Provider 2 spends 70 minutes to complete progress notes on all ten (10) beneficiaries

Method:

- Provider 1: 100 minutes of service time + 80 minutes of documentation time = 180 minutes divided by 10 beneficiaries = 18 minutes
- Provider 2: 60 minutes of service time + 70 minutes of documentation time = 130 minutes divided by 10 beneficiaries = 13 minutes

Provider 1 would bill 18 minutes per beneficiary and provider 2 would bill 13 minutes per beneficiary.

## **O. CLAIMING FOR TRAVEL TIME**

### **1. Is travel time reimbursable?**

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

- Travel time from a provider site<sup>3</sup> to an off-site location(s) where Medi-Cal SMHS are delivered is claimable. The travel time must be directly linked or related to the services provided which should be clearly documented in the progress note. In addition, the amounts of travel time and service time should each be reflected in the progress note.
- Travel time between provider sites or from a staff member's residence to a provider site may not be claimed.
- Travel time between a staff's home and a beneficiary's home may be claimed as long as the MHP permits such activity and MHP travel

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<sup>3</sup> A "provider site" is defined as a site with a provider number. This includes affiliated satellite sites and school sites."

guidelines are followed. (Cal. Code Regs., tit. 9, § 1840.316(b)(3); Medi-Cal Billing Manual)

## **P. CLAIMING FOR CHART REVIEW**

### **1. Is time spent reviewing a beneficiary's chart reimbursable? For which SMHS and under what circumstances is it reimbursable?**

Record review is reimbursable when performed as part of the following services and service activities:

- Mental Health Services (assessment, plan development, collateral, rehabilitation, therapy)
- Targeted Case Management
- Medication Support Services, and
- Crisis Intervention

Chart review is included in the hourly, half day, full day, or calendar day rate for the following services and cannot be claimed separately:

- Day Treatment Intensive and Day Rehabilitation Services are claimed as either half or full days (Cal. Code of Regs., tit. 9, § 1840.318).
- Adult Residential, Crisis Residential, and Psychiatric Health Facility services are claimed based on calendar days (Cal. Code of Regs., tit. 9, § 1840.320). Crisis Stabilization services are claimed based on hours of time where each one-hour block that the beneficiary receives Crisis Stabilization services shall be claimed (Cal. Code of Regs., tit. 9, § 1840.322). Only twenty (20) hours of Crisis Stabilization services may be claimed in a 24-hour period (Cal. Code of Regs., tit. 9, § 1840.368(c)).

### **2. If a provider reviews a beneficiary's chart, in preparation for a session with a beneficiary, and the beneficiary no-shows, is the time for chart review claimable? If so, can the provider submit a subsequent claim for chart review in preparation of the beneficiary's next appointment?**

Yes, as long as the provider documents the circumstances of the beneficiary no-show, the time spent to review the chart in preparation for the beneficiary's appointment is reimbursable. The provider may submit another claim for chart review prior to the beneficiary's next appointment, as long as the time claimed is reasonable and in preparation for the beneficiary's appointment.

The guidance and clarification provided in this IN will enhance DHCS' efforts to standardize documentation requirements. Consistent understanding and application of uniform minimum standards will improve the overall quality of chart documentation, as well as enhance monitoring and oversight of mental health providers statewide. If you have any questions about the content of this IN, please contact the Lanette Castleman at [Lanette.Castleman@dhcs.ca.gov](mailto:Lanette.Castleman@dhcs.ca.gov).

Sincerely,

Original signed by

Karen Baylor, Ph.D., LMFT, Deputy Director  
Mental Health & Substance Use Disorder Services

Attachment